Warrington
Community Safety Partnership

Executive Summary
Domestic Homicide Review

Name: Tasmin

Died: May 2021

Chair and author: Ged McManus
Supported by: Carol Ellwood Clarke QPM

Date: May 2023

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1 The Review Process

1.1 This summary outlines the process undertaken by the Warrington Community Safety Partnership Domestic Homicide Review panel in reviewing the death of Tasmin, who was a resident in their area. The panel would like to offer their condolences to Tasmin's family on their tragic loss.

1.2 The following pseudonyms have been used in this review to protect the identities of the victim her partner and others referred to in the review.

Name	Who	Age	Ethnicity
Tasmin	Victim	35	White British
Sean - Person of interest [not a subject of the review due to residence in Ireland]	Perpetrator of abuse against Tasmin in Ireland	39	White Irish

1.3 Tasmin was originally from Warrington but moved to Ireland when she was 17 and later married and had children. When that relationship broke down, Tasmin's children stayed with their father. Tasmin entered a relationship with another man known in the review by the pseudonym Sean, where she suffered from severe domestic abuse. Tasmin returned to England and was known to services in three local authority areas. Tasmin briefly went back to Ireland before returning to Warrington in September 2020, following further serious domestic abuse in Ireland. In May 2021, Tasmin took her own life whilst at home. This case illustrates the deep effects that previous domestic abuse and trauma can have on an individual and how it can affect agencies' ability to engage with victims.

1.4 The review considers agencies' contact and involvement with Tasmin from 1 January 2018 until Tasmin's death in May 2021. This time period was chosen to ensure that agency contact with Tasmin was captured when she first returned to the UK from Ireland in 2018. Background information prior to 1 January 2018 is used in the report for context.

1.5 An inquest was opened and adjourned immediately following Tasmin's death. The coroner requested, and was provided with, a copy of an advanced draft of the overview report. The inquest was concluded in April 2023.

The medical cause of Tasmin's death was recorded as:

1 a Multiple Organ Failure
1 b Cardiorespiratory Arrest
1 c Asphyxiation
2 Post Traumatic Stress Disorder, Emotionally Unstable Personality Disorder, Anxiety, and depression.

The circumstances of Tasmin's death were recorded as:

On [date redacted] the police responded to an abandoned 999 call to 35 year old Tasmin. They attended her home and found her on the bathroom floor with a ligature tied around her neck. The ambulance service transported her to Warrington Hospital. She remained in a serious condition until she sadly passed away [time and date redacted].

She had a history of domestic violence with a partner currently based in Ireland. She also had a history of attempts to take her own life.

The conclusion of the coroner, as to the death, was:

Suicide

1.6 Following Tasmin's death in hospital, Cheshire Constabulary were notified. A referral was made by Cheshire Constabulary on 11 May 2021 to the Warrington Safeguarding Adults Board for consideration of a Safeguarding Adult Review, under section 42 of the Care Act 2014. Consultation took place between representatives of the Safeguarding Adult Board and Community Safety Partnership, and it was agreed that a Domestic Homicide Review was the most appropriate form of review for this case.

1.7 The 2016 Domestic Homicide Review statutory guidance[1] says:
'Where a victim took their own life (suicide) and the circumstances give rise to concern, for example it emerges that there was coercive controlling behaviour in the relationship, a review should be undertaken, even if a suspect is not charged with an offence or they are tried and acquitted. Reviews are not about who is culpable'.

[1] www.gov.uk/government/uploads/system/uploads/attachment_data/file/575273/DHR-Statutory-Guidance-161206.pdf

1.8 The Home Office was informed of the review on 1 December 2021. The first panel meeting took place on 16 February 2022.

1.9 In deciding who should be subjects of the review, the panel considered all the information that was known. Tasmin was greatly affected by domestic abuse perpetrated against her in Ireland. Although the offender, Sean, is known and has been convicted of offences in Ireland, the panel chose not to make him a subject of the review. This decision was because the offending behaviour took place outside the United Kingdom, and the panel judged that it was not possible to effectively conduct a review outside the jurisdiction of the legislation and statutory guidance for DHRs.

1.10 During the timescale of the review, Tasmin was also known to have a had a brief relationship in Cambridgeshire in which domestic abuse was reported. The panel chose to take this information into account in the review but did not think it was useful to make the other party subject to the review – as the relationship was brief and Tasmin went on to have further trauma in Ireland before latterly returning to Warrington.

1.11 The panel was clear that whilst all information available to the review should be taken into account, their main focus should be on events that took place in Warrington in the last year of Tasmin's life, as this was most likely to produce contemporaneous learning capable of improving services.

1.12 DHR panel meetings took place using Microsoft Teams video conferencing, and the panel met seven times. Outside of meetings, issues were resolved by emails and the exchange of documents. The final scheduled panel meeting took place on 21 February 2023. After which, minor amendments were made to the report that were agreed with the panel by email.

1.13 The report was then shared with Tasmin's family via their advocate. After an extensive period of consolation, they did not wish to provide detailed feedback or discuss the report further, as they found it too emotionally difficult to do so. The advocate provided some feedback on their behalf. Consequently, minor amendments were made to the report.

2 Contributors to the Review

2.1

Agency	Contribution
Lancashire Constabulary	Short report
Lancashire and South Cumbria NHS Foundation Trust (LSCFT)	Chronology
Lancashire Victims Services	IMR
Lancashire and South Cumbria Integrated Care Board (on behalf of West Lancashire GP)	IMR
Mountain Healthcare (Cambridgeshire Sexual Assault Referral Centre)	Chronology
East of England Ambulance Service	Chronology
North West Anglia NHS Foundation Trust	Chronology
Cambridge and Peterborough NHS Foundation Trust	Chronology
Cambridgeshire Constabulary	Chronology
Cambridgeshire GP	Chronology
Cheshire Constabulary	IMR
North West Ambulance Service	IMR
Warrington and Halton Hospitals NHS Trust	IMR
Warrington Borough Council Families and Wellbeing Department	IMR
North West Boroughs Healthcare NHS Foundation Trust [now part of Mersey Care NHS Foundation Trust]	IMR
Warrington GP	IMR
Warrington Borough Council Housing	IMR

Department	
Refuge Warrington IDVA Service	IMR
Cheshire and Merseyside RASAC	Chronology

2.2 The panel obtained information from agencies in Cambridgeshire, Lancashire, and Warrington. An Garda Siochana, Ireland's National security and police service, declined to share information with Warrington Community Safety Partnership for the purposes of the review. The request was made in order to obtain background information. Furthermore, because Tasmin suffered domestic abuse whilst in Ireland during the time period of the review, the panel thought it relevant to obtain as much information as possible. An Garda Siochana suggested that a request from Cheshire Constabulary, via Interpol, would be considered. Therefore, Cheshire Constabulary made a request for information through Interpol on behalf of the DHR. Towards the end of the DHR process, Cheshire Constabulary received a brief response from An Garda Siochana, which confirmed that Tasmin and Sean were known to An Garda Siochana and that there had been an abusive relationship. No further details were shared.

2.3 The Community Safety Partnership also wrote to domestic abuse services in Ireland, in the area where Tasmin lived. They confirmed that they had no record of engagement with her.

3 The Review Panel Members

3.1

Ged McManus	Chair and Author
Carol Ellwood Clarke	Support to Chair and Author
Claire Powell	Area Manager, Victim Support
Damian McAlister	Review Officer, Lancashire Constabulary
Lorraine Elliott	Designated Lead Nurse for Safeguarding Adults & MCA, Lancashire and South Cumbria Integrated Care Board

Cherry Collinson	Safeguarding and MCA Named Professional, Lancashire and South Cumbria NHS Foundation Trust
Cathy Fitzgerald	Head of Service – Addictions, Homelessness and Chaotic Lifestyles, Warrington Borough Council
Julie Ryder	Designated Nurse for Safeguarding Adults, NHS Cheshire and Merseyside Integrated Care Board, Warrington Place
Katie Mowe / Nicky Brown	Case Review Officers, Cheshire Constabulary
Martina Palmer	Service Manager, Refuge Warrington IDVA Service
Nick Woods	Advanced Practitioner, Safeguarding Adults, Mersey Care NHS Foundation Trust
Thara Raj	Director of Public health, Warrington Borough Council
Michelle Greenwood	Head of Adult Safeguarding and Quality Assurance, Warrington Borough Council
Jaria Hussein-lala	Domestic Abuse Safeguarding Manager, Warrington Borough Council
Theresa Whitfield	Head of Strategic Support & Coordination, Warrington Borough Council
Wendy Turner	Lead Nurse for Adult Safeguarding, Warrington and Halton Teaching Hospitals NHS Foundation Trust

Emma Foley	Adult Safeguarding Lead Practitioner North West Anglia NHS Foundation Trust
Ann Woods	Homelessness & Housing Advice Manager, Warrington Borough Council
Susan Hewitt	Safeguarding Practitioner, North West Ambulance Service NHS Trust
Vickie Crompton	Domestic Abuse & Sexual Violence Partnership Manager, Cambridgeshire & Peterborough

3.2 The review Chair was satisfied that the members were independent and did not have any operational or management involvement with the events under scrutiny.

4 Chair and author of the overview report

4.1 Sections 36 to 39 of the Home Office Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews December 2016, set out the requirements for review Chairs and Authors.

4.2 Ged McManus was chosen as the Chair and Author of the review. He is an independent practitioner who has chaired and written previous DHRs and Safeguarding Adult Reviews. He has experience as an Independent Chair of a Safeguarding Adult Board (not Cheshire) and was judged to have the skills and experience for the role. He served for over thirty years in different police services in England (not Cheshire). Prior to leaving the police service in 2016, he was a Superintendent with particular responsibility for partnerships, including Community Safety Partnership and Safeguarding Boards.

4.3 Carol Ellwood Clarke supported the Chair of the review. She retired from public service (British policing, not Cheshire) in 2017, after thirty years, during which she gained experience of writing Independent Management Reviews, as well as being a panel member for Domestic Homicide Reviews, Child Serious Case Reviews, and Safeguarding Adults Reviews. In January 2017, she was awarded the Queens Police Medal (QPM) for her policing services to Safeguarding and Family Liaison. In addition, she is an Associate Trainer for SafeLives[2].

[2] A UK-wide charity dedicated to ending domestic abuse.

4.4 Between them, they have undertaken over sixty reviews including the following: child serious case reviews; Safeguarding Adult Reviews; multi-agency public protection arrangements (MAPPA) serious case reviews; Domestic Homicide Reviews; and, have completed the Home Office online training for undertaking DHRs. They have also completed accredited training for DHR Chairs, provided by AAFDA[3].

4.5 Neither of them has worked for any agency involved in this review.

5 Terms of Reference

5.1 The purpose of a DHR is to:

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

Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result;

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

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;

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

Highlight good practice.

(Multi-Agency Statutory guidance for the conduct of Domestic Homicide Reviews 2016 section 2 paragraph 7)

5.2 Timeframe under Review

The DHR covers the period 1 January 2018 to Tasmin's death in May 2021.

[3] Advocacy After Fatal Domestic Abuse.

5.3 **Subjects of the DHR**

Victim: Tasmin, aged 35 years

Person of interest [not a subject of the review due to residence in Ireland]

Perpetrator of abuse against Tasmin in Ireland: Sean.

Specific Terms

1. What indicators of domestic abuse, including coercive and controlling behaviour, did your agency have that could have identified Tasmin as a victim of domestic abuse, and what was your response?

2. What risk assessments did your agency undertake for Tasmin, and what was the outcome? Were risk assessments accurate and of the appropriate quality?

3. What consideration did your agency give to any mental health issues or substance misuse when identifying, assessing, and managing risks around domestic abuse?

4. What knowledge did your agency have that indicated Tasmin could be at risk of suicide as a result of any coercive and controlling behaviour?

5. What services did your agency provide for Tasmin; were they timely, proportionate, and 'fit for purpose' in relation to the identified levels of risk, including the risk of suicide?

6. Did your agency consider that Tasmin could be an adult at risk within the terms of the Care Act 2014? Were there any opportunities to raise a safeguarding adult concern and request or hold a strategy meeting?

7. How did your agency ascertain the wishes and feelings of Tasmin, and were her views considered when providing services or support?

8. Were single and multi-agency policies and procedures, including the MARAC and MAPPA protocols, followed? Are the procedures embedded in practice, and were any gaps identified?

9. Were there any barriers to sharing information with, or receiving information from, agencies outside your area? What did you do to overcome them?

10. What knowledge did family, friends, and employers have that Tasmin was in an abusive relationship, and did they know what to do with that knowledge?

11. Were there any examples of outstanding or innovative practice?

12. What learning did your agency identify in this case?

13. Were there issues in relation to capacity or resources in your agency that impacted on its ability to provide services to Tasmin, or on your agency's ability to work effectively with other agencies? Did Covid-19 related work practices affect your response?

14. Was the learning in this review similar to learning in previous Domestic Homicide Reviews commissioned by Warrington Community Safety Partnership?

6 Summary chronology

6.1 Relevant History Prior to the Timeframe of the Review

6.1.1 Tasmin was one of three siblings. She was born and spent her early years in Warrington. As a child growing up, Tasmin was described as 'fearless' and strong-willed, whose nickname was 'Taz' – deriving from the cartoon character 'Tasmanian devil'.

6.1.2 Tasmin had a horse as a teenager and did not particularly focus on school. After leaving school, Tasmin worked for a florist. Her mum recalls that as a teenager, there were several incidents where Tasmin self-harmed by taking overdoses of over- the-counter medication.

6.1.3 When she was 17 years of age, Tasmin made contact with her maternal grandfather, with whom she had not had significant previous contact. This led to her moving, on her own, to live in Ireland to be near to him.

6.1.4 Tasmin then made her life in Ireland. She became a talented cook and worked in the kitchens of a number of pubs and restaurants. It was in Ireland where Tasmin met and married her husband. The couple built their own house on land

owned by her husband's family and went on to have two children, who were secondary school age at the time of Tasmin's death.

6.1.5 Tasmin's husband told the DHR Chair that Tasmin became pregnant soon after they got together. She was unwell after the pregnancy and did not often leave the house. Tasmin went to her local GP on many occasions but did not receive specialist treatment (to her husband's knowledge). The issues were repeated again after the birth of the couple's second child (two years later). Tasmin's husband did not know whether Tasmin's illness had a physical or mental cause. The couple got married in 2012.

6.1.6 Tasmin's husband told the DHR Chair that he had an extra marital affair, which resulted in a child being born. This resulted in the breakdown of his relationship with Tasmin, and he left the family home whilst she stayed there with the children for some time. Tasmin's husband said that she sometimes took medication, resulting in overdose and admission to hospital. Whilst they were living together, Tasmin had sometimes written suicide notes.

6.1.7 Tasmin asked her husband to 'buy her out' of the property, which resulted in him paying Tasmin a settlement of 50,000 Euros. The couple's childcare arrangements were complicated. Initially, Tasmin looked after the children, with her husband having them Wednesday's and every other weekend. Tasmin then took the children to live in England briefly. When they returned to see their father for a holiday, they stayed with him in Ireland. Tasmin then returned to Ireland and stayed with the family for a few weeks before moving into her own property.

6.1.8 Tasmin and her husband had a series of court appearances regarding custody of the children. Her husband told the DHR Chair that, in 2017, Tasmin was unable to cope with the children and asked the court to award custody to him. After that, Tasmin visited them every two or three months. The children had their own phones and were able to talk to Tasmin when she contacted them.

6.2 Events within Timeframe of Review

6.2.1 Ireland – April 2018

According to press reports, Tasmin was arrested for stabbing Sean. It is reported that Tasmin said that she had stabbed Sean in the leg in self-defence. It is reported that no action was taken against her as Sean did not make a complaint to the Garda.

Following the decision of An Garda Siochana not to share information, the DHR panel has not been able to independently verify this information.

6.2.2 Ireland – 25 August 2018

According to press reports, Tasmin was assaulted by Sean in a pub and later at home when he poured solvents on her and tried to set her on fire. He then dragged her outside and hit her several times with a plastic fuel container.

The DHR panel understand that after this incident, Tasmin left Ireland and moved to England. The reason for her moving was to flee domestic abuse.

6.2.3 On 5 September 2018, Tasmin saw a GP in Lancashire. The notes of the consultation show that she disclosed domestic abuse, which had happened in Ireland. She had bruising to the ribs and marks on her neck from possible strangulation. She was referred to Mindsmatter (the local Improving Access to Psychological Therapies service) and given information about the local women's refuge service. The referral to Mindsmatter was not progressed because by the time it was processed, Tasmin was open to mental health services.

6.2.4 On 10 September 2018, whilst visiting her family in Warrington, Tasmin was taken to Warrington Hospital [Warrington and Halton Hospitals NHS Foundation Trust], by ambulance, after she suffered suicidal ideation. Tasmin was seen by mental health practitioners [North West Boroughs NHS Foundation Trust – now Mersey Care NHS Foundation Trust] and disclosed an extensive history of domestic abuse in Ireland. The outcome of the assessment was that significant life events had led to feelings of hopelessness and suicidal ideation. No protective factors were identified, Tasmin had no contact with her children, and she could see no reason for not ending her life, particularly as her ex-partner may get bail and be released the following day and come looking for her. Tasmin believed this was highly likely as she had received threatening messages from his friends. Tasmin stated that she would end her life by jumping in the river. Due to this, the mental health nurse felt that Tasmin would be best managed by admission to a mental health bed. No mental health bed was available, and Tasmin remained at Warrington Hospital awaiting a placement.

6.2.5 On 14 September 2018, Tasmin was transferred to a local crisis house where she was visited every day by the Lancashire and South Cumbria NHS Foundation Trust (LSCFT) Home Treatment Team.

6.2.6 On 26 September 2018, Tasmin was discharged from the crisis house to her father's address, where she was visited by the LSCFT Home Treatment Team. A DASH risk assessment was completed: this indicated a high risk, and a referral to MARAC was made.

6.2.7 On 2 October 2018, Tasmin attended a police station in Cambridgeshire to report that her ex-partner, who lived in Ireland and was on bail for a serious assault on her, was breaching his bail by contacting her via Snapchat. He had threatened to find where she was and threatened to set her father's house on fire. A DASH risk assessment was completed. This was initially graded as medium; however, the risk was upgraded to high by the MASH, and a referral to MARAC was made. The crime regarding threats to destroy property, was transferred to the Garda. Tasmin said that her ex-partner did not know where she was living in Cambridgeshire.

6.2.8 On 3 October 2018, Lancashire Constabulary received a MARAC referral for Tasmin from West Lancashire Mental Health Home Treatment Team.

The referral stated that Tasmin had fled serious domestic abuse in Ireland and was now residing with her father at an address in Lancashire. No criminal offences were alleged to have occurred within Lancashire. Following appropriate checks, the case was graded as high risk. It was shared appropriately with the IDVA for ongoing support and divisional Public Protection Unit.

A vulnerable marker was placed on her father's' address, detailing the risk. Furthermore, the case was listed to be heard at West Lancashire MARAC on 7 November 2018 (this was later cancelled).

6.2.9 On 5 October 2018, an officer from Lancashire Police spoke with Tasmin, who confirmed she was currently living between her father's address in Lancashire and her mother's address in Cambridgeshire. It was confirmed that Cambridgeshire Constabulary were aware of this fact. Tasmin stated she felt safer in Cambridgeshire, as that address was not known to Sean (in Ireland). Further contact was made with Tasmin on 12 October 2018. She confirmed that she was now residing solely at her mothers' address.

6.2.10 On 8 October 2018, Tasmin's case was heard at Cambridgeshire MARAC. Actions were:

For the police to update MARAC partners on their investigation. Action completed.

For an IDVA to contact Tasmin. This was initially unsuccessful, but an IDVA did meet Tasmin in person on 17 October. Action completed.

6.2.11 On 10 October 2018, after an earlier call was unsuccessful, a Lancashire IDVA spoke to Tasmin. Tasmin said that she had moved to her mother's address in Cambridgeshire as she felt safer there. A MARAC-to-MARAC transfer was made by Lancashire Constabulary to Cambridgeshire Constabulary, and the case was removed from the West Lancashire MARAC list. Tasmin was given contact details for the Lancashire IDVA service in case she needed support in the interim.

Throughout early October, the LSCFT Home Treatment Team continued to be in touch with Tasmin by telephone. Tasmin said that she had moved to Cambridgeshire and decided to stay there. She felt much better and had registered with a local GP. It was agreed to discharge her from LSCFT services.

6.2.12 On 12 October 2018, Tasmin took an overdose of prescribed medication whilst at her mother's house in Cambridgeshire. She was taken to the emergency department of North West Anglia NHS Foundation Trust, by ambulance, and received appropriate medical treatment. She was then admitted to a mental health ward at a different site managed by Cambridgeshire and Peterborough NHS Foundation Trust. A DASH risk assessment was conducted, which scored 25. She was discharged on 16 October 2018. She was then followed up by the Crisis Resolution Home Treatment Team until she was discharged from that team on 29 October 2018.

6.2.13 On 17 October 2018, after several attempts by the Cambridgeshire IDVA to contact her, Tasmin agreed to see the IDVA: they met at Tasmin's mother's house. Tasmin said that she was concerned as her ex-partner in Ireland had links to the IRA. She said that her phone had been blocked – the IDVA offered to provide a new phone. Tasmin said that she had applied for housing and was starting training for a role as a carer. The IDVA was then in regular contact with Tasmin, by telephone. Not every contact is listed here.

6.2.14 On 16 November 2018, Tasmin called the IDVA. She said that she had been told by the Garda that she was expected to appear at a bail hearing for her ex-partner on 12 December 2018. The Garda informed Tasmin that if she didn't appear, then he would be released from his bail. She was advised to ask if a video link was possible.

6.2.15 On 17 November 2018, a call was received by Cambridgeshire Constabulary that Tasmin had taken an overdose of both paracetamol and ibuprofen. She was

concerned in relation to the impending trial relating to her ex-partner in Ireland. Tasmin was detained under Section 136 of the Mental Health Act and taken to hospital. Tasmin was admitted, as a voluntary patient, to a mental health ward managed by Cambridgeshire and Peterborough NHS Foundation Trust. She self-discharged the following day and was followed up by the Crisis Resolution Home Treatment Team until she was discharged from that team on 23 November 2018. She was signposted to the local drugs and alcohol service.

6.2.15 On 19 November 2018, Tasmin called the Cambridgeshire IDVA and told them of the incident of 17 November. Tasmin said that she had taken the overdose because her ex-partner had contacted her on Snapchat, saying he knew where she was living. The IDVA advised her to visit her GP and emailed the police to notify the contact made by the ex-partner.

6.2.16 On 8 December 2018, an East of England Ambulance Service crew came across Tasmin in a distressed state. She reported a domestic abuse assault from her boyfriend of three months. The ambulance crew reported the matter to the police and took Tasmin to an ambulance station where she was seen by officers from Cambridgeshire Police. A DASH risk assessment was completed, which showed a medium risk. The suspect was arrested and interviewed, but there was insufficient evidence to charge him due to conflicting accounts and there being no independent or corroborating evidence. Tasmin's family told the Chair of the review that they were aware of the relationship and that the man had stayed briefly at their home; however, they had asked him to leave. Although they were not aware of the specific incident described here, there were other incidents, including the man pawning a ring belonging to Tasmin. They were both banned from a local pub for allegedly taking cocaine.

6.2.17 On 30 December 2018, Tasmin jumped into a river in Cambridgeshire. She had consumed a significant amount of alcohol and taken an overdose of prescription medication. She was pulled from the water by the Fire and Rescue Service and taken to hospital by ambulance. Tasmin stayed on a mental health ward, managed by Cambridgeshire and Peterborough NHS Foundation Trust, until 4 January 2019. She then discharged herself.

6.2.18 On 31 December 2018, the IDVA service received notification from Cambridgeshire Constabulary of Tasmin's self-harm the previous day. The case was referred to MARAC on professional judgement.

6.2.19 On 7 January 2019, Tasmin's case was heard at Cambridgeshire MARAC. The single action was for the IDVA to confirm if Tasmin had contact with her children,

where they lived, and with whom. This was actioned by 8 January 2019, with the following information: the children lived with their father in Ireland, and Tasmin did not currently have contact with them.

6.2.20 On 9 January 2019, Tasmin reported a rape to Cambridgeshire Constabulary. She was taken to the emergency department of North West Anglia NHS Foundation Trust for medical treatment. At this time, Tasmin put a ligature around her neck whilst in the women's toilets. She was found and treated for her injuries.

Following extensive liaison between services and with appropriate safety measures in place, Tasmin then agreed to attend the local Sexual Assault Referral Centre, where a forensic medical examination took place.

Tasmin was then admitted to a mental health ward (at a different site managed by Cambridgeshire and Peterborough NHS Foundation Trust) until 16 January 2019, when she self-discharged against advice. At that time, Tasmin was not legally detainable under the Mental Health Act and declined any further input from mental health services.

6.2.21 On 20 February 2019, the Lancashire GP received a summary of Tasmin's notes from the Cambridgeshire GP. Tasmin was seen and requested medication – as she had taken an overdose and didn't now have medication. This was confirmed and medication was then prescribed on a weekly basis in an attempt to limit the risk of a further overdose. It was confirmed that Tasmin was living with her father. The GP made an urgent referral to LSCFT mental health services. LSCFT made contact with Tasmin the same day and booked an assessment for 22 February.

6.2.22 On 22 February 2019, Tasmin was seen for an assessment by LSCFT. She said that she had been in Ireland where she had taken an overdose and jumped in a canal, resulting in a five-day admission to hospital. Sean had visited her in hospital to ask her to drop the charges against him. She was seeing her children less than once a week on a video call, as her ex-partner controlled access. Tasmin said that she was suffering trauma-related flashbacks. A further appointment was booked with a psychologist for 2 May.

6.2.23 On 25 February 2019, Tasmin called the Cambridgeshire IDVA. Tasmin said that she had moved to her father's address in Lancashire.

6.2.24 On 27 February 2019, Lancashire Constabulary received a MARAC-to-MARAC transfer from Cambridge Constabulary. The referral recorded Tasmin as a victim

of serious domestic abuse, within the Cambridge force area. No offences were alleged to have occurred within Lancashire. Tasmin was recorded as residing at her father's address in Lancashire. The case was listed to be heard at West Lancashire MARAC on 3 April 2019.

On 3 April 2019, the case was discussed. Concerns were shared regarding Tasmin's location and that of her children. Her two children were confirmed as residing in Ireland with their father.

The following actions were allocated:

1. IDVA to contact Tasmin and offer support. Text messages were sent on 09/04/2019, but there was no response.
2. Information to be shared with Detective Sergeant via email. Action is shown as completed, in that an email was sent. Due to Lancashire Constabulary's force email retention policy, it has not been possible to confirm the content of that email.

Tasmin's case was referred to the Lancashire IDVA service, but they were unsuccessful in contacting her and closed the case after they had tried to contact her three times – in line with the contract that they are commissioned to deliver.

6.2.25 On 19 April 2019, whilst visiting Warrington, Tasmin took an overdose of prescribed medication, together with alcohol and cocaine. An ambulance was called, and she was taken to Warrington Hospital. Following a detailed assessment by a mental health nurse [North West Boroughs NHS Foundation Trust – now Mersey Care NHS Foundation Trust], admission to hospital was not thought necessary. Contact was made with West Lancashire Mental Health Services, who confirmed that Tasmin was known to them, and a referral was made to the LSCFT Home Treatment Team in Lancashire, where Tasmin was living with her father.

6.2.26 On 21 April 2019, Tasmin attended an appointment for an assessment with the LSCFT Home Treatment Team. For continuity, she was seen by the same practitioner that had previously worked with her. Tasmin said that the court case in Ireland had been scheduled for the end of May. She had been told by the Garda that she needed to attend to give evidence, which she didn't feel emotionally well enough for. Cambridgeshire Police had advised her it wouldn't be safe for her to return to Ireland, but she had worries that a warrant would be issued for her arrest if she didn't. Tasmin denied any plans to harm herself. An enhanced risk assessment was completed, and it was agreed that the next contact would be the planned appointment with a psychologist on 2 May. Tasmin

was signposted to local domestic abuse services.

6.2.27 On 1 May 2019, Tasmin contacted LSCFT to cancel her appointment for the following day – as she was going on holiday to Ireland – and would get in touch to make another appointment when she got back. This was the last contact LSCFT had with Tasmin.

6.2.28 On 2 June 2019, after a number of failed contacts, Cambridgeshire Police spoke to Tasmin, by telephone, in relation to the rape of January 2019. She said that she had moved to Ireland and did not wish to progress the case any further.

6.2.29 On 2 January 2020, Tasmin attended at Warrington Hospital, following an overdose. She was admitted to the hospital for observation in relation to physical symptoms of an overdose. She was reviewed by the mental health liaison team [North West Boroughs NHS Foundation Trust – now Mersey Care NHS Foundation Trust] the following day. Tasmin said that she had moved to Warrington three weeks ago to live with her mother, as she had started a full-time job as a chef in a local hotel. The record noted that there were no financial issues or housing issues, and she was currently single. Tasmin said that she had consumed a lot of alcohol and had no recollection of the overdose. Her ex-partner in Ireland had contacted her by social media, asking her to drop a court case. She planned to make contact with the local IDVA service to get support. Tasmin stated that she often snapped when she got upset and voiced a long history of emotional instability. She explained that everything "got on top of her recently" but stated that she now had plans to get support from Talking Matters (the local Improving Access to Psychological Therapies service) and was awaiting an appointment after self-referring 3 weeks ago. Tasmin also agreed to a referral to Outreach – for social inclusion, anxiety management, and confidence building. Tasmin identified that her confidence and self-esteem had taken a blow due to being in the violent relationship previously for three years. Tasmin stated that she had a diagnosis of anxiety, depression, PTSD from previous abuse/bullying, and EUPD.

6.2.30 On 8 January 2020, Tasmin registered with a Warrington GP. She attended a new patient check on 22 January, where she was given information about local mental health services. She was prescribed 60 x quetiapine 2.5mg tablets (two at night) and 28 x zopiclone 3.75mg tablets (one to be taken at night).

6.2.31 On 2 February 2020, Tasmin was detained under Section 136 of the Mental Health Act by Cheshire Constabulary. She was taken to a mental health hospital 136 Suite managed by North West Boroughs NHS Foundation Trust [now Mersey Care NHS Foundation Trust] due to her being on the wrong side of a bridge over

the River Mersey. She was making threats to jump and end her life, and the police were contacted by members of the public.

A Mental Health Act Assessment was requested and later completed by an Approved Mental Health Practitioner and two doctors. During the assessment, Tasmin reported that a culmination of factors had made her feel depressed and had worsened her PTSD symptoms within the past month: these included her children cutting contact with her and an upcoming court case due to being the victim of domestic violence and sexual abuse. Tasmin said that she had been experiencing more frequent flashbacks of the trauma, which were particularly worse at night-time. She agreed to an informal admission to a mental health ward.

Tasmin stayed in hospital until 27 February. Whilst in hospital, she was contacted by an officer from Garda asking her to attend court in Ireland. Staff provided evidence of her hospitalisation to the Garda. Prior to her discharge, a referral was made to the Refuge IDVA service and the local drug and alcohol service. [there is no record of Tasmin engaging with the drug and alcohol service].

6.2.32 On 26 February 2020, the Refuge Warrington Domestic Abuse service, which provides the IDVA service for Warrington, received a referral for Tasmin from North West Boroughs NHS Foundation Trust [now Mersey Care NHS Foundation Trust]. Calls were made to the number provided for Tasmin, on five separate occasions. The IDVA spoke to Tasmin during the first call. Tasmin said that she was discharged from the hospital and asked for a call back. Following this, the IDVA made a further four calls. During the third call, the message on the phone stated that the phone number was no longer in use. A few days later, the IDVA called Tasmin again on the same number. The call was unanswered. No messages were left on Tasmin's answerphone. On two separate occasions, the IDVA sought alternative contact details from the referrer, but no numbers were provided. The case was closed due to Tasmin being non-contactable.

6.2.33 On 28 February 2020, Tasmin was seen by the Mental Health Home Treatment Team. A plan was agreed for Tasmin to engage with drugs and alcohol support and to discuss her anxiety symptoms with her GP. A telephone follow-up was planned for the following week.

6.2.34 The Mental Health Home Treatment Team phoned Tasmin on 7, 9 and 10 March 2020, with no answer. A letter was hand delivered to her address, and a further phone call was made on 13 March 2020, with no answer. Tasmin was then discharged from the Home Treatment Team.

6.2.35 On 15 March 2020, Tasmin was detained under Section 136 of the Mental Health Act by Cheshire Constabulary. She was taken to a mental health hospital 136 Suite managed by North West Boroughs NHS Foundation Trust [now Mersey Care NHS Foundation Trust]. Tasmin had jumped from a bridge into the river Mersey. When officers entered the water to rescue her, she resisted and attempted to swim away. She was retrieved from the water.

Tasmin was reviewed by two doctors and the AMHP for the Mental Health Act Assessment. She initially refused to engage. She presented as tearful and very distressed. Tasmin told them that she had not informed her mother of the incident and if her mother found out, she would 'kick her out and become homeless', which would increase the risk. It is documented that Tasmin presented as a high risk to herself, and the risk needed to be managed in a safer environment such as hospital. Tasmin was detained under Section 2 of the Mental Health Act, and an out-of-area bed was found for her as there were no beds locally.

6.2.36 On 21 March 2020, Tasmin was transferred back to a local hospital in Warrington managed by North West Boroughs NHS Foundation Trust [now Mersey Care NHS Foundation Trust]. Tasmin discussed her recent home situation and contact from her ex-partner, which had made her feel very down and anxious. She also discussed how she had been unable to obtain her medication from her GP, as the surgery had not received a discharge summary from the ward: this made her feel like she could no longer cope with life. She stated that she had not planned to jump off the bridge, and that it was an impulsive act; however, she also stated that she was sad that it had not succeeded. Tasmin said that her stepfather reminded her of her ex-partner in the way that he speaks to her; however, she stated that there was no history of abuse in the relationship with her stepfather.

6.2.37 On 23 March 2020, Tasmin was reviewed by a consultant psychiatrist. She was euthymic in mood. She said that she planned to return to education and attend college, once discharged from hospital. She denied suicidal ideation and any further plans to harm herself or end her life. Her detention under the Mental Health Act was rescinded, and Tasmin was discharged from hospital. The following actions were recorded:
1) Discharge from [redacted] Ward this afternoon.
2) 7 days' worth of prescribed medication to be provided.
3) Emergency contact numbers for mental health services to be provided to Tasmin, should her mental state decline following discharge.

4) Referral to HTT to be completed. HTT informed that Tasmin will require 72hr follow- up once discharged.
5) Tasmin's father will collect her from the ward this evening.

6.2.38 On 25 March 2020, the Home Treatment Team contacted Tasmin's father after being unable to contact her. He confirmed that she was staying with him (in Lancashire). The team spoke to Tasmin later in the day. She said that she was planning to stay with her father for a while. There were no immediate risks identified, and Tasmin was discharged. She was encouraged to register with a local GP. Tasmin then had no contact with services in England until 21 September. It seems that during that time, she went to live in Ireland. After 21 September 2020, Tasmin was primarily engaged with services in Warrington.

6.2.39 On 6 April 2020, Tasmin posted photographs of her tattoos on social media. One reads:

"You never know how strong you are until being strong is the only choice you've got"

6.2.40 Tasmin's family told the Chair of the review that in September 2020, they received a telephone call from an officer from An Garda Siochana telling them that Tasmin had been the victim of an assault and that she wanted to leave Ireland. She was taken to Dublin by officers from Garda and got the ferry to England. She then moved in with her mother and stepfather.

6.2.41 On 21 September 2020, Cheshire Constabulary received a concern for safety call from a friend of Tasmin's, as she had contacted them to say that she was standing on a bridge. Tasmin was said to have recently returned from Ireland. Officers located Tasmin, who was on the wrong side of a bridge, climbing down towards the water. Tasmin went into the water and was recovered on a boat by the Fire and Rescue Service. She was detained under Section 136 of the Mental Health Act and taken to A&E at Warrington Hospital for a medical review and X-rays.
She was then transferred to a Section 136 Suite managed by North West Boroughs NHS Foundation Trust [now Mersey Care NHS Foundation Trust]. She was detained under Section 2 of the Mental Health Act and admitted to a ward.

Whilst at the hospital, Tasmin made a series of disclosures of serious domestic abuse in Ireland over recent weeks, including coercive and controlling behaviour, false imprisonment, and rape. The suspect was said to have remained in Ireland and was believed to be unaware of Tasmin's location. The offences had been reported to the Garda prior to Tasmin leaving Ireland to come to the UK on 19

September 2020. Tasmin's first disclosure to officers from Cheshire Police was captured on body worn video.

Officers from Cheshire Police's specialist Public Protection Directorate (PPD) were tasked with assisting the Garda in evidence gathering for their investigation, and when Tasmin was deemed fit to be spoken to, officers attended at the hospital to obtain her account and an early evidence kit.

Tasmin said that she had been in an on/off relationship with her ex-partner for the last 3-4 years, whilst living in the Republic of Ireland. She said that during their relationship, he raped her and assaulted her on numerous occasions, most recently in the early hours of Thursday 17 September 2020.

Tasmin provided details of the most recent allegation of rape and said that she could not leave until the Saturday because Sean had taken all of her clothes. She finally left on the Friday and went straight to the Garda station to report the incident.

Tasmin said that she came to Warrington as this was where she was from and where her mother lived. She had fled Ireland on Saturday night (19 September 2020) and arrived at her mother's home at 02:00 hours on Sunday 20 September 2020. Later in the day, Tasmin went to see friends and during her visit, she decided she'd had enough and went to the swing bridge.

Summary of offences:

Serious assault – Sean was alleged to have assaulted Tasmin with a fire poker, causing injuries to her head. He had been charged with this offence, and the investigation was ongoing.

Serious assault – Sean was alleged to have assaulted Tasmin by hitting her with a barrel, pouring bleach on her, and then trying to set her on fire. This incident had been investigated, and Sean was due in court in November 2020.

Rape (24 July 2020) – this was under investigation.

Rape (17 September 2020) – this incident was reported to the Garda. Tasmin agreed to provide a statement, which was arranged for 19 September; however, she had fled to the UK by then. No forensic evidence was obtained, as Tasmin was said to have refused to assist.

Tasmin did not disclose any further offences to Cheshire Constabulary.

Safeguarding was considered, and contact was made with Tasmin's mother and stepfather, who confirmed that she was welcome to return to their home address, which was said not to be known to the suspect.

However, following a Mental Health Act Assessment, Tasmin was detained under Section 2 of the Mental Health Act and admitted to a local mental health hospital.

6.2.42 On 28 September 2020, Tasmin was reviewed by a consultant psychiatrist. Her mother also joined the review via phone. Tasmin said that she was keen to move forward and had plans to speak to the police and engage with further enquiries. She felt that it would be different now as she had her mother and stepfather's support. The risk to self was documented as unpredictable. Tasmin reported doing online counselling whilst in hospital, which she had found to be very helpful. She felt that if she was to have suicidal thoughts, she could talk to her family and was responsive to community mental health support. Tasmin felt that inpatient mental health environment was not for her and that she would rather be at home where she felt more familiar and had her own coping mechanisms. In the review, Tasmin's mother and stepfather disclosed that Tasmin's ex-partner was out on bail in Ireland and was awaiting sentencing for a significant assault, including kidnapping and physical abuse. Her parents were supportive and keen to help her in anyway. Her detention under the Mental Health Act was rescinded, and Tasmin was discharged from hospital, with planned follow-up by the Home Treatment Team.

6.2.43 On 1 October 2020, Tasmin attended her appointment with the Home Treatment Team. She presented as bright in mood and manner and had good insight into her mental health. She stated that she was feeling much better in comparison to the days leading to her admission, and that she was no longer feeling suicidal. She reported feeling anxious about having to go and give a police statement; however, she stated that she was being supported well by her family, in addition to seeking counselling from MIND charity. Tasmin agreed to self-refer to Talking Matters and speak with her GP regarding her poor sleep. She denied any further thoughts/plans or intentions to harm herself or to end her life. Tasmin was discharged from the Home Treatment Team and referred to the Warrington Recovery Team.

6.2.44 On 14 October 2020, Tasmin's case was discussed in the Warrington Mental Health MDT. It was decided to discharge her from secondary care mental health

services, as she was happy to self-refer to Talking Matters. Talking Matters could bring Tasmin back to the MDT to discuss if Talking Matters was not appropriate.

6.2.45 On 20 November 2020, as a result of a request from An Garda Siochana, a written statement was obtained from Tasmin by an officer from Cheshire Constabulary: this related to the rape and serious assaults that Tasmin had experienced in Ireland in September 2020. The request for a written statement was initially challenged in favour of a video interview, but An Garda Siochana advised that the criminal justice system in Ireland did not have the ability to accept video evidence from a complainant. The officer noted that Tasmin's demeanour and her physical and emotional reactions were in keeping with what they would expect to see from a victim recounting a traumatic memory, and that her account remained consistent throughout.

A DASH risk assessment was not completed; therefore, there was no referral to MARAC.

6.2.46 On 27 November 2020, according to press reports, Sean was convicted at an Irish court of an assault on Tasmin and possession of cannabis, which took place on 25 August 2018. Sean was sentenced to three years in prison, with the last two years being suspended. He was also ordered to pay 14,000 Euros in compensation.

6.2.47 On 10 December 2020, a concern for safety report was made by a member of the public, as Tasmin was on the wrong side of a bridge. It was noted that Tasmin was troubled by a previous 'serious domestic assault'. Tasmin was detained by Cheshire Constabulary under Section 136 of the Mental Health Act and taken to a mental health hospital 136 Suite managed by North West Boroughs NHS Foundation Trust [now Mersey Care NHS Foundation Trust]. No VPA was submitted by the police. The ambulance service submitted a safeguarding concern to Adult Social Care.

On arriving at the Section 136 Suite, Tasmin was intoxicated and retired to bed. She refused to engage with the practitioner. The practitioner spoke to Tasmin's father (with consent), who reported that things had been going well recently, and that he believed that she was presenting this way due to alcohol and for attention. A Mental Health Act Assessment was completed. Tasmin denied any further thoughts of self- harm and reassured practitioners that she would be safe at home. She was not detained, and she returned home, with follow-up from the Warrington Home Treatment Team.

6.2.48 On 11 December 2020, Tasmin was seen by the Home Treatment Team. She reported feeling exhausted and rated her mood as 5/10 (10 being the highest). She reported stopping her medication two weeks earlier as she felt it was ineffective. She said that she had discussed this with her GP, who was unwilling to make changes. She stated that she still got flashbacks but would not discuss this further. Tasmin said that she had started a job as a chef but had to give this up due to being unable to sustain it, which had a negative impact on her mood. She denied having any suicidal ideation and cited her children as a protective factor. She said that she was living with her mother and stepfather, who wouldn’t let her out of their sight, and she reported feeling able to maintain her own safety. Tasmin agreed to input from the Home Treatment Team (3 – 4 times per week).

Tasmin was then seen by the Home Treatment Team on 14, 15, 16, 19 and 22 December. Her medication was adjusted after consultation with a consultant psychiatrist, and a referral was made to Outreach support – for help with housing applications and to ensure that she was in receipt of any benefits that she may be eligible for.

6.2.49 On 12 December 2020, Tasmin posted a video on social media of her singing a song by Chloe Adams. The lyrics are as follows:

Oh, I book a new appointment
Yet another disappointment
They're all the same, same, same
When the doctor says I'm fine
One at morning, one at night
These pills will help you remember how to smile
But what does he know?
'Cause I feel so alone
And mom and dad both tell me I'm alright
'Cause the doctor said you're fine
But he don't care about me
He'll just go home to his family
Why does no one see?
I'm not the girl I wish that I could be

6.2.50 On 22 December 2020, Tasmin posted a video to social media of her narrating a poem by Najwa Zebian:
To A Narcissist I Once Loved

I know that you're waiting for me to break down again and contact you.
I know that you must be thinking that I am miserable waiting for you to give me attention.
But. You see. I am not the person I once was.
You destroyed me over and over, but I built myself back up into someone you will never have the honour of getting to know.

6.2.51 On 24 December 2020, a concern for safety was reported by a person who had stopped Tasmin jumping from a bridge. Police patrols attended and returned Tasmin to her mother's address. A VPA was submitted, which reported that Tasmin had been out with her 'boyfriend' and had been drinking. They were said to have had an argument and separated ways. There is reference to Tasmin suffering depression and that she was due to attend court in Ireland for a rape offence. She was said to be incredibly concerned and anxious about attending court and said that she did not want to carry on. A referral was made to the mental health team; however, no details were recorded concerning Tasmin's 'boyfriend'. At this time, the occurrences linked to Tasmin on the police records management system, did not highlight that she was at high risk of domestic abuse, or that the rape investigation was related to this.

6.2.52 On 28 December, Tasmin was contacted by the Home Treatment Team, by phone. She told them of the incident on 24 December. She said that she did not intend to harm herself. She was then seen on 29 December 2020 and again on 2, 9 and 12 January 2021.

At the 12 January appointment, Tasmin said that she had been contacted by Outreach, who were going to arrange a face-to-face visit, and that she had applied for several jobs. She said that she did not feel that she required any further support and had been referred to Outreach and Talking Matters. Tasmin was made aware that she would need to contact her GP the following week for medication. She reported that her mood was 5/10 (0 being the worst she has ever felt). She denied any current thoughts/plans/intent to harm herself or end her life and appeared to have good insight throughout. She was discharged from the Home Treatment Team.

6.2.53 On 19 January 2021, Tasmin contacted the Warrington Council housing department for housing advice and potentially to make a homelessness application. She was living with her mother and stepfather and finding things difficult. Tasmin only wanted to live in one particular area of Warrington and was advised that if she made an application, she could be offered housing in any area

of the borough. She said that she would make enquiries in the private sector. On 6 March 2021, she advised that she had found privately rented accommodation.

6.2.54 On 3 February 2021, a Mental Health Outreach Team worker visited Tasmin, and they went for a walk in the local area. Tasmin said that she was in the process of renting a property in the private sector, which her father and sister were helping with. She was applying for work as a chef and updating her qualifications online. A further meeting was arranged for 11 February.

6.2.55 On 8 February 2021, Tasmin was taken to Warrington Hospital, by ambulance, after calling for help due to taking an overdose of mirtazapine, along with vodka. She was found lying in an alleyway. Tasmin was difficult to rouse and didn't want to engage with staff. As Tasmin came round, she attempted to leave but was prevented from leaving hospital, as she was deemed to lack capacity at that time.

Due to her intoxication, the mental health liaison team were unable to review Tasmin for 22 hours. Tasmin did not want to engage with them. She denied taking an overdose and said that she had not been in the alleyway, she had been at a friend's address. She could not account for being outside and was unaware that it was the middle of the night. Tasmin was noted to be still awaiting an appointment to access Talking Matters. She agreed to support from the Outreach team and to contact her GP for an antidepressant medication review. Tasmin was given the mental health crisis line contact number and was aware that she should call 999 if she was unwell. Although Tasmin knew she was excessively drinking, she did not want to engage with a drug and alcohol agency.

6.2.56 On 26 February 2021, Tasmin met the worker from the Mental Health Outreach Team. She said that she had most things for her new flat and was waiting to start a job as a chef at a care home, depending on her DBS check. The worker raised the issue of domestic abuse support, and Tasmin agreed to a referral to Refuge. The referral was made the same day. Another meeting was arranged for 5 March.

6.2.57 On 1 March 2021, Tasmin attended Warrington Hospital A&E, following an overdose; however, she left before assessment.

6.2.58 On 5 March 2021, Tasmin did not arrive for the meeting with the Mental Health Outreach Team. Following a number of text messages, Tasmin spoke to the Mental Health Outreach Team worker on 11 March. She said that she was no longer working because the people she worked with were horrible. She was offered support to find work but said that she felt able to do that independently. Tasmin said that she had not heard from the Refuge Warrington IDVA service,

which prompted a further referral the same day. A further meeting was arranged for 25 March.

6.2.59 On 6 March 2021, Tasmin told Warrington Borough Council housing department that she had found her own flat in the private sector. Tasmin moved to a two bedroomed privately rented flat near to her mum's house. Tasmin loved charity shops and furnished the flat by shopping carefully and by appeals for things on social media. Tasmin had a male lodger, in order to help out with the bills, who had been introduced by a friend.

6.2.60 On 11 March 2021, a referral for Tasmin was received by the Refuge Warrington IDVA service from the Mental Health Outreach Team.

The worker on duty attempted contact with Tasmin on the same day of receiving the referral: there was no answer. The next contact made to Tasmin was on 23 March, when an IDVA spoke with Tasmin and explained the service and the support that could be offered. Tasmin wanted to be supported by the service, and she identified that she would like support through the criminal courts and the family court. The IDVA completed a DASH risk assessment, which scored 17. As a result of this, a referral was made to MARAC on the same day.

6.2.61 On 17 March 2021, Tasmin posted a video to social media of her narrating words by Rhianna:

It's like your screaming and no one can hear
You almost feel ashamed that someone could be that important that without them you feel like nothing
No one will ever understand how much it hurts
You feel hopeless
Like nothing can save you
Then when it's over and its gone
You almost wish you that you could have all that bad stuff back
So you that you could have the good

6.2.62 On 18 March 2021, Tasmin posted a video to social media. It was captioned:

"Really struggling right now and don't know how to fix it"

In the video, she sang a lyric, titled 'the unhappy blues.'

"I'm sorry that I'm not a person anymore I'm a problem"

6.2.63 On 23 March 2021, Cheshire Police received a MARAC referral from the Warrington IDVA service. Tasmin was deemed to be high risk of domestic abuse. The IDVA noted that they had not received a Vulnerable Person Assessment from Cheshire Police, following Tasmin's disclosure in September 2020, and a vulnerability marker was requested on Tasmin's address. It was also recorded that Sean was aware of Tasmin's sister's and mother's address in Warrington, that he had previously travelled to Warrington with her and would know she would be there, and that he was due for release from prison in April 2021.

6.2.64 On 25 March 2021, Tasmin did not attend the meeting with the Mental Health Outreach Team due to a GP appointment: the worker spoke to her on the phone the next day. Tasmin said that she had moved into her new flat and had a job offer in a pub, which she was thinking about. She also said that the IDVA service had been in touch. Another meeting was arranged for 30 March at Tasmin's new flat. When the worker attended the meeting, Tasmin was not in: they spoke on the phone the next day. Tasmin said that she had been to A&E as she had had difficulty breathing. She agreed for her case to be closed to the Mental Health Outreach Team but was aware that she could access the team again if she needed support.

On the same day, Tasmin posted a video to social media. The video, titled *'I don't want to lose control'*, showed a photograph of her children and then panned to a bottle of vodka.

6.2.65 Tasmin's flatmate told the police that he had been in a relationship with Tasmin for around two months before her death. The exact date is not known. The information is included at this point as an approximation of the date. He said that he was introduced to Tasmin by a friend and went for drinks at her flat. Tasmin offered him the use of the spare bedroom as he was struggling for accommodation. They got on well and became a couple. Tasmin's family say that whilst they knew of Tasmin's flatmate, they did not know of a relationship until he told them of it when they visited the flat after Tasmin's death. The flatmate has not been spoken to directly by the DHR Chair, as he may be a witness at the inquest.

6.2.66 On 7 April 2021, Tasmin's case was heard at MARAC. Actions recorded were:

1. A referral to be made to RASAC (this was delayed pending obtaining Tasmin's consent).
2. A vulnerability marker to be placed on the police computer regarding Tasmin's address.

3. A risk assessment to be completed regarding the perpetrator in Ireland [Sean], pending his release from prison.

6.2.67 On 20 April 2021, Cheshire Police received a call from the mental health crisis line, reporting that Tasmin had a rope around her neck.

The vulnerability marker on the police system was noted:

'TREAT ALL CALLS AS URGENT AND SUBMIT A VPA'. There was no mention on the vulnerability marker that Tasmin was at high risk of domestic abuse and had been heard at MARAC.

Officers attended at the address. They found Tasmin with a ligature around her neck and cut her free. She was taken to hospital by ambulance.

6.2.68 On arrival at Warrington Hospital, Tasmin was very agitated and was given diazepam to help her. Tasmin was referred to the mental health liaison team (now known as Core 24 team) after the initial assessment by a nurse. Whilst being assessed in an A&E cubicle, Tasmin attempted to strangle herself again (with a gown). She had tied it to the trolley and wrapped it around her neck. There was a brief period of cyanosis and unresponsiveness; however, she recovered quickly, with some redness around the front of the neck being noted. Tasmin told staff that she wanted to die. Tasmin was reported to smell strongly of alcohol but said that she had only had two cans of larger. During conversation with a carer, Tasmin disclosed that she had "been recently prostituting herself for money as she can't afford her new accommodation".

The Core 24 team attended A&E to assess Tasmin and agreed to return later when Tasmin was recovered from her alcohol intake. The mental health nurse noted that Tasmin could not identify any protective factors that would stop her ending her life. On reattending to Tasmin later in the day, the mental health nurse noted that Tasmin said that she had only consumed two pints of lager and denied any use of illicit substances. Tasmin said that she was struggling to go on living at present and that she had recently returned to work as a chef at a pub; however, she said that she was very stressed and felt like she could not do it anymore. Tasmin told the mental health nurse that she had also recently found out that she had a 25 year old sister and met her for the first time the previous day. Tasmin informed the mental health nurse that she had not been eating or drinking much due to a loss of appetite and deterioration in her mood. Returning to work had been very stressful for her and she felt exhausted. Tasmin felt that

she did not have any support or any protective factors and would be better off dead.

A referral was completed to Park House and Warrington Home Treatment Team for some short-term support during this period of crisis. Tasmin was provided with a safety management plan and crisis numbers. Tasmin was discharged from Core 24 psychiatric liaison team. On leaving hospital that day, Tasmin went to stay at Park House. *Park House* provides a relaxing and tranquil environment to support people during a time of mental health crisis.

6.2.69 On 21 April 2021, a nurse from the Home Treatment Team visited Tasmin at Park House. Tasmin said that she wanted to leave Park House as she had to go work the day after, having just started a new job as a chef a few days ago. She said that work and rent arrears were significant stressors for her. Tasmin said that she couldn't relax at Park House and would be better at home in her own environment, where her sister would stay with her. Tasmin went home later that day.

6.2.70 On 22 April 2021, Tasmin was visited at home by the Home Treatment Team. She reported that her mood was a 'bit down' and reported that the main contributing factor to this was her lack of sleep. She reported that she had previously been prescribed zopiclone (for around two years whilst in Ireland) but her current GP was refusing to prescribe it, so she was considering moving GP practices. Tasmin said that she was due to start therapy with RASAC the following week and that she was looking forward to this. She denied any current thoughts/plans or intent to engage in any self-harm or suicide. She said that if this changed, she would contact her father or her sister. Tasmin and her sister were provided with advice on how to contact the team, and they were encouraged to utilise it if required.

6.2.71 On 23 April 2021, Tasmin was taken to Warrington Hospital by ambulance: this followed her making a call to the crisis line to report that she had tied the cord from her apron around her neck and was wanting to end her life.

Ambulance staff made a safeguarding referral to Adult Social Care. The referral stated that when the ambulance crew had arrived at Tasmin's home, they found two men in the home with her, with Tasmin acting agitated and cautious around them. She stated that she did not know the men and that she had asked them to leave, but they refused.

Whilst in the A&E department, Tasmin made a further attempt on her life: using her tie from her dressing gown as a ligature. She was then placed on 1:1 observations. Tasmin said that her next of kin was her father, but she didn't want him informed that she was in hospital. Tasmin was reviewed and was awaiting further mental health review. Tasmin said that she had an appointment at 10 am with the mental health team in an adjoining building, and she wished to go to that appointment. A referral was made to the internal Warrington and Halton Hospitals NHS Foundation Trust safeguarding team, but by the time they began work at 8.30 am, Tasmin had left the hospital. There is no evidence that the appointment Tasmin referred to existed.

Later in the day, a nurse from the Home Treatment Team contacted Tasmin by telephone. Tasmin said that she was at home. She presented as tearful on the phone and said that she had been sent home from A&E. She was asked if she was going to attend work that day; however, she stated that there was no point. Tasmin was discussed in the team's safety huddle, and a plan was made for practitioners to attend her home later in the day for a full review of her mental health. When the two mental health practitioners attended Tasmin's property, they were unable to gain access to her flat due to the communal door entry system. The practitioners buzzed Tasmin's door several times, with no response. Three telephone calls were made, with no answer. A text message was sent to Tasmin, advising of an appointment for the following day.

6.2.72 On 24 April 2021, a nurse from the Home Treatment Team contacted Tasmin by phone. Tasmin said that she was going to work and was therefore willing to speak to the nurse on the telephone. Tasmin said that she had been struggling with intrusive thoughts but had not harmed herself since recent attendance at A&E. She was being supported by her sister, who was staying with her. Tasmin denied any plans or intent to act on these thoughts and identified her sister as a strong protective factor. She said that work was challenging, as she was working 60 hours plus per week as a chef. She said that she was unable to sustain this, and that she was looking for a new job with reduced hours. Tasmin said that she was able to maintain her own safety whilst in the community, with support from her sister. Safety management advice was discussed and a face-to-face visit was arranged for the following day.

6.2.73 On 25 April 2021, a practitioner from the Home Treatment Team visited Tasmin at her home address. Tasmin appeared low in mood and facially flat; however, her mood lifted throughout the review. She said that she continued to struggle to sleep. Tasmin said that her sister had been staying with her due to the low mood. This had been helpful and a distraction from her negative thoughts. However, she

stated that she would prefer to be alone but acknowledged the risk associated with this at the present time.

Tasmin said that she continued to work full-time but was seeking new employment due to colleagues using drugs and alcohol at work, and she described the work environment as unhealthy. Tasmin stated that she was unable to quit until she gained new employment, due to money worries. There was a discussion around the disclosure whilst in A&E of Tasmin signing up to a website for sex work. Tasmin stated that she was finding it difficult to pay her rent, which led her to signing up to the website; however, she said that she had deactivated the account.

There was a discussion surrounding any additional support that could be offered, including a food voucher, and Tasmin was signposted to Citizens Advice for further support. She declined this offer, stating that she was on top of things. Tasmin continued to report intrusive thoughts to harm herself; however, there were no other actions since her attendance at A&E. She denied any plans or intent to act upon these thoughts. Safety management advice was provided, including 24/7 contact details. Additionally, Tasmin stated that she would reach out to her sister for support. There was a discussion around Tasmin's current alcohol use and the noticeable increase in risk whilst under the influence of alcohol. This was identified through review of clinical documentation and a discussion with Tasmin, which she agreed with. She stated that she was drinking 1 litre of vodka a night, to aid sleep and feel numb. Support from a drug and alcohol agency was discussed, but Tasmin declined. Due to low mood and poor sleep, there was a discussion around an increase in her mirtazapine prescription. The nurse advised Tasmin that she would ask her GP to review prescribed medication, and Tasmin was advised to contact her GP the following week to chase up.

6.2.74 On 28 April 2021, Tasmin was seen at home by a practitioner from the Home Treatment Team. Tasmin said that she was due to attend court in Ireland and was worried about this. Also, that her ex-partner was due to be released from prison in Ireland, and that he knew that she lived in Warrington but not her address. Tasmin had now left her job as a chef. Money was very tight, but she was managing. She had enough food within the property. She said that she was still not sleeping, even though her medication had been increased. Sleep hygiene techniques were discussed, which she could try. Tasmin denied any thoughts of self-harm or suicidal ideation. She planned on going to her sister's home to help in the garden and said that she was starting counselling the following day.

Tasmin's flatmate told the police that, on this date, Tasmin had contact with her children by FaceTime, and that she was upset afterwards.

6.2.75 Following Tasmin's attendance at hospital on 20 April, a referral was made to the Cheshire and Merseyside Rape and Sexual Abuse Support Centre. An Independent Sexual Violence Advocate contacted Tasmin on 21 April, when she was at Park House, and arranged an initial assessment on 29 April. At that telephone assessment, a face-to-face appointment was arranged in May.

6.2.76 Tasmin's flatmate told the police that on the evening before her death, Tasmin contacted him and told him that she was at an address where some lads were doing drugs, and she didn't want to be there. He arranged for a taxi to collect her. When she got home, she told him everything was okay and there wasn't a problem. They had a couple of drinks and then went to bed together.

6.2.77 On a date in May 2021, Tasmin contacted the mental health crisis line, stating that she was safe at home at the time of the call but was worried about what had occurred earlier in the night. She reported that she had had a meltdown during the night and had started to drink alcohol. She was tearful during the call and was worried that something may have happened that she didn't want to. Tasmin reported that she was worried that she had been taken advantage of earlier in the night, reporting that she felt 'sore down below'. Tasmin said that she had got drunk and had gone back to a male's house, and when she had tried to leave, he kept grabbing her. She said that her flatmate got a taxi to the address and collected her, but she could not remember the whole night and that there were blanks in her memory. Tasmin stated that she had not reported these things to the police and had no intention of doing so. The practitioner advised that they would need to report this to the police, which Tasmin agreed to, but she advised that she would not be taking this any further. During the call, Tasmin did not express any thoughts or plans to harm herself or end her own life. Tasmin said that she was in bed at the time of calling, and that previously when she had experienced such a meltdown, she would have taken herself to a bridge; however, on this occasion, she had not. There was a safety huddle between the practitioner and colleague, and the call with Tasmin unexpectedly ended. Attempts were made to call her back, but contact was not established. An emergency police response to Tasmin's home was requested.

Police and ambulance service attended at Tasmin's home and found her with a ligature around her neck and unconscious. She was taken to Warrington Hospital by ambulance.

6.2.78 Tasmin was transferred to the Intensive Care Unit but, despite treatment, passed away a few days later.

6.2.79 On the day Tasmin took her own life, her mum described how she had seen Tasmin before she went to work, and Tasmin had given her a hug and told her that 'she really loved her'. When her mum came home from work that night, she had a text from Tasmin that said that she had ordered and paid for a takeaway meal for her. After Tasmin's death, it was discovered that Tasmin had paid her rent and all her bills, in advance, to avoid leaving any debt.

7 Conclusions

7.1 Tasmin suffered from traumatic domestic abuse in Ireland. She sought refuge with her family in Lancashire and then Cambridgeshire, and the panel saw that during those interactions, services had largely been appropriate and effective.

7.2 From January 2020, Tasmin was engaged with services in Warrington. The panel's main focus was on the interaction between Warrington services and Tasmin from then until her sad death. In March 2020, Tasmin travelled to Ireland where it is believed that she resumed a relationship with the perpetrator, Sean. Tasmin suffered further serious abuse and returned to Warrington in September 2020.

7.3 The panel identified seven missed opportunities for agencies, in Warrington, to have completed a DASH risk assessment or to have made a referral to domestic abuse services during this time. The fact that Tasmin was thought to be safe from physical abuse because the perpetrator was in Ireland, is likely to have affected the actions of professionals.

7.4 Tasmin was referred to the IDVA service in March 2021 by a Warrington Borough Council Mental Health Outreach Team worker. That resulted in support from an IDVA and an appropriate referral to MARAC. Tasmin was also referred to RASAC and intended to engage with the service but was unable to do so before her death. An earlier completion of a DASH risk assessment, may have resulted in an earlier referral to an IDVA and RASCAC.

7.5 At about that time, Tasmin posted two videos to social media. Tasmin's voice can no longer be heard, but the content of the videos may assist in understanding Tasmin's thoughts and feelings at the time. The information is in section 6 of the executive summary and is deliberately repeated here.

7.6 On 17 March 2021, Tasmin posted a video to social media of her narrating words by Rhianna:

It's like your screaming and no one can hear
You almost feel ashamed that someone could be that important that without them you feel like nothing
No one will ever understand how much it hurts
You feel hopeless
Like nothing can save you
Then when it's over and its gone
You almost wish you that you could have all that bad stuff back
So you that you could have the good

7.7 On 18 March 2021, Tasmin posted a video to social media. It was captioned:

"Really struggling right now and don't know how to fix it"

In the video, she sang a lyric, titled 'the unhappy blues.'

"I'm sorry that I'm not a person anymore I'm a problem"

7.8 These posts were not known to Tasmin's family nor professionals involved in supporting her.

7.9 Tasmin then made two attempts to take her own life, before a third attempt resulted in her death in May 2021. She was engaged with appropriate mental health services throughout that time.

7.10 Tasmin was consistent in telling services that she was greatly affected by the domestic abuse assaults that she had suffered. The panel was in no doubt that the trauma she had suffered, contributed to her poor mental health.

7.11 The panel would like to thank Tasmin's family for their involvement in the review.

8 LEARNING

This multi-agency learning arises following debate within the DHR panel.

8.1 Narrative

The panel thought that professionals may have been deflected from conducting DASH risk assessments because the abuse had been suffered in Ireland, and Tasmin was not apparently at physical risk from Sean in England.

Learning

Professionals need to understand and act appropriately on all disclosures of domestic abuse. Opportunities to conduct risk assessments, which may have usefully guided the work of professionals, were missed.

Panel recommendation 1

8.2 Narrative

The panel heard that it would be helpful if referrals to the IDVA service, indicated the client's consent to speak to other services.

Learning

Obtaining consent of the client to speak to other services, may lead to improved communication between services and therefore enhance service provision and protection for the client.

Panel recommendation 2

8.3 Narrative

The panel thought that research linking domestic abuse to the risk of suicide, was not well known by staff in their organisations.

Learning

Professionals will be better able to manage risk if they are familiar with research that links domestic abuse and suicide.

Panel recommendation 3

8.4 **Narrative**

Research identifies that there is an increased risk of suicide amongst parents who have either lost children or have limited contact with them, whether through care proceedings or other processes.

Learning

Professionals' understanding of these risks can improve engagement and identify opportunities for referrals and/or signposting for support.

Panel recommendation 4

8.5 **Narrative**

This case illustrates the deep effects that previous trauma can have on someone and how this can lead to agencies having difficulty engaging with them.

Learning

Trauma-informed practice was not evident during Tasmin's interactions with agencies in Warrington. The development of a plan for trauma-informed practice across the multi-agency partnerships in Warrington, would build on the work currently taking place to deliver awareness training. Staff need to be appropriately trained and supported to deliver trauma-informed practice.

Panel recommendation 5

8.6 **Narrative**

The review was unable to obtain information from Irish authorities, which may have assisted in understanding Tasmin's victimisation.

Learning

The inability to obtain relevant information may result in an incomplete picture of the issues affecting a victim and therefore reduce the effectiveness of a DHR.

Panel recommendation 6

9 RECOMMENDATIONS

DHR Panel

9.1 Warrington agencies contributing to the review, should provide the Warrington Community Safety Partnership with evidence that the learning from this review has been shared with practitioners. The Community Safety Partnership, working with the Warrington safeguarding Adults Board, should co-ordinate a multi-agency audit to assure themselves of the extent to which disclosures of domestic abuse lead to appropriate risk assessment or referral.

9.2 The new provider of IDVA services in Warrington should consider the learning regarding consent and ensure that this is addressed in its work with other agencies in Warrington.

9.3 Agencies contributing to the review, should provide Warrington Community Safety Partnership with evidence that their staff have been provided with information in relation to the link between domestic abuse and suicide risk.

9.4 That all agencies that have contributed to this review, should provide evidence to Warrington Community Safety Partnership on how the learning on this case – around the indicators of increased risk of suicide, including where individuals no longer have contact and access with their children, and when this contact is 'controlled' due to the children living with and being cared for by others – has been disseminated and embedded into practice.

9.5 A trauma-informed strategy needs to be developed that encompasses the agencies engaged in this review and others providing services in Warrington. The Safeguarding Adults Board may be best placed to lead this work and should be strongly supported by the Community Safety Partnership.

9.6 The Home Office should seek to achieve agreement with relevant authorities on the provision of relevant information, within the common travel area, for the purposes of DHRs.

9.7 That Warrington Community Safety Partnership should share the learning from this review with CHAMPS Public Health collaborative, to inform their ongoing work on suicide prevention.

9.8 The learning from this review should be shared with Warrington Safeguarding Adult Board.

9.9 The learning from this review should be shared with the Community Safety Partnerships for Cambridgeshire and West Lancashire.

Single Agency Recommendations

9.10 All single agency recommendations are shown in the DHR action plan

End of executive summary