Warrington Community Safety Partnership

Domestic Homicide Review

Overview Report

'Tasmin'

Died May 2021

Chair and Author: Ged McManus

Supported by: Carol Ellwood Clarke

Date: May 2023

INDEX

1 Introduction

1.1 This report of a Domestic Homicide Review (DHR) examines agency responses and support given to Tasmin[1], a resident of Warrington, prior to her death. The panel would like to offer its condolences to Tasmin's family on their tragic loss. All names used in the report are pseudonyms.

1.2 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.

1.3 In addition to agency involvement, the review also examines the past to identify any relevant background of abuse before the death, whether support was accessed within the community, and whether there were any barriers to accessing support. By taking a holistic approach, the review seeks to identify appropriate solutions to make the future safer.

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 The intention of the review is to ensure agencies are responding appropriately to victims of domestic violence and abuse by offering and putting in place appropriate support mechanisms, procedures, resources, and interventions with the aim of avoiding future incidents of domestic homicide, violence, abuse, and suicide. Reviews should assess whether agencies have sufficient and robust procedures and protocols in place, and that they are understood and adhered to by their employees.

[1] A pseudonym chosen by the victim's family.

1.6 **Note:**
It is not the purpose of this DHR to enquire into how Tasmin died: that is a matter that has been examined during the coroner's inquest.

2 Timescales

2.1 This review began on 16 February 2022 and was concluded on 11 May 2023, following an extensive period of consultation with Tasmin's family. More detailed information on timescales and decision-making is shown at paragraph 5.2

3 Confidentiality

3.1 The findings of each review are confidential until publication. Information is available only to participating officers, professionals, their line managers and the family, including any support worker, during the review process.

3.2 A pseudonym was agreed with the victim's family to protect her identity.

4 Terms of Reference

4.1 The purpose of a DHR is to:

Establish what lessons are to be learned from the death 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)

4.2 Timeframe Under Review

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

4.3 Case Specific Terms

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[2].

[2] A pseudonym chosen by the panel from a list of names.

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?

5 Methodology

5.1 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.

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

5.3 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.

5.4 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.

5.5 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.

5.6 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.

5.7 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.

5.8 The panel experienced delays in obtaining some of the information it required. Delays were also experienced in effectively engaging with Tasmin's family. This was partly to ensure that they could be represented by an advocate and also because of challenges in arranging meetings due to holidays and the work patterns of those involved.

5.9 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. The panel met seven times.

5.10 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.

6 Involvement of Family, Friends, Work Colleagues, Neighbours, and Wider Community

6.1.1 The Community Safety Partnership wrote separately to Tasmin's mother and father (who are no longer in a relationship) informing them of the review and inviting them to make contact with the review Chair. The letters included the Home Office domestic homicide leaflet for families and the Advocacy After Fatal Domestic Abuse (AAFDA)[3] leaflet.

6.1.2 Tasmin's mother contacted the Chair, and an initial online meeting was arranged with her, Tasmin's stepfather, and her sisters. Following the initial meeting, a request was made to AAFDA for advocacy support for the family.

6.1.3 Tasmin's father did not reply to two letters from the Community Safety Partnership.

6.1.4 The DHR Chair met, in person, with Tasmin's mother and stepfather, who were supported by their AAFDA advocate. Their contribution is referenced where appropriate throughout the review. Tasmin's mother and stepfather were offered the opportunity to meet the DHR panel but did not wish to do so.

6.1.5 Tasmin's mother and stepfather supported Tasmin, and she lived with them when she returned to England. In the last few months of her life, she had established her independence in a rented flat close to their home. Tasmin did not share everything in her life with her family, and they did not know the details of everything that was going on in her life.

6.1.6 The panel was keen to understand Tasmin's experiences in Ireland and wished to engage with Tasmin's husband as a way of doing so. Following contact facilitated by Tasmin's mother and stepfather, her husband agreed to speak to the DHR Chair: his contribution is referenced appropriately throughout the review.

6.1.7 The panel discussed, at length, whether it was appropriate to offer Sean the opportunity to contribute to the review. The panel concluded that it was best to contact Sean, as it was possible that his contribution to the review could help to develop learning. The Community Safety Partnership therefore wrote to Sean at his last known address in Ireland, offering the opportunity to contribute to the review. The letter included appropriate information about the DHR and contact details. Nothing was heard from Sean.

[3] Advocacy After Fatal Domestic Abuse (AAFDA) www.aafda.org.uk

6.1.8 Tasmin had arranged for a man to move into her flat as a flatmate, in order to help with paying the rent and other bills. This person provided a statement to the police for the purposes of their enquiries on behalf of the coroner. The coroner has consented to information from that statement being disclosed for the purposes of the DHR. This man, who is referred to in the report as 'flatmate', has not been seen or spoken to directly by the DHR Chair. Information that he provided is referenced appropriately throughout the report.

7 Contributors to the Review / Agencies Submitting IMRs[4]

7.1.1	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

[4] Individual Management Reviews (IMRs) are detailed written reports from agencies on their involvement with Tasmin.

Warrington GP	IMR
Warrington Borough Council Housing Department	IMR
Refuge Warrington IDVA Service	IMR
Cheshire and Merseyside RASAC	Chronology

7.1.2 As well as the IMRs, each agency provided a chronology of interaction with Tasmin, including what decisions were made and what actions were taken. The IMRs considered the Terms of Reference (TOR) and whether internal procedures had been followed and whether, on reflection, they had been adequate. The IMR authors were asked to arrive at a conclusion about what had happened from their own agency's perspective, and to make recommendations where appropriate. Each IMR author had no previous knowledge of Tasmin, nor had any involvement in the provision of services to her.

7.1.3 The IMR should include a comprehensive chronology that charts the involvement of the agency with the subject of the review, over the period of time set out in the 'Terms of Reference' for the review. It should summarise: the events that occurred; intelligence and information known to the agency; the decisions reached; the services offered and provided to Tasmin; and any other action taken.

7.1.4 It should also provide: an analysis of events that occurred; the decisions made; and the actions taken or not taken. Where judgements were made or actions taken that indicate that practice or management could be improved, the review should consider not only what happened, but why.

7.1.5 The IMRs in this case were of good quality and focussed on the issues facing Tasmin. They were quality assured by the original author, the respective agency, and by the Panel Chair. Where challenges were made, they were responded to promptly and in a spirit of openness and co-operation.

7.2 Information About Agencies Contributing to the Review

Lancashire Constabulary

Lancashire Constabulary is a large organisation with 5,400 police officers and members of staff covering around 2,000 square miles.

The county is split into three main policing areas, known as Basic Command Units. Each Basic Command Unit (BCU) is run by a Chief Superintendent, known as the BCU Commander. Under each BCU Commander sits the local neighbourhood policing teams, which are supported by a range of other specialist departments.

Lancashire and South Cumbria NHS Foundation Trust

Lancashire and South Cumbria NHS Foundation Trust was established in April 2002 and authorised as a foundation Trust on 1/12/07.

The Trust provides a range of health and well-being services for children and adults and specialist secure, inpatient and community mental health services across a number of areas: Pan Lancashire, Sefton and Formby, Blackburn with Darwen and Cumbria.

The Trust's vision is to provide high quality care in the right place at the right time.

Lancashire Victims Services

Victim Support is the commissioned provider of support services for victims of crime in Lancashire. Victim Support provides practical and emotional support to any victim of crime, regardless of whether they have reported it to the police or not. This includes specialised support for victims of domestic violence, sexual assault, hate crime, and children and young people.

Lancashire and South Cumbria Integrated Care Board (on behalf of West Lancashire GP)

Cheshire and Merseyside Integrated Care Board (on behalf of Warrington GP)

An ICB is a statutory NHS organisation that is responsible for developing a plan for meeting the health needs of the population, managing the NHS budget, and arranging for the provision of health services in a geographical area. Its role is to join up health and care services, improve people's health and well-being, and to make sure everyone has the same access to services and gets the same outcomes from treatment. It also oversees how money is spent and makes sure health services work well and are of high quality.

Mountain Healthcare (Cambridgeshire Sexual Assault Referral Centre)

Mountain Healthcare is commissioned by the NHS and police, to provide forensic healthcare services for Sexual Assault Referral Service contracts in the UK. One of the areas covered is Cambridgeshire.

East of England Ambulance Service

Covering an area of 7,500 square miles and a population of 6.2 million people, the service provides 24 hour, 365 days a year accident and emergency services to those in need of emergency medical treatment and transport in – Bedfordshire, Hertfordshire, Essex, Norfolk, Suffolk, and Cambridgeshire.

North West Anglia NHS Foundation Trust

The Trust provides emergency and acute services at Peterborough and Hinchingbrooke Hospitals.

The Trust provided physical health services to Tasmin in Cambridgeshire.

Cambridge and Peterborough NHS Foundation Trust

The Trust provides physical and mental health, and specialist services. It is a health and social care organisation and has clinical teams providing services in inpatient, community, and primary care settings. Services include:

- Adult mental health
- Forensic and specialist mental health
- Older people's mental health
- Children's mental health
- Children's community
- Older people and adult community
- Specialist learning disability
- Primary care and liaison psychiatry
- Substance misuse
- Social care
- Research and development

The Trust provided mental health services to Tasmin in Cambridgeshire.

Cambridgeshire Constabulary

Cambridgeshire Constabulary is the territorial police force responsible for policing Cambridgeshire. It serves a population of over 800,000. Many of its teams work together with other neighbouring police forces, such as Bedfordshire Police and Hertfordshire Constabulary.

Cheshire Constabulary

Cheshire Constabulary is the territorial police force responsible for policing the English unitary authorities of Cheshire East, Cheshire West and Chester, Halton (including Runcorn and Widnes), and Warrington. The force is responsible for policing an area of 946 square miles (2,450 km2), with a population of approximately 1 million.

North West Ambulance Service

Covering an area of 5,400 square miles and a population of more than seven million people, the service provides 24 hour, 365 days a year accident and emergency services to those in need of emergency medical treatment and transport in – Cumbria, Lancashire, Greater Manchester, Merseyside, Cheshire, and Glossop (Derbyshire).

Warrington and Halton Hospitals NHS Trust

Warrington and Halton Hospitals NHS Foundation Trust manages two major hospital sites: Warrington Hospital and The Nightingale Building at Halton. The Trust also provides services at the Captain Sir Tom Moore Building on the Halton site.

The majority of emergency care and complex surgical care is based at Warrington Hospital, whilst The Nightingale Building in Runcorn is a centre of excellence for routine surgery. The Captain Sir Tom Moore Building is home to orthopaedic surgery services.

Mersey Care NHS Foundation Trust

Mersey Care is one of the largest Trusts providing physical health and mental health services in the North West – serving more than 1.4 million people across our region and are also commissioned for services that cover the North West, North Wales, and the Midlands.

The Trust offers specialist inpatient and community services that support physical and mental health and specialist inpatient mental health, learning disability, addiction, and brain injury services. Clinical services are provided across over 170 sites, spanning a large part of the North West.

Warrington Borough Council Adult Social Care Department

Warrington Borough Council provides the Adult Social Care service across the Warrington area. Adult Social Care is about providing personal and practical support to help people live their lives. It's about supporting individuals to maintain their independence and dignity. There is a shared commitment by the Government, local councils, and providers of services, to make sure that people who need care and support have the choice, flexibility, and control to live their lives as they wish.

Refuge Warrington IDVA Service

The service supports women and men experiencing domestic abuse in Warrington. Independent domestic violence advocates and outreach workers:

- Provide emotional and practical support to victims from the point of crisis
- Offer intensive support to help ensure short-, medium-, and long-term safety
- Provide information and guidance on civil and criminal court proceedings and legal options
- Empower victims to make informed decisions about their safety, and the safety of their children
- Help victims access other specialist support e.g., refuge accommodation.

Cheshire and Merseyside RASAC

A charity providing advice, information, and support to survivors of sexual violence, whether it happened recently or in the past.

- Specialist Counselling – pre- and post-trial for adults and children
- Information Line
- Independent Sexual Violence Advisors – providing support through criminal justice process
- Group work.

8 The Review Panel Members

8.1	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

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

9 Author and Chair of the Overview Report

9.1 Sections 36 to 39 of the Home Office Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews December 2016 sets out the requirements for review Chairs and Authors. In this case, the Chair and Author were the same person.

9.2 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.

9.3 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[5].

9.4 Between them, they have undertaken over sixty reviews, including the following: child serious case reviews; Safeguarding Adults 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.

9.5 Neither of them has previously worked for any agency involved in this review. Ged has previously chaired two DHRs in Warrington and was the Author of one of them.

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

10 Parallel Reviews

10.1 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

10.2 Following Tasmin's death, North West Boroughs Healthcare NHS Foundation Trust [now part of Mersey Care NHS Foundation Trust] undertook a rapid Appraisal of Care (72 hour investigation). This was followed by a StEIS[6] comprehensive review of care. The panel was assured that the information and recommendations from those reports were reflected in the IMR provided for the purposes of the DHR.

10.3 A DHR should not form part of any disciplinary inquiry or process. Where information emerges during the course of a DHR that indicates disciplinary action may be initiated by a partnership agency, the agency's own disciplinary procedures will be utilised; they should remain separate to the DHR process.

[6] https://www.england.nhs.uk/2018/02/transfer-of-strategic-executive-information-system-steis/

There has been no indication from any agency involved in the review that the circumstances of the case have engaged their disciplinary processes.

11 Equality and Diversity

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

- **age** [for example an age group would include “over fifties” or twenty-one year olds. A person aged twenty-one does not share the same characteristic of age with “people in their forties”. However, a person aged twenty-one and people in their forties can share the characteristic of being in the “under fifty” age range].
- **disability** [for example a man works in a warehouse, loading and unloading heavy stock. He develops a long-term heart condition and no longer has the ability to lift or move heavy items of stock at work. Lifting and moving such heavy items is not a normal day-to-day activity. However, he is also unable to lift, carry or move moderately heavy everyday objects such as chairs, at work or around the home. This is an adverse effect on a normal day-to-day activity. He is likely to be considered a disabled person for the purposes of the Act].
- **gender reassignment** [for example a person who was born physically female decides to spend the rest of her life as a man. He starts and continues to live as a man. He decides not to seek medical advice as he successfully ‘passes’ as a man without the need for any medical intervention. He would have the protected characteristic of gender reassignment for the purposes of the Act].
- **marriage and civil partnership** [for example 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].
- **pregnancy and maternity**
- **race** [for example colour includes being black or white. Nationality includes being a British, Australian or Swiss citizen. Ethnic or national origins include being from a Roma background or of Chinese heritage. A racial group could be “black Britons” which would encompass those people who are both black and who are British citizens].
- **religion or belief** [for example the Baha’i faith, Buddhism, Christianity, Hinduism, Islam, Jainism, Judaism, Rastafarianism, Sikhism and Zoroastrianism are all religions for the purposes of this provision. Beliefs such as humanism and atheism would be beliefs for the purposes of this provision but adherence to a particular football team would not be].

- **sex**
- **sexual orientation** [for example a man who experiences sexual attraction towards both men and women is “bisexual” in terms of sexual orientation even if he has only had relationships with women. A man and a woman who are both attracted only to people of the opposite sex from them share a sexual orientation. A man who is attracted only to other men is a gay man. A woman who is attracted only to other women is a lesbian. So, a gay man and a lesbian share a sexual orientation].

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.

11.2 Tasmin was a 35-year-old white British woman. She was heterosexual and married with two children. Her marriage had broken down, and she was separated from her husband.

11.3 Tasmin had a diagnosis of anxiety, depression, post-traumatic stress disorder (PTSD), and emotionally unstable personality disorder (EUPD). She was greatly affected by traumatic abuse that she had suffered. She was sometimes detained under the Mental Health Act and spent periods of time in hospital as a result of mental ill health.

11.4 Tasmin disclosed the occasional use of illicit drugs (for example, cocaine), and she was often intoxicated by alcohol when in crisis. She disclosed to a worker in 2021, that she was drinking a litre of vodka a day. She was offered referrals and signposted to local drugs and alcohol services on a number of occasions; however, she did not engage with those services.

11.5 The Equality Act 2010 (Disability) Regulations 2010 (SI 2010/2128) states that addiction to alcohol, nicotine or any other substance (except where the addiction originally resulted from the administration of medically prescribed drugs) is to be treated as not amounting to an impairment for the purposes of the Equality Act 2010. Alcohol addiction is not, therefore, covered by the Act.

11.6 It should be noted that although addiction to alcohol, nicotine, and drugs is excluded from The Equality Act 2010, addiction to alcohol and drugs should be

taken into account when a Care Act 2014 (care and support) assessment is completed. Although Tasmin experienced periods where she was unwell, she was independent and, within the timeframe of the review, obtained her own accommodation. She obtained employment on a number of occasions but struggled to maintain employment.

11.7 There is no evidence arising from the review of any negative or positive bias on the delivery of services to Tasmin based on the protected characteristics.

11.8 Domestic homicide and domestic abuse in particular, is predominantly a gender crime – 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 gendered differences.

According to the Office for National Statistics homicide report[7]:

'There were 114 domestic homicides in the year ending March 2021. This is a similar number to the average over the last five years (121). These numbers reflect the low level of domestic homicides seen since year ending March 2017 and the general downward trend in the number of domestic homicides over the last 10 years. While the coronavirus (COVID-19) pandemic restrictions did not lead to an increase in domestic homicides in the latest year, as may have been expected, non-domestic homicides decreased by 17% (from 508 to 420).

'Of the 114 domestic homicides, 67 victims were killed by a partner or ex-partner (down from 74), 27 were killed by a parent, son or daughter (down from 32) and 20 were killed by another family member (up from 15).

'Almost half (49%) of adult female homicide victims were killed in a domestic homicide (75). During COVID-19 lockdown periods covering 23 March to 3 July 2020, 5 November to 2 December 2020 and 5 January to 31 March 2021, this was 56%, highlighting the change in composition of homicides during the restrictions. Of the 75 female victims, 72 were killed by a male suspect (Appendix table 31).

'Males were much less likely to be the victim of a domestic homicide, with only 10% (39) of male homicides being domestic related in the latest year, a similar proportion to the previous year.

7 https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/homicideinenglandandwales/yearendingmarch2021

'In over a third of female adult victims, the suspect was their partner or ex-partner (37%, 57 homicides)'.

11.9 'It is estimated that 3 women a week commit suicide as a result of domestic abuse'.[8]

11.10 'In England, a total of 4,017 deaths were registered as suicide among men in 2019, up 5.7% from the total in 2018 (3,800); however, this increase was not statistically significant. This equates to a male suicide rate of 16.7 deaths per 100,000 males in 2019, significantly higher than rates seen in other recent years, between 2015 and 2017, and the highest rate observed since 2000. The latest rate remains statistically significantly lower than that observed in 1981, when there were 19.3 deaths per 100,000 males in England.

'In 2019, a total of 1,299 deaths were registered as suicide among females in England, up from 1,221 deaths registered in the previous year. In recent years, there have been increases in the suicide rate among females in England with the 2019 rate (5.2 per 100,000) being the highest observed since 2004, and significantly higher than rates seen in 2016 and 2017'.[9]

Area	Age-standardised rate
England	5.2
North East	4.1
North West	5.2
Yorkshire and The Humber	7.3
East Midlands	5.2
West Midlands	4.8
East	5.9
London	4.6
South East	4.9
South West	4.9
Wales	5.8
England and Wales average	5.3

Source: Office for National Statistics

[8] Walby 2004
[9] Data from the Office for National Statistics

12 **Dissemination**

Home Office
Warrington CSP
Police and Crime Commissioner
All agencies contributing to the review
Domestic Abuse Commissioner
Warrington Safeguarding Adults Board
Tasmin's family
Cambridgeshire CSP
West Lancashire CSP
Warrington coroner

13 Background, Overview and Chronology

This part of the report combines the Background, Overview and Chronology sections of the Home Office DHR Guidance overview report template. This was done to avoid duplication of information. The information is drawn from documents provided by agencies, and material gathered by the police during their investigation following Tasmin's death, as well as information from Tasmin's family. The information is presented in this section without comment. Analysis appears at section 14 of the report.

13.1.1 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'

Her family gave some examples, such as:

'When 4yrs old one of her sisters put her in tumble dryer and turned it on – Tasmin described this as fun.

'Another time she was found going down from the top of a slide on her bike'.

13.1.2 Tasmin's parents divorced when she was 12, and she spent a year in the south of England with her mother and siblings. The family then returned to live in Warrington. Both parents went on to have other relationships, and Tasmin described how she was lucky to have two mums and dads.

13.1.3 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.

13.1.4 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.

13.1.5 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.

13.1.6 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.

13.1.7 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.

13.1.8 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.

13.1.9 On one occasion when dropping the children off at Tasmin's home, Tasmin asked her husband to come in and meet Sean. Her husband refused. Tasmin's husband was arrested later the same evening by the police, after Tasmin had reported that her husband had assaulted her. Tasmin's husband said that he later recorded a telephone call with Tasmin in which Tasmin acknowledged that the allegation was not true and stated that Sean had forced her to make the allegation. Tasmin's husband said that he took the recording of the telephone call to the police, resulting in the case against him being dropped.

13.1.10 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.

13.1.11 Tasmin's husband was aware that Tasmin had told her mother and father that he had physically abused her but denied that this was true.

The information from Tasmin's husband has not been challenged. The panel is aware that aspects of it could be considered to be victim blaming. However, in light of the lack of other sources of information from Tasmin's time in Ireland, the panel felt that Tasmin's husband's account provided important contextual information and therefore made a decision that it should be included in the report.

13.1.12 Following the breakdown of her marriage, Tasmin formed a relationship with Sean. Tasmin's family were aware that Tasmin suffered from domestic abuse in the relationship and said that Sean introduced Tasmin to illicit drugs, particularly cocaine.

13.1.13 Tasmin's family said that Tasmin was a very social person and loved going to the pub. Tasmin made friends very quickly; however, her friendships were transient, and her family were not able to identify any friends with whom the review could engage. Tasmin enjoyed karaoke and would often sing in public, as well as posting clips on social media of herself singing and reciting poetry. The Chair of the review was able to access some of Tasmin's social media posts: these are referenced later in the report.

13.2 Relevant Events within the DHR Timeframe

13.2.1 The DHR panel felt that the focus of the review should be on domestic abuse and safeguarding issues rather than the detail of Tasmin's medical conditions and appointments. Some medical issues are therefore not covered in the report, with only those being directly relevant included. The following paragraphs summarise those issues affecting Tasmin, within the timeframe of the DHR Terms of Reference, which the panel felt were most relevant.

13.2.2 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.

13.2.3 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.

13.2.4 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.

13.2.5 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.

13.2.6 On 13 September 2018, Tasmin was transferred to Arkwright Unit at Royal Preston Hospital. This hospital is managed by Lancashire and South Cumbria NHS Foundation Trust (LSCFT).

13.2.7 On 14 September 2018, Tasmin was transferred to a local crisis house where she was visited every day by the LSCFT Home Treatment Team.

13.2.8 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.

13.2.9 On 27 September 2018, Tasmin's medication was adjusted by a psychiatrist to weekly prescriptions in order to reduce the risk of overdose. Her Lancashire GP was informed of this.

13.2.10 On 30 September 2018, the LSCFT Home Treatment Team rang Tasmin to confirm some details in order to make a MARAC referral. She was upset after receiving information from the Garda about her ongoing case as a victim of domestic abuse.

13.2.11 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.

13.2.12 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).

13.2.13 On 4 October 2018, Lancashire Victim Services, which provides IDVA services for Lancashire, received a referral for Tasmin from Lancashire Constabulary.

13.2.14 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.

13.2.15 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. [see paragraph 13.2.18]. Action completed.

13.2.16 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.

13.2.17 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.

13.2.18 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.

13.2.19 On 24 October 2018, a professionals' meeting took place to facilitate a multi-agency discussion about Tasmin's case. Actions were agreed for housing and for the mental health crisis team to provide face-to-face counselling. [the counselling did not happen as Tasmin later moved away from the area].

13.2.20 On 25 October 2018, Tasmin registered with a Cambridgeshire GP.

13.2.21 On 15 November 2018, following contact from housing [Cambridgeshire], Tasmin was able to bid for properties.

13.2.22 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.

13.2.23 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.

13.2.24 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.

13.2.25 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.

13.2.26 On 28 December 2018, the Cambridgeshire IDVA spoke to Tasmin about the domestic abuse incident of 8 December – having received the DASH risk assessment from the police. Safety planning was completed.

13.2.27 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.

13.2.28 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.

13.2.29 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.

13.2.30 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.

13.2.31 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.

13.2.32 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.

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

13.2.34 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.

13.2.35 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.

13.2.36 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.

13.2.37 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.

13.2.38 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.

13.2.39 On 11 October 2019, Tasmin attended the Cambridgeshire GP. She said that she was in the area to help her mother move house [to move to Warrington]. The GP prescribed 60 quetiapine and 21 zopiclone tablets. This was reported to the Lancashire GP.

13.2.40 On 30 October 2019, Tasmin attended the Cambridgeshire GP. She said that she was anxious about a domestic abuse court case in Ireland. She was prescribed 21 zopiclone tablets.

13.2.41 On 20 November 2019, Tasmin saw the Lancashire GP. She discussed recent prescriptions by the Cambridgeshire GP. It was agreed to trial escitalopram[10], due to

[10] Escitalopram is a type of antidepressant known as a selective serotonin reuptake inhibitor (SSRI). It's often used to treat depression and is sometimes used for anxiety, obsessive compulsive disorder (OCD), or panic attacks.

ongoing anxiety, and a 28-day prescription was issued. A repeat prescription was issued on 17 December 2019.

13.2.42 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.

13.2.43 On 6 January 2020, Warrington Borough Council Mental Health Outreach Team (Adult Social Care) received a referral for support for Tasmin from the mental health liaison team.

13.2.44 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).

13.2.45 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].

13.2.46 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.

13.2.47 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.

13.2.48 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.

13.2.49 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.

13.2.50 On 16 March 2020, Tasmin was closed to the Warrington Borough Council Mental Health Outreach Team because, despite many attempts, they had been unable to see her, and she was now an inpatient in hospital.

13.2.51 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.

13.2.52 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.

13.2.53 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.

13.2.54 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.

13.2.55 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"

13.2.56 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.

13.2.57 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.

13.2.58 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.

13.2.59 On 29 September 2020, Tasmin was contacted by the Home Treatment Team. She said that she was away for a few days, was doing fine, and would attend an appointment the following week.

13.2.60 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.

13.2.61 On 13 October 2020, Tasmin's Warrington GP received a discharge letter following Tasmin's admittance to hospital on 21 September and discharge on 28 September. This included information that Tasmin had been subject to sexual and physical

abuse from her ex-partner, and that this was under investigation by the police.

13.2.62 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.

13.2.63 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.

13.2.64 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.

13.2.65 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.

13.2.66 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.

13.2.67 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

13.2.68 On 14 December 2020, Warrington Borough Council Mental Health Outreach Team (Adult Social Care) received a referral for support for Tasmin from the Home Treatment Team.

13.2.69 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.

13.2.70 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.

13.2.71 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.

13.2.72 On 19 January 2021, a worker from the Mental Health Outreach Team contacted Tasmin, by phone, and arranged to meet her on 26 January.

13.2.73 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.

13.2.74 On 26 January 2021, the Mental Health Outreach Team received a text from Tasmin, stating:

"Hi I am going to have to cancel today as things got bad with my stepfather at the weekend and I have had to leave. just trying to sort somewhere to live".

A worker contacted Tasmin, by phone, to confirm that she was well. Tasmin said that things had been brewing with her stepfather, and that she had had to move out and was staying with her sister. Another meeting was arranged for 3 February.

Tasmin's mother and stepfather confirmed that there had been family disagreements at this time but that they continued to support Tasmin.

13.2.75 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.

13.2.76 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.

13.2.77 On 11 February 2021, Tasmin cancelled the planned meeting with the Mental Health Outreach Team. She agreed to a phone call and spoke to a worker on the phone. Tasmin discussed her hospital admission on 8 February and said that she had got overwhelmed with everything and commented that she had now secured the flat but was worried about not having anything for her flat. The worker offered help in obtaining items for the flat that Tasmin might need. A meeting in a public place was arranged for 17 February 2021.

13.2.78 Tasmin cancelled the meeting on 17 February, as she was doing an induction for a new job, but she spoke to the worker on the telephone. A further meeting in a public place was arranged for 26 February.

13.2.79 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.

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

13.2.81 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.

13.2.82 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.

13.2.83 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.

13.2.84 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

13.2.85 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"

13.2.86 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.

13.2.87 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.

13.2.88 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.

13.2.89 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.

13.2.90 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.

13.2.91 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.

13.2.92 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.

13.2.93 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.

13.2.94 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.

13.2.95 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.

13.2.96 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.

13.2.97 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.

13.2.98 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.

13.2.99 On 30 April 2021, a practitioner from the Home Treatment Team contacted Tasmin, by phone, to offer a visit. However, she declined. She stated that she wished to spend the day with her sister and therefore it was agreed to phone again to arrange a face-to-face appointment.

13.2.100 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.

13.2.101 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. 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.

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

13.2.103 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.

END OF CHRONOLOGY

14 Analysis

14.1 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?

14.1.1 The panel wished to emphasise that Tasmin was primarily a victim of physical, domestic, and sexual abuse in Ireland. The panel also acknowledged that Tasmin was a victim of post-separation emotional abuse (from a perpetrator in Ireland) whilst she was resident in England, and that she had lost access to her children. The panel has been unable to obtain access to information from agencies in Ireland. This has limited the panel's understanding of that abuse, as the panel has relied on contemporary reports from Tasmin to agencies in England, Irish media, and family knowledge. The panel's focus was on learning from the services provided to Tasmin in England.

14.1.2 On 5 September 2018, Tasmin told her Lancashire GP that she had been a recent victim of domestic abuse in Ireland. This resulted in the GP referring her to Mindsmatter (local Improving Access to Psychological Therapies service) and the local women's refuge service. The referral to Mindsmatter was not ultimately progressed because by the time it was processed, Tasmin was open to mental health services

14.1.3 On 10 September 2018, Tasmin was taken to Warrington Hospital after experiencing suicidal ideation. She disclosed domestic abuse in Ireland. This attendance at hospital resulted in an admission to a mental health hospital managed by Lancashire and South Cumbria NHS Foundation Trust (LSCFT). This was followed by a stay in a crisis house. On her discharge, LSCFT staff completed a DASH risk assessment and a referral to MARAC was made. This was appropriate, given the disclosures of domestic abuse that Tasmin made.

14.1.4 On 3 October 2018, Lancashire Constabulary received a MARAC referral from West Lancashire Mental Health Home Treatment Team. This was actioned, and the case was scheduled to be heard at Lancashire MARAC on 7 October. In the meantime, Tasmin travelled to stay with her mother in Cambridgeshire, where she reported to the police, on 2 October, 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 but upgraded by MASH to high and referred to MARAC. 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.

Tasmin had been referred to both Lancashire and Cambridgeshire IDVA services. The Lancashire IDVA ensured that a MARAC-to-MARAC transfer took place and offered support whilst a Cambridgeshire IDVA was allocated. The panel thought that this was good practice.

14.1.5 From 12 – 16 October 2018, Tasmin was an inpatient at a mental health hospital in Cambridgeshire [Cambridgeshire and Peterborough NHS Foundation Trust], following an admission as a result of an overdose of prescribed medication. During her time in hospital, a DASH risk assessment was conducted, which indicated a high risk.

14.1.6 On her discharge from hospital, Tasmin was contacted by a Cambridgeshire IDVA who had been trying to reach her. Tasmin outlined the domestic abuse issues in Ireland, and the IDVA offered practical support, for example, a new phone. On 24 October 2018, a professionals' meeting took place to facilitate a multi-agency discussion about Tasmin's case. Actions were agreed for housing and for the mental health crisis team to provide face-to-face counselling. The panel thought that this response to Tasmin was timely and helpful.

14.1.7 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, and if she didn't appear, then he would be released from his bail. She was advised to ask if a video link was possible. The following day, Tasmin took an overdose of prescribed mediation and was admitted to hospital after being detained by Cambridgeshire Constabulary under Section 136 of the Mental Health Act. Her detention and admission to hospital were appropriate in the circumstances.

14.1.8 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.

14.1.9 On 30 December 2018, Tasmin jumped into a river in Cambridgeshire, having consumed 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.

Cambridgeshire Constabulary notified the IDVA service of Tasmin's self-harm. The case was referred to MARAC on professional judgement and heard at MARAC on 7 January 2019. The MARAC referral was appropriate.

14.1.10 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. Whilst there, 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.

She 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. She was not legally detainable under the Mental Health Act at that time, and she declined any further input from mental health services at that juncture.

Soon after this, Tasmin moved back to Lancashire, and a MARAC-to-MARAC transfer was completed. The case was heard at Lancashire MARAC on 3 April 2019. Following that, a Lancashire IDVA attempted to contact Tasmin but was unsuccessful.

Cambridgeshire Constabulary were unable to contact Tasmin until 2 June 2019, when she told an officer that she had moved back to Ireland and did not want to progress the rape case any further.

14.1.11 On 19 April 2019, whilst visiting a friend in 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. A referral was made to the Home Treatment Team in Lancashire, where Tasmin was living with her father. Tasmin was seen by the Home Treatment Team two days later. The panel thought that it was good practice that she was seen by the same practitioner who had previously worked with her. She was worried about the court case in Ireland and was signposted to local domestic abuse services. Tasmin was due to attend an appointment with a psychologist on 2 May but

cancelled the appointment as she said she was going on holiday to Ireland. LSCFT had no further contact with her.

14.1.12 On 2 January 2020, Tasmin attended at Warrington Hospital, following an overdose, and was reviewed by the mental health liaison team [North West Boroughs NHS Foundation Trust – now Mersey Care NHS Foundation Trust]. She said that she had been living back in Warrington for three weeks and had taken an overdose after Sean had contacted her to ask that she drop the court case against him. Tasmin identified that her confidence and self-esteem had taken a blow due to being in the violent relationship previously for 3 years. She stated that she had a diagnosis of anxiety, depression, PTSD, and EUPD. Tasmin agreed to a referral to Warrington Borough Council Mental Health Outreach Team or social inclusion, anxiety management, and confidence building. Between January and March 2020, attempts were made by the team to meet Tasmin to conduct a Star assessment. Tasmin was then detained under S2 of Mental Health Act. Due to being detained in hospital, the referral to Mental Health Outreach was closed. The panel was informed that this was appropriate, as Tasmin was in hospital.

14.1.13 Between 2 – 27 February 2020, Tasmin was a voluntary patient on a mental health ward managed by North West Boroughs NHS Foundation Trust [now Mersey Care NHS Foundation Trust]. Tasmin told staff about the abuse she had suffered in Ireland and was even contacted on the ward by an officer from the Garda dealing with her case. Prior to her discharge, a referral was made to the Refuge Warrington IDVA service. When contacted by an IDVA, Tasmin asked for a call back; however, the IDVA was then unable to contact her again.

14.1.14 On 15 March 2020, Tasmin was admitted to hospital under Section 2 of the Mental Health Act, after she had been rescued from a river. Tasmin was initially accommodated in a private out-of-area hospital due to a lack of capacity. However, she was transferred back to a hospital managed by North West Boroughs NHS Foundation Trust [now Mersey Care NHS Foundation Trust] on 21 March. During this admission, Tasmin did not discuss or disclose domestic abuse. The panel member for North West Boroughs NHS Foundation Trust [now Mersey Care NHS Foundation] told the panel that whilst it is often not appropriate for medical professionals to probe for information at a time of crisis, the abuse that Tasmin had suffered should have been discussed and followed up on her return to Warrington, when her mental health had improved. Tasmin was discharged from hospital on 23 March 2020. North West Boroughs NHS Foundation Trust [now Mersey Care NHS Foundation Trust] staff were aware of the background of domestic abuse. A DASH risk assessment was not completed on this occasion, and there was no referral to the Refuge IDVA service in Warrington.

The panel was informed that significant work has been completed within the Trust since this time, in order that there are robust safeguarding referrals across the Trust: these are reviewed daily (with advice from the Trust safeguarding team) until a completion of the referral is reached.

14.1.15 On 21 September 2020, Tasmin was rescued from water in Warrington and taken to hospital. After an initial assessment, she was detained under Section 2 of the Mental Health Act and stayed in a hospital managed by North West Boroughs NHS Foundation Trust [now Mersey Care NHS Foundation Trust]. Tasmin disclosed to Cheshire Constabulary and medical staff, significant physical assaults and rapes that she had been subjected to by Sean (in Ireland over the summer), with the last incident happening on 19 September. The information was also shared with Tasmin's Warrington GP.

Cheshire Constabulary assisted An Garda Siochana by obtaining a written statement from Tasmin and providing a copy of her disclosures (captured on an officer's body worn video), when she was rescued from the water.

Neither Cheshire Constabulary nor North West Boroughs NHS Foundation Trust [now Mersey Care NHS Foundation Trust] completed a DASH risk assessment or a referral to the Refuge Warrington IDVA service. Given the detailed disclosures that Tasmin made of violence and rape, a referral should have been made.

This is further discussed at paragraph 14.5.

14.1.16 Tasmin stayed in hospital until she was discharged a week later. Community mental health services and her GP were made aware of the abuse she had suffered.

14.1.17 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. This went against normal procedure in England, as a video interview would normally be used in such circumstances. However, Cheshire Constabulary were told that there was no such provision in the Irish criminal justice system. A DASH risk assessment was not completed and therefore there was no referral to MARAC. Given the disclosures that Tasmin made, a DASH risk assessment should have been completed. It is likely that given the risks, this would have resulted in a referral to MARAC and appropriate support being offered to Tasmin, for example, from the Refuge Warrington IDVA service.

14.1.18 Over the following months, Tasmin had further contact with the police, hospital mental health services, and community mental health services. All these services knew of Tasmin's experience of domestic abuse. A referral was made to the Warrington Borough Council Mental Health Outreach Team, and it was as a result of Tasmin's discussions with a worker from that team, that a referral was made to the Refuge Warrington IDVA service (initially on 26 February 2021 and again on 11 March 2021). The referrals were appropriate. A referral could have been made by any of the agencies involved with Tasmin, as she freely disclosed information in relation to her experiences.

14.1.19 The panel thought it likely that professionals had been distracted from conducting DASH risk assessments or making referrals because the abuse that Tasmin had suffered happened in Ireland. It is likely that there was a perception that she was safe, as she was in England. The result of this was that between September 2020 and February 2021, she did not have contact with specialist domestic abuse services or RASAC in Warrington (where she was living).

14.1.20 Following the referral, an IDVA made contact with Tasmin on 27 February, and Tasmin said she would call back a few days later. She did not do so and attempts to contact her were unsuccessful. Following the second referral, an IDVA contacted Tasmin on 23 March 2021. As a result of Tasmin's disclosures on that occasion, a referral was made to MARAC: information was then shared appropriately with other agencies involved. The Refuge Warrington IDVA service considers that, on this occasion, information could have been shared earlier with the community mental health team, prior to the MARAC meeting.

14.1.21 The DASH risk assessment completed on 23 March 2021, identified how Sean had used technology in his abuse towards Tasmin. She disclosed how Sean had previously placed a tracker on her phone to monitor her movements and how he would use numerous social media accounts to make contact with her. The records show that Tasmin informed the IDVA that all her apps / social media accounts and her mobile phone location settings were turned off now. This would have been an opportunity for the IDVA to discuss a referral to Refuge's Tech Abuse and Empowerment Team for additional support and possibly reduce the risk of further technological abuse; however, this referral was not made. The service manager has since organised for the Tech Lead, in Refuge's Tech Abuse and Empowerment Team, to attend a team meeting and talk to the team on how to make referrals into the tech service. The manager has arranged for the Tech Lead to attend the service team meetings yearly.

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

1. A referral to be made to RASAC – the referral was made and Tasmin was in touch with RASAC but did not receive services before her death.
2. A vulnerability marker to be placed on the police computer regarding Tasmin's address – this was completed. The marker did not mention that Tasmin was at high risk of domestic abuse and had been heard at MARAC.
3. A risk assessment to be completed regarding the perpetrator [Sean] in Ireland, pending his release from prison.
   [checks revealed he was not due for release until August 2021 – Tasmin was informed of this by the IDVA on 28 April].

14.1.23 Throughout the rest of April 2021, Tasmin continued to have contact with services. Following attempted ligature, she was admitted to hospital twice and was followed up by the Mental Health Home Treatment Team. Tasmin described issues that were causing her stress, for example, work and financial issues, but she did not make further disclosures in relation to domestic abuse.

14.1.24 During the period that Tasmin engaged with services in Warrington, she always described her parents and stepfather as being supportive. This changed to some extent in January 2021, when Tasmin contacted the Warrington council housing department for housing advice and to make a potential homelessness application. She said that she was living with her mother and stepfather and finding things difficult.

A week later, the Mental Health Outreach Team received a text from Tasmin, stating:

"Hi I am going to have to cancel today as things got bad with my stepfather at the weekend and I have had to leave. just trying to sort somewhere to live". A worker contacted Tasmin, by phone, to confirm that she was well. Tasmin said that things had been brewing with her stepfather, that she had had to move out, and that she was currently staying with her sister. Tasmin described her stepfather's conduct as 'controlling'.

There is no evidence that there was any further exploration of the difficulties that Tasmin described. The panel thought that in such circumstances it would have been good practice for professionals to have explored the situation further, which may have indicated or negated the possibility of domestic abuse. The IMR author for North West Boroughs Healthcare NHS Foundation Trust [now Mersey Care NHS Foundation Trust], concluded that a DASH risk assessment should have been completed on this occasion.

14.1.25 The panel considered whether there was evidence that Tasmin had been subjected to coercion and control. In doing so, the panel referred to the Crown Prosecution Service's policy guidance.

14.1.26 The Crown Prosecution Service's policy guidance on coercive control states:[11]

'Building on examples within the Statutory Guidance, relevant behaviour of the perpetrator can include:

- Isolating a person from their friends and family
- Depriving them of their basic needs
- Monitoring their time
- Monitoring a person via online communication tools or using spyware
- Taking control over aspects of their everyday life, such as where they can go, who they can see, what to wear and when they can sleep
- Depriving them access to support services, such as specialist support or medical services
- Repeatedly putting them down such as telling them they are worthless
- Enforcing rules and activity which humiliate, degrade or dehumanise the victim
- Forcing the victim to take part in criminal activity such as shoplifting, neglect or abuse of children to encourage self-blame and prevent disclosure to authorities
- Financial abuse including control of finances, such as only allowing a person a punitive allowance
- Control ability to go to school or place of study
- Taking wages, benefits or allowances
- Threats to hurt or kill
- Threats to harm a child
- Threats to reveal or publish private information (e.g., threatening to 'out' someone)
- Threats to hurt or physically harming a family pet
- Assault

[11] www.cps.gov.uk/legal-guidance/controlling-or-coercive-behaviour-intimate-or-family-relationship

- Criminal damage (such as destruction of household goods)
- Preventing a person from having access to transport or from working
- Preventing a person from being able to attend school, college or university
- Family 'dishonour'
- Reputational damage
- Disclosure of sexual orientation
- Disclosure of HIV status or other medical condition without consent
- Limiting access to family, friends and finances

This is not an exhaustive list and prosecutors should be aware that a perpetrator will often tailor the conduct to the victim, and that this conduct can vary to a high degree from one person to the next'.

14.1.27 The panel thought that there was clear evidence that Tasmin had been subjected to behaviour that – had it had happened in England and Wales – would have amounted to coercive and controlling behaviour. However, from the information available to the panel, almost all acts appear to have been perpetrated in Ireland, and the perpetrator, Sean, was dealt with according to Irish law.

14.1.28 As Tasmin had sometimes complained of financial hardship, the panel considered the definition of economic abuse contained within the Domestic Abuse Act 2021:

"any behaviour that has a substantial and adverse effect on an individual's ability to:

- acquire, use or maintain money or other property (such as a mobile phone or car) or
- obtain goods or services (such as utilities, like heating, or items such as food and clothing)"

Surviving Economic Abuse[12] (the UK charity), state:

Economic abuse is a legally recognised form of domestic abuse and is now defined in the Domestic Abuse Act [post Tasmin's death]. It often occurs in the context of

[12] https://survivingeconomicabuse.org/what-is-economic-abuse/

intimate partner violence and involves the control of a partner or ex-partner's money and finances, as well as the things that money can buy.

1 in 6 women in the UK has experienced economic abuse by a current or former partner.

Economic abuse can include exerting control over income, spending, bank accounts, bills and borrowing. It can also include controlling access to and use of things like transport and technology, which allow us to work and stay connected, as well as property and daily essentials like food and clothing. It can include destroying items and refusing to contribute to household costs.

Financial abuse is controlling finances, stealing money or coercing someone into debt. Economic abuse and financial abuse involve similar behaviours, but it is helpful to think of financial abuse as a subcategory of economic abuse.

Tasmin may have been subjected to financial abuse in her brief relationship with a man in Cambridgeshire. For example, her family say that he pawned a ring without permission. This was not reported to the police or any other agency.

Tasmin disclosed that she was struggling financially when living in Warrington. Having taken the tenancy of a flat, she arranged for a flatmate to use the spare bedroom and therefore help with the rent. Tasmin disclosed that she had signed up to a website for sex work, but there is no evidence that she engaged in that work. Tasmin worked sporadically. However, together with benefits and income from her lodger, it allowed her to manage her finances.

Department for Work and Pensions records indicate that Tasmin was in receipt of Universal Credit from 17 September 2018 until her death. The money was paid into a UK bank account in her sole name. The panel did not have information on Tasmin's financial situation in Ireland.

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

14.2.1 **DASH Risk assessments completed**

Date	Agency completing	Result
26.9.18.	Lancashire and South Cumbria NHS Foundation Trust	High risk – MARAC referral

2.10.18.	Cambridgeshire Constabulary	High risk – MARAC referral
12.10.18.	Cambridgeshire and Peterborough NHS Foundation Trust	High risk – already engaged with IDVA
8.12.18.	Cambridgeshire Constabulary	Medium risk with new boyfriend
11.3.21	Refuge Warrington IDVA service	High risk – MARAC referral

The panel thought that the DASH risk assessments completed were all appropriate. All agencies completing them, considered that they were accurate and the appropriate quality.

14.2.2 One element of risk was Tasmin's concern that Sean was linked to a proscribed organisation[13]. The review did not identify any evidence or intelligence linking Sean to a proscribed organisation.

14.2.3 The panel also identified a number of missed opportunities to carry out DASH risk assessments.

Date	Agency	Circumstances
5.9.18.	Lancashire GP	Tasmin disclosed domestic abuse in Ireland. She was referred to Mindsmatter (the local Improving Access to Psychological Therapies service) and given information about the local women's refuge service.
2.1.20.	North West Boroughs NHS Foundation Trust [now Mersey Care NHS Foundation Trust]	Tasmin was seen, following an overdose taken after contact from Sean. She said that she planned to contact the local IDVA service.
26.2.20.	North West Boroughs NHS Foundation Trust [now Mersey Care NHS Foundation Trust]	Whilst in hospital, Tasmin was referred to the IDVA service. An IDVA did speak briefly to Tasmin but was then unable to contact her again.

[13] Section 3 Terrorism Act 2000

21.9.20.	Cheshire Constabulary and North West Boroughs NHS Foundation Trust [now Mersey Care NHS Foundation Trust]	Tasmin made significant disclosures to Cheshire Constabulary and medical staff about recent domestic abuse in Ireland.
20.11.20.	Cheshire Constabulary	Cheshire Constabulary interviewed Tasmin and obtained a written statement from her about domestic abuse that she had suffered in Ireland in September 2020 (on behalf of An Garda Siochana).
9.1.21.	North West Boroughs NHS Foundation Trust [now Mersey Care NHS Foundation Trust]	Tasmin told a Home Treatment Team worker that her stepfather was controlling.
26.1.21.	North West Boroughs NHS Foundation Trust [now Mersey Care NHS Foundation Trust]	Tasmin told a Home Treatment Team worker that she had had to move out due to issues with her stepfather.

14.2.4 The panel discussed the significance of the missed opportunities to conduct DASH risk assessments. Given that when risk assessments were conducted, three out of five resulted in a referral to MARAC (with a further linked referral to MARAC after a self-harm attempt in December 2018), the panel thought that it was highly likely that had DASH risk assessments been undertaken at the identified points above, Tasmin would have been referred to MARAC on other occasions. This was especially the case when she returned to Warrington in September 2020 and disclosed further significant domestic abuse in Ireland. The consequence of a DASH risk assessment not being completed at this point was that Tasmin was not referred to MARAC and did not have the opportunity to engage with an IDVA or RASAC until March 2021. The referral to MARAC in March 2021 was made on essentially the same information that Tasmin had disclosed in September 2020. 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. This is a learning point, leading to panel learning and recommendation 1.

14.2.5 The panel also noted that referrals were sometimes made to the IDVA service without a DASH risk assessment being completed. This is accepted by the Warrington Refuge IDVA service as appropriate, especially if a person is in crisis.

The panel heard that it would be helpful if referrals indicated the clients' consent to speak to other services. This is a learning point, leading to panel learning and recommendation 2.

The panel heard that the Warrington Refuge IDVA service is soon to be transferred to another provider and took that into account in its recommendation.

14.2.6 North West Ambulance Service attended to Tasmin on five occasions. On each occasion, staff conducted a dynamic risk assessment. On four occasions, this resulted in a safeguarding adult concern being raised with Adult Social Care. The panel thought that the concerns were appropriate. East Of England Ambulance Service also submitted a safeguarding concern to Cambridgeshire Adult Social Care on one occasion.

The safeguarding adult concerns are further discussed at paragraph 14.6.

14.2.7 Mersey Care completed a number of risk assessments for Tasmin arising from their involvement in her mental health care.

Risk Assessments completed:

10.09.2018 – A&E attendance
19.04.2019 – Initial Assessment
03.01.2020 – MH Liaison following impulsive overdose
02.02.2020 – Admission to ward
24.02.2020 – Care review / discharge planning from ward
27.02.2020 – Discharge summary
28.02.2020 – 72-hour follow-up by Home Treatment team (HTT)
21.03.2020 – Admission to Ward
22.03.2020 – Discharge planning
28.09.2020 – Discharge planning
01.10.2020 – 72-hour review by HTT
Risk Summary updated 10.12.22 – 22.12.22 – 28.12.22
09.02.2021 – A&E attendance
20.04.2021 – A&E attendance
21.04.2021 – HTT appointment RAG rated red (daily visits)
23.04.2021 – A&E attendance
25.04.2021 – HTT appointment RAG rated amber (3 visits per week).

14.2.8 Risk assessments should be completed following significant events, crisis periods, safeguarding concerns, and changes in circumstances. For example, hospital admissions, etc. There is evidence of regular risk assessments being completed at the appropriate times.

Risk assessments are carried over from assessment to assessment. Therefore, each new assessment that is completed, reflects previously identified risks: this contributes to the development of an overall risk profile. Some early risk assessments lack detail, especially around decision-making rationale. For example, identifying what has changed from a previous risk assessment in order to amend a risk level. There are, however, some good examples that provide this level of detail.

Throughout the assessments, there is regular reference to safety planning being agreed with Tasmin.

14.2.9 The risk assessment of 28 September 2020 identified that Tasmin declined a referral to drug and alcohol support services. There are no further references, in risk assessments, to this offer being made. This is despite continued reference, in subsequent risk assessments, to the risks increasing following alcohol consumption.

14.2.10 The last risk assessment was completed by Mersey Care on 25 April 2021, which identified 'risk to self'.

Tasmin reported intrusive thoughts to harm herself. Tasmin denied any plans or intent to act on these thoughts. A safety management plan was discussed. Tasmin was aware of the contact details (24/7) for support if required. Tasmin also indicated that she would reach out to her sister for support. Tasmin denied any thoughts, plans or intent to harm others: no hostility or aggression was noted throughout the review. There was no evidence of self-neglect identified.

This assessment indicates that the risk of vulnerability – in relation to Tasmin signing up to a website for sex work – was now historical, and there was no current risk.

It is noted that: Tasmin demonstrated capacity; was able to recall, retain, and relay information; and showed insight into her mental health. It is identified in this assessment that Tasmin was engaging with Talking Matters (Psychological Therapy) and Outreach. This is first identified within the risk assessment dated 21.10.20 and is referenced in all subsequent risk assessments. In fact, Tasmin was never successfully referred to Talking Matters and was not engaged in psychological therapy. This is further explored at paragraph 14.3.4.

14.2.11 The panel heard that a comprehensive programme of mandated training is taking place in Mersey Care: this addresses the learning points for Mersey Care, raised at

paragraphs 14.2.7 to 14.2.10, in relation to risk assessment and referrals to other organisations. No further recommendation is therefore made on these points.

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

14.3.1 Tasmin freely disclosed information in relation to her victimisation and mental health. All agencies involved in the review were aware to some extent of the issues affecting her.

14.3.2 At times of crisis, Tasmin was often intoxicated by alcohol and sometimes disclosed use of illicit drugs. She declined a referral to local substance misuse services and did not self-refer to those services.

14.3.3 Tasmin appeared to be under the impression that she had been referred to Talking Matters; however, there is no evidence that any referrals had been generated or accepted.

14.3.4 Following Tasmin's discharge from a mental health inpatient ward on 28 September 20, a referral was completed to Warrington Recovery Team for inclusion on the Personality Disorder pathway. This referral was closed. However, based on the clinical information, Tasmin did meet the criteria for the Personality Disorder pathway.

A Multidisciplinary Team discussion had been completed. This was attended by primary and secondary care services, which is deemed good practice, to ensure that referral, risk, and concerns were discussed.

The plan from this MDT was for Talking Matters to assess Tasmin further and to discuss further with the MDT, if they felt they were unable to manage the risks associated with Tasmin's difficulties. However, as no referral had ever been made, this was unsuccessful. This was a missed opportunity to clarify if Talking Matters had received a referral for Tasmin and to determine why she had not completed a self-referral, as Tasmin continued to report being on the waiting list for therapy on contact with North West Boroughs Healthcare NHS Foundation Trust [now part of Mersey care NHS Foundation Trust]. The care offer could have been strengthened if clinical staff had explored this further with Tasmin and Talking Matters, to ensure a referral was completed and in process.

14.3.5 The Refuge Warrington IDVA service received referrals for Tasmin on three occasions – all of the referrals included information relating to Tasmin's mental

health. On the first two occasions, the service was unsuccessful in engaging with Tasmin.

14.3.6 On the third occasion following a referral on 11 March 2021, an IDVA did achieve engagement with Tasmin and completed a DASH risk assessment. Tasmin was open about her mental health issues and current medication. She said that she had felt suicidal on numerous occasions in the past but did not currently feel suicidal. She confirmed that she was receiving help from mental health practitioners.

14.3.7 The IDVA had further calls with Tasmin, and on 28 April 2021, Tasmin explained that she was feeling very depressed and low in mood, and that she had been reflecting upon what had happened to her. She said that the Home Treatment Team were coming to her home every day, which was helping with her mental health, and that RASAC were contacting her tomorrow.

14.3.8 There were no actions taken following the call on 28 April 2021. The call was an opportunity to obtain consent from Tasmin to speak with other agencies, such as the Home Treatment Team, or make a referral to the Safeguarding Adults team to share relevant information in relation to the domestic abuse and the self-harm/suicidal thoughts she had been experiencing. If consent had not been obtained, there could have been consideration to completing an adult safeguarding concern. The panel was informed that Warrington Adult Social Care now has a duty line where agencies can speak to a safeguarding manager for advice. This would have been an option had it been in place at the time of these events.

Although Tasmin had stated that she was not currently having any thoughts of harm, she expressed feeling very depressed and low in mood. There was a discussion with the IDVA around support from family members, and for Tasmin to not spend too much time on her own.

Consent from Tasmin to speak to the Home Treatment Team, may have led to joint working in relation to her mental health and the impact domestic violence may have had on this.

The IDVA's training records show that they had not completed Refuge's internal training around providing a support service to survivors of domestic abuse and suicide & self-harm, nor had they completed Refuge's or local safeguarding training, even though they had started at Refuge in 2019. The manager was unable to explain why the IDVA had not completed the training. There was no robust system in place to monitor which training staff had attended, leading to key mandatory training being missed. Refuge has reviewed its training programme, to make training more accessible for staff and give managers a tool to monitor their staff's training needs. Refuge's updated training system was implemented in July

2022. The manager has contacted Warrington's local safeguarding service to access the local training for all staff.

14.3.9 The panel discussed whether Tasmin's use of alcohol may have impacted on her mental health treatment. Alcohol was often a factor when Tasmin was in crisis, and access to a local drugs and alcohol support agency was discussed with Tasmin on four occasions by mental health practitioners.

Those occasions were:

28/2/20, 28/9/20, 8/2/21 and 21/4/21, which are referenced in section 13 of the report.

Tasmin did not access local drug and alcohol services. The panel discussed that, on occasion, if an individual has drug and alcohol issues, they are told by mental health services that they are not able to access mental health services until they address their addictions. However, this was not the case with Tasmin, who was able to access mental health services.

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

14.4.1 Prior to her death in May 2021, Tasmin had attended, or been admitted to, hospital in England on 14 occasions due to suicidal ideation or self-harm. These included overdoses of drugs, entering water, and ligatures.

14.4.2 In January 2019, an attempt at self-harm by ligature followed Tasmin reporting a rape. On all other occasions, Tasmin was open and clear in stating that her actions were as a result of feelings brought about by the domestic abuse that she had suffered in Ireland. All agencies involved in the review, had information to indicate that Tasmin's self-harming was linked to the domestic abuse that she had suffered.

14.4.3 This was exacerbated by the impending court cases in Ireland and Tasmin's stated fears of having to attend court in Ireland.

14.4.4 The panel was aware that research has indicated a significant number of domestic abuse victims suffer from suicidal ideation. A study[14] in 2019, estimated that between 20 – 80% of victims of domestic abuse had suicidal ideation. Panel members thought that the research should be widely shared in domestic abuse training. This is a learning point, leading to panel learning and recommendation 3.

14.4.5 Tasmin also made disclosures to mental health services and others regarding the difficulties that she experienced in seeing or keeping in touch with her children who lived in Ireland with her former husband. The panel looked for evidence that may point to increased suicide risk for mothers who struggle to keep in contact with their children.

14.4.6 An article in 'The Conversation'[15], written by Elizabeth Wall-Wieler (a PhD student at the University of Manitoba, Canada), highlights key research that shows an increased mortality rate for mothers who lose their children to the care system.

Wall-Wieler explains that, while mothers whose children are taken into care sometimes have underlying health conditions, the studies take those pre-existing conditions into account, meaning that the data is directly linked to the impact of losing a child to the care system.

The first study, published in December 2017 in the Canadian Journal of Psychiatry[16], was co-produced by Wall-Wieler, and examines suicide attempts and suicide completions amongst mothers whose children were placed in care. The researchers discovered that the suicide rate amongst these women was almost three times higher, and the death rate almost four times higher, than those mothers whose children had not gone into foster care.

More research co-produced by Wall-Wieler and published in the American Journal of Epidemiology[17], in March 2018, found that mothers whose children were placed in care, were almost five times more likely to die from avoidable causes, such as unintentional injury and suicide, and almost three times more likely to die from

[14] From hoping to help: Identifying and responding to suicidality amongst victims of domestic abuse [*Vanessa E. Munro & Ruth Aitken]*

[15] https://theconversation.com/losing-children-to-foster-care-endangers-mothers-lives-
[16] https://journals.sagepub.com/doi/full/10.1177/0706743717741058
[17] https://academic.oup.com/aje/article/187/6/1182/4956003

unavoidable causes, including car accidents and heart disease.

A third study, published in the British Medical Journal of Epidemiology and Community Health, in October 2017[18], shows that when a mother loses her child to the care system, her physical and mental health become significantly worse.

14.4.7 The report, "Staying Mum[19]" published by the charity Against Violence and Abuse, found the following impacts on mothers who lost their children.

- The emotional impact of child removal for mothers was profound, including lasting feelings of fear, guilt, shame and humiliation, as well as exhaustion, powerlessness and anger.
- Many women told us that their mental health deteriorated sharply after their children were removed, and a high number had considered or attempted suicide.
- Child removal had wide-ranging impacts on mothers' relationships with friends, family, colleagues and communities, leaving women isolated.
- Mothers told us that the severe impact of child removal left them vulnerable to control and abuse in future partner relationships, as well as post-separation abuse from ex-partners.
- Damaging impacts on living standards and financial stability for mothers following child removal had the added effect of limiting the potential for children to be returned to them.
- These emotional and practical impacts on mothers' lives had the effect of limiting the ability of mothers to keep themselves and their children safe from domestic abuse.

14.4.8 Tasmin's mum stated that towards the end of her life, Tasmin thought that she had lost her children for good. Tasmin loved her children unconditionally. Tasmin would ring and video call them but could not get through to them.

The panel thought that Tasmin may have been referring to her loss of contact with her children when Tasmin posted a video to social media in March 2021. The video, titled *'I don't want to lose control'*, showed a photograph of her children and then panned to a bottle of vodka.

[18] https://jech.bmj.com/content/71/12/1145.info

[19] AVA, 2022. Staying Mum: Findings from peer research with mothers surviving domestic abuse & child removal. London, AVA (Against Violence and Abuse)

14.4.9 Although Tasmin had not 'lost' her children to the care system, the panel thought that her position of having to leave Ireland for her own safety and the infrequent contact that she was able to arrange with her children, was analogous to that position.

This is a learning point, leading to panel learning and recommendation 4.

14.5 **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?**

14.5.1 On reviewing the available information, the panel thought that the response of the police, Fire and Rescue, and ambulance service (in both Cambridgeshire and Cheshire) to Tasmin's self-harm, was good. Emergency responses included rescuing her from water and cutting ligatures.

14.5.2 Tasmin was supported by IDVAs in both Lancashire and Cambridgeshire. There was potential here for confusion as Tasmin quickly moved areas but both services appear to have managed the situation well with appropriate MARAC-to-MARAC transfers and personal contact with Tasmin. For example, in October 2018 after Tasmin had been referred to the Lancashire IDVA service but had already moved to Cambridgeshire, the Lancashire IDVA spoke to her and made sure that she had their contact details in case she needed support whilst she was getting settled and engaging with services in Cambridgeshire.

14.5.3 Cambridgeshire Constabulary placed risk markers on the address that Tasmin was living at and provided a personal attack alarm. The activation of this alarm by Tasmin in January 2019, resulted in a police response assisted by the GPS facility of the alarm. Tasmin made an allegation of rape, and three men were arrested. Tasmin later moved to Ireland and did not wish to continue with the case when contacted.

14.5.4 Tasmin's movement between three different areas meant that she was registered with three different GPs in England during the review period. Generally, the transfer of information and case summaries between the areas was in line with expected practice.

In October 2019, Tasmin attended at the GP surgery in Cambridgeshire, where she had previously been registered, because she was in the area visiting her mother. She was prescribed several weeks' worth of medication. She was registered with her Lancashire GP at this time and had previously been prescribed medication for

only seven days at a time by her Lancashire GP, in order to reduce the risk of overdose.

14.5.5 In September 2020, when Tasmin made disclosures to Cheshire Constabulary about domestic abuse that had taken place in Ireland, including rape, false imprisonment, and coercive and controlling behaviour, response officers recorded her first disclosure on body worn video, and specialist Public Protection officers took primacy in further evidence gathering. Contact was made with the An Garda Siochana, an early evidence kit was obtained as soon as Tasmin was deemed fit, and advice was sought from a doctor at the Sexual Assault Referral Centre (SARC).

14.5.6 Initial safeguarding was considered, with officers making contact with Tasmin's parents to ensure that she could return to their address if she was not detained in hospital. It is recorded that their address was not known to Sean, but a vulnerability marker should have been added to this address.

14.5.7 When An Garda Siochana requested a statement be obtained from Tasmin, officers challenged this and explained that Tasmin's evidence should be captured by way of Visually Recorded Interview, with a view to entitled special measures at trial. However, An Garda Siochana confirmed that no such provisions were available for victims within the Irish criminal justice system. As Tasmin's evidence was not captured visually, the officer taking her statement, provided a statement to describe her demeanour whilst speaking about the allegation, which is good practice.

14.5.8 When Tasmin's statement had been obtained, she was advised that the officer in the case from An Garda Siochana would update her directly, and the occurrence was closed. That action was appropriate.

A DASH risk assessment was not completed, and a Vulnerable Person Assessment (VPA) was not submitted. Although the offences were in Ireland, Tasmin was a victim of domestic abuse living in Cheshire. Multi-agency support and risk management should have been in place via the MARAC process. Sean was believed to be a dangerous individual, and Tasmin believed he would kill her if he found her. Whilst it is recorded that he did not know Tasmin's whereabouts or her mother's address, he was not believed to be in custody at that time, and he had breached bail conditions when committing the further offences against her. Tasmin's safety was based on Sean not knowing where her mother lived. There is no record of the risk being reassessed during this time, and vulnerability markers were not in place until requested when the MARAC referral was received in March 2021. Tasmin was known to be at risk of suicide and had expressed that the domestic abuse, rape, false imprisonment, and coercive and controlling behaviour had a huge impact on her mental health. Although mental health services were

involved, as S136 Mental Health Act had been utilised, specialist rape and domestic abuse support was not in place at a time when Tasmin was the victim in an ongoing criminal investigation, as well as the victim of serious offences going through the courts in Ireland: all of which were domestic related and involved the same perpetrator – Sean.

14.5.9 The impact of domestic abuse and coercive and controlling behaviour on Tasmin's mental health, and associated risk of suicide, along with the risk posed by Sean, should have been identified by Cheshire Constabulary when this information was received in September 2020. This then could have been managed via MARAC, where appropriate support services and effective risk management plans could have been put in place and reviewed to reflect changes in circumstances.

14.5.10 The Warrington IDVA supported Tasmin with a referral to RASAC. There was support offered for the sanctuary scheme and contact with the police for an update on Sean and the date of his release from prison. Further support included talking about the history of abuse that she had suffered, reviewing the risk assessments, safety planning, and a referral being made to the MARAC. The IDVA provided emotional support, discussed support from her family, and discussed speaking to her GP about her health and medication.

14.5.11 Refuge has a comprehensive casework management policy, which covers all aspects of supporting those who are accessing services. This includes the DASH risk assessment. The policy states that a risk assessment should be completed within 24 hours of contact and every survivor should have an individual support and risk management plan within three days. A discussion was held with Tasmin on her first contact. The duty worker was able to complete the risk assessment. The case was sent to the manager to be allocated to an IDVA on the 23 March 2020. The DASH risk assessments were reviewed twice after this: on 19 April 2021 and 28 April 2021. This is in line with Refuge's casework management policy, which states that DASH risk assessments will be reviewed by the worker with the client at least every four weeks and whenever there is a change in circumstances or new incident.

14.5.12 The third referral to the Refuge Warrington IDVA service was received on 11 March 2021. The worker on duty attempted contact with Tasmin on the same day: there was no answer. The next contact made to Tasmin was on the 23 March 2021. Although contact was successful, this is not in line with Refuge policy, which outlines staff will try to contact each client a total of five times within two working weeks. The first three attempts must be made within three working days of

receiving the referral. It is unclear why the first three attempts to contact Tasmin were not made within the three days.

Following her assessment, the timeframe for contacting Tasmin was lengthy. The assessment was made on 23 March 2021, but the allocated IDVA did not speak with Tasmin until the 7 April 2020.

The client risk assessment, which identifies risks of services users to themselves and others, was not completed until 19 April 2021. This is not in line with the policies at Refuge, which outline risk assessments should be completed within three days of contact, and risk assessments will be reviewed by the survivor and her key worker at least every four weeks and whenever there is a change in circumstances.

During this period, IDVAs were holding a caseload of 35 cases, somewhat above the normal threshold of 30 cases, and this may have had an impact. In future, managers in the service will communicate when the service receives higher than manageable referrals. This will be highlighted to senior management teams in Refuge and included to the service's departmental risk register, to capture the risk and what measures can be implemented to manage the risk.

14.5.13 The Refuge Warrington IDVA service did not appropriately liaise with referrers when staff were unable to contact Tasmin. The timescales for contacting referrers were not within Refuge policy, which states that staff will try to obtain additional/alternative contact details from the referrer if they cannot contact the client after three attempts within three working days. The service did not inform referrers appropriately that they would be closing the case, nor did the service share with referrers any outcomes of assessments when they did have contact with Tasmin. As a result of learning, the service manager has discussed in team meetings, staff contacting the referrer before closing the case, and that there is timely contact made with the referrer to try and obtain alternative contact details for clients. The service will share with referrers any outcomes of risk assessments when they do have contact with clients.

14.5.14 Tasmin was in receipt of services, in relation to her mental health, from three different mental health Trusts:

1. Lancashire and South Cumbria NHS Foundation Trust – September/October 2018 and February–April 2019

2. Cambridgeshire and Peterborough NHS Foundation Trust – October 2018–February 2019

3. North West Boroughs Healthcare NHS Foundation Trust [now Mersey Care NHS Foundation Trust] – January 2020 until Tasmin's death.

The first two Trusts were involved with Tasmin for relatively short periods of care, which were ended when Tasmin moved away from their geographic area. The panel agreed that the most significant involvement in relation to Tasmin's mental health, was with North West Boroughs Healthcare NHS Foundation Trust [now Mersey Care NHS Foundation Trust].

14.5.15 Tasmin was admitted to hospital under the care of North West Boroughs Healthcare NHS Foundation Trust [now Mersey Care NHS Foundation Trust] on eight occasions between January 2020 and her death in May 2021. The IMR author for the Trust concluded that Tasmin's discharge from hospital on each occasion was appropriate, and that referrals to the Home Treatment Team were the correct course of action.

14.5.16 The Home Treatment Team initially had little success in engaging with Tasmin. For example, after an initial appointment on 28 February 2020, the Home Treatment Team phoned Tasmin on 7, 9 and 10 March 2020, with no answer. A letter was hand delivered, and a further phone call was made on 13 March 2020, with no answer. Tasmin was then discharged from the Home Treatment Team. Whilst this met the policies of the Trust, the panel questioned whether engagement with a person who had clearly suffered such significant trauma, could have been more persistent and creative. The panel was told that the Home Treatment Team deal with each case on an individual basis. Engagement with the HTT is by consent, and the team need to be proportionate in balancing persistence in engagement with people whilst not overstepping into a situation where they could be seen to be harassing an individual.

14.5.17 Following a hospital attendance on 10 December 2020, 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. She was seen again later in December and three times in January, following another episode of potential self-harm.

14.5.18 One of the outcomes of Tasmin's engagement with the Home Treatment Team was a referral to the Warrington Borough Council Mental Health Outreach Team. This is a team that offers short-term support in the community. A worker engaged with Tasmin between 19 January and 25 March 2021: they met Tasmin on two occasions and spoke on the telephone on others. Tasmin cancelled, or was not at home for, other appointments. During this period, Tasmin moved into a new flat and was looking for work. She was worried about money. Practical support was

offered, and Tasmin agreed to a referral for domestic abuse support. This was important as the referral to the Refuge Warrington IDVA service then led to a referral to MARAC. Tasmin's case was closed to this service on 30 March 2021 by mutual agreement, and Tasmin was told that she could access the service again if she wished.

14.5.19 On 20 and 23 April 2021, Tasmin contacted the mental health crisis line, following attempts at self-harm. She attended at hospital on both occasions. She was followed up by the Home Treatment Team. The team were persistent and saw Tasmin at home on 25 and 28 April 2021, following a number of failed calls and appointments. Tasmin reiterated that the main cause of her issues was the domestic abuse that she had suffered. Earlier in April, a further cause of stress had been a new job, where she was working long hours. However, on 28 April, Tasmin said that she had given that job up. Tasmin disclosed that she was drinking up to a litre of vodka a day. A referral to alcohol and drugs services was discussed but declined by her.

Whilst in A&E, there was a discussion around the disclosure 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.

Tasmin was offered additional support that could be provided, including a food voucher and signposting 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.

14.5.20 On a day in May at 5.10 am, Tasmin phoned the crisis line, and a discussion took place for approximately 35 minutes. Full details of the call are contained at paragraph 13.2.91 and are not repeated here

14.5.21 A safety huddle was completed with another practitioner. Tasmin had agreed to hold the line. However, on return, she stopped responding to communication, and the call was terminated unexpectedly. An emergency 999 response was requested from the police, and information was provided to the police as to the nature of the contact and concern.

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

The professional opinion of the North West Boroughs Healthcare NHS Foundation Trust [now Mersey Care NHS Foundation Trust IMR] author, is that the actions of the crisis line staff were appropriate in the circumstances.

14.5.22 There was no offer of a psychological assessment throughout Tasmin's journey with mental health services, including her time as an inpatient. The care offer from mental health services could have been strengthened if a psychological assessment had been completed to inform how mental health services understood how her past and current experiences could impact on her, and any associated risks relating to her trauma. A psychological formulation[20] would have also considered what Tasmin found helpful when she was struggling to manage her emotional difficulties. Such an assessment could have been offered during her inpatient admissions or in community secondary mental health services.

14.5.23 The panel thought that Tasmin's experiences may have been an example of traumatic bonding. The term traumatic bonding was developed by Patrick Carnes.[21] It is said to occur as a result of ongoing cycles of abuse in which the intermittent reinforcement of reward and punishment creates powerful emotional bonds that are resistant to change. A simpler definition is that traumatic bonding is a strong emotional attachment between an abused person and their abuser – formed as a result of the cycle of violence.

14.5.24 The panel agreed that the domestic abuse Tasmin suffered, together with other life events such as rape and losing access to her children, was likely to have resulted in significant trauma.

14.5.25 The review has seen no contemporary evidence of trauma-informed practice.

14.5.26 The panel was informed that significant work is underway in Warrington, and that training in trauma-informed practice was now being delivered by the Warrington Safeguarding Adults Board. 350 professionals across the partnership have been trained so far, with a further 350 scheduled to receive training during 2023. The training has been developed by Mersey Care on behalf of the partnership, and Mersey Care is also delivering the training to their own staff across the wider geographical area that they cover.

[20] A psychological formulation is a structured approach to understanding the factors underlying distressing states in such a way that it informs the changes needed and the mechanisms and treatments for such change to occur.

[21] https://healingtreenonprofit.org/wp-content/uploads/2016/01/Trauma-Bonds-by-Patrick-Carnes-1.pdf

The panel thought that the learning from this review evidenced a need to build on what has been achieved so far and has made an appropriate recommendation. [Panel learning and recommendation 4].

14.6 **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?**

14.6.1 Section 42 of the Care Act 2014 states:

(1)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.

(2)The local authority must make (or cause to be made) whatever enquiries it thinks necessary to enable it to decide whether any action should be taken in the adult's case (whether under this Part or otherwise) and, if so, what and by whom.

(3)"Abuse" includes financial abuse; and for that purpose "financial abuse" includes—

(a)having money or other property stolen,

(b)being defrauded,

(c)being put under pressure in relation to money or other property, and

(d)having money or other property misused.

14.6.2 The only agencies to raise a safeguarding adult concern with Adult Social Care were North West Ambulance Service and East of England Ambulance Service. Beyond that, there is no contemporary record that agencies in Lancashire, Cambridgeshire, and Warrington considered Tasmin to be an adult at risk within the terms of the Care Act.

14.6.3 On 10 September 2018, Tasmin was taken to hospital, by ambulance, after suicidal ideation resulting from domestic abuse. North West Ambulance Service raised a safeguarding alert with Lancashire Adult Social Care, as that was the area that

Tasmin was then living in. The alert was not accepted as it did not meet the referral criteria and Tasmin was then engaged with mental health services.

14.6.4 After Tasmin had been admitted to hospital in Cambridgeshire and engaged with an IDVA and the police, a professionals' meeting took place in October 2018 to facilitate a multi-agency discussion about Tasmin's case.
[see paragraph 14.1.5]. This is the only multi-agency meeting to discuss Tasmin's case that the panel identified.

14.6.5 On 8 December 2018, after an East of England Ambulance crew came across a domestic incident involving Tasmin and her then boyfriend, the crew submitted a safeguarding concern to Cambridgeshire Adult Social Care. The concern was reviewed by Cambridgeshire Adult Social Care, with no further action being taken as Tasmin was known to be safe.

14.6.6 On reviewing all of the information available to it, and with the benefit of hindsight, the panel thought that Tasmin's presentation in Warrington after September 2020, when she returned to the area having suffered further traumatic abuse, did place her as an adult at risk.

- She was in need of care and support for her mental health.
- She was experiencing abuse from Sean in Ireland – although not physical by this time, due to her return to England.
- The effects of the abuse on her mental health meant that she was unable to keep herself safe.

14.6.7 The only agency to raise a safeguarding concern with Warrington Adult Social Care was North West Ambulance Service, which raised three concerns with Warrington Adult Social Care.

15 March 2020 – taken to hospital by ambulance after entering river as a self-harm attempt. Referred to Warrington Adult Social Care.
Result
Tasmin was detained in hospital under the Mental Health Act, and no further action was taken by Adult Social Care.

10 December 2020 – taken to hospital by ambulance having been the wrong side of a bridge safety barrier. She was sectioned by the police under Section 136 of the Mental Health Act. Referred to Warrington Adult Social Care.

Result

Tasmin was referred to the Warrington Borough Council Mental Health Outreach Team.

23 April 2021 – taken to 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. Referred to Warrington Adult Social Care.

Result
This was erroneously recorded as a contact assessment, not a safeguarding adult alert. Therefore, no action was taken.

14.6.8 The panel acknowledged that this was not a straightforward case, and agencies at the time, did not always think that Tasmin was an adult at risk. For example, Tasmin was capable of living independently and although she had periods of crisis, she also had periods where she was stable and was able to find independent accommodation and employment.

14.6.9 North West Boroughs Healthcare NHS Foundation Trust [now Mersey Care NHS Foundation Trust] staff did not raise any safeguarding concerns with Adult Social Care because, at the time of Tasmin's presentations, it was not thought that she had any presenting social care needs that indicated an eligibility for social care.

14.6.10 All of the agencies worked independently. Although there were appropriate referrals and some information sharing between agencies, this did not lead to agencies working together or discussing Tasmin's case until the MARAC meeting of 7 April 2021. [this meeting is discussed further at paragraph 14.8]. There are no records to suggest that any service asked Tasmin for consent to discuss her situation with the other services that she was accessing support from. There are no records to suggest that the services in Warrington, other than the ambulance service, considered making a referral without consent (based on the information disclosed by Tasmin).

14.6.11 A previous Domestic Homicide Review commissioned by Warrington Community Safety Partnership and concluded in 2019, made the following recommendation:

Warrington Community Safety Partnership and Warrington Safeguarding Adult Board should consider the feasibility of developing a co-ordinated case management / information sharing approach to the care of high intensity service users who, for whatever reason, engage in risky behaviours that are not captured by other safeguarding processes. The two boards are best placed to collaborate

and facilitate discussion around this, with a view to agreeing and implementing a multi-agency protocol.

14.6.12 The recommendation resulted in the introduction of a Multi-Agency Risk Assessment and Management (MARAM) process, which was initially piloted in 2021 and then introduced for a trial period in February 2022. The panel heard that following that trial, the MARAM process has now been adopted and launched across Warrington. The panel thought that the use of MARAM would have been helpful in Tasmin's case. As the process is now in operation, there is no further recommendation on this point.

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

14.7.1 Tasmin's voice is clearly illustrated in the records of a number of agencies involved in the review. She was candid in sharing details of traumatic events in her life and how some of those events continued to affect her. Examples include, sharing details of the breakdown of her relationship with the father of her children and her continuing struggle to keep in touch with them, as well as details of the traumatic assaults and abuse that she had suffered.

14.7.2 On a number of occasions, Tasmin was detained under the Mental Health Act. The act of detaining a person, in effect, because they are unable to keep themselves safe, is a serious step and was not taken lightly by the agencies involved. From the information available to the panel, all of the detentions appeared to be a proportionate response in the prevailing circumstances and were reviewed appropriately.

14.7.3 Records from Tasmin's attendance at Warrington Hospital show that staff recorded what she told them and were sympathetic to her situation. Referrals to mental health services were prompt, but Tasmin's narrative did not result in other action, for example, a safeguarding adult alert.

14.7.4 Whilst involved with North West Boroughs Healthcare NHS Foundation Trust [now Mersey care NHS Foundation Trust], Tasmin demonstrated good insight into her mental health and demonstrated capacity in related decision-making. There are good examples throughout interventions, that Tasmin's wishes and feelings were considered.

For example, during an inpatient admission in September 2020, Tasmin indicated, on more than one occasion, that acute wards were detrimental to her mental health and caused flashbacks to incidents of abuse where Sean had detained her against her will. This was discussed within the Multidisciplinary Team and clearly

impacted on the decision to discharge Tasmin from hospital to the care of the Home Treatment Team.

14.7.5 When Tasmin made disclosures of domestic abuse that had occurred in Ireland in September 2020, although all appropriate action was taken by Cheshire Constabulary to assist the Garda in evidence gathering, there is no formal record of Tasmin's views, around support services, being taken into account. For the purposes of this review, the police IMR author spoke to the officer who dealt with Tasmin at that time. The officer recalls that Tasmin did not want to engage, as she had been detained under the Mental Health Act and was in hospital against her will.

Whilst obtaining her written statement, the officer discussed a referral to RASAC with Tasmin, but she declined. She said that she just wanted to get the statement done and that she did not want ISVA/counselling because she had support at home from family and was doing much better. The officer reports that they explained what support RASAC could provide and asked Tasmin to let them know, at any time, if her decision changed.

14.7.6 When Tasmin engaged with the Refuge Warrington IDVA team, the IDVA duty worker at the initial assessment, ascertained what support Tasmin would like from the IDVA service. She was able to explain the abuse that she had been suffering, both historic and current, and to explore what she would like from the service.

A referral was made to RASAC for extra support, as Tasmin had requested this. The IDVA ensured that Tasmin was aware that she could access the sanctuary scheme (target hardening). However, this was declined as Tasmin reported that Sean did not know the address and that she was in a secure block of apartments. The IDVA contacted the police officer that Tasmin had spoken to, for an update on Sean and the date of his release from prison.

There is evidence that Tasmin felt comfortable talking to the Refuge Warrington IDVA team, as she shared significant details of the abuse and her recent thoughts of feeling low. She had previously shared similar information with Cheshire Constabulary.

14.7.7 The MARAC referral form completed by the IDVA, asks referrers to describe the reason for referral – with additional information, including background and risk issues. The IDVA detailed the history of abuse and Tasmin's fears of what Sean could do to her. The MARAC referral form directly asks: *"who does the victim believe it safe to talk to?"* The IDVA recorded that Tasmin felt safe talking to the police [Cheshire] and the IDVA. The MARAC referral form does not explicitly ask referrers to describe the views, wishes, and outcomes that victims would like to

see, nor the victim's greatest priorities around their safety.

14.8 **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?**

14.8.1 MAPPA protocols were not engaged in this case, as Sean lived in Ireland. Agencies in England would have been able to consider engagement with him if he had moved to England. There is no evidence that he spent any time in England during the timeframe the review.

14.8.2 There is good evidence of effective work to transfer Tasmin's case from Lancashire to Cambridgeshire MARAC, and back again when she moved areas. The transfers were carried out in a timely way and included all necessary information. Following Tasmin's return to Lancashire, she then moved between Warrington [Cheshire] and Ireland. Although her issues were not resolved, there were no further reports to Lancashire.

14.8.3 When Tasmin was living in Cambridgeshire in December 2018 and was subject to domestic abuse by a new boyfriend, the DASH risk assessment was graded as medium risk. As Tasmin had recently been recognised as a high- risk victim of domestic abuse, the case was referred to MARAC.

14.8.4 As previously discussed at paragraphs 14.1.15 and 14.5.4 – 14.5.9, when Tasmin made disclosures to Cheshire Constabulary in September 2020, a DASH risk assessment was not completed. When Tasmin made the same disclosures to the Refuge Warrington IDVA service in March 2021, the DASH risk assessment generated a score of 17.

The criteria for referral to MARAC are:

- 14 or more ticks on DASH risk assessment
- escalation (3 or more domestic abuse incidents in a 12-month period)
- professional concern, whereby a practitioner, with managerial agreement, believes a victim to be potentially at high risk despite a lower actuarial score. This may be due to particular factors in their background or nature of risk, or the victim's apparent minimisation of risk or non-engagement with protective agencies.

14.8.5 During her conversation with the IDVA, Tasmin disclosed that Sean had links with a proscribed organisation. This information was shared with the police immediately, ahead of the MARAC meeting.

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

1. A referral to be made to RASAC – the referral was made, and Tasmin was in touch with RASAC but did not receive services before her death.
2. A vulnerability marker to be placed on the police computer regarding Tasmin's address – this was completed. The marker did not mention that Tasmin was at high risk of domestic abuse and had been heard at MARAC.
3. A risk assessment to be completed regarding Sean in Ireland, pending his release from prison.
   [checks revealed he was not due for release until August 2021 – Tasmin was informed of this by the IDVA on 28 April].

All of the actions were appropriate.

14.8.7 Between September 2020 and March 2021, Tasmin had many interactions with health professionals, where she made clear disclosure of the domestic abuse that she had suffered in Ireland, and that she was worried about the future risk to her from Sean. None of those interactions resulted in a DASH risk assessment or a safeguarding adult alert. The panel did not question the healthcare that Tasmin had received; however, the focus on Tasmin's mental health appeared to deflect health professionals from following normal processes for risk assessment and referral.

14.8.8 Tasmin's case could have been heard at MARAC after the September disclosure if a referral had been made. Before a worker from the Warrington Borough Council Mental Health Outreach team obtained Tasmin's consent for a referral to the IDVA service in March 2021, there were also many other opportunities when a DASH risk assessment and referral to MARAC could have taken place.

14.8.9 On 15 November 2022, the CHAMPS suicide prevention strategy was launched. This strategy brings together all areas in Cheshire and Merseyside, with the aim of preventing as many suicides as possible. The panel thought it was important for the learning from this review to be shared with the CHAMPS collaborative[22], in order to inform future work. This leads to panel recommendation 7.

[22] https://champspublichealth.com/about-us/
The Champs Public Health Collaborative has developed a comprehensive and systematic approach to improving public health priorities by large scale action and working together as system leaders across Cheshire and Merseyside. The Collaborative is a long-standing formal partnership of Cheshire and Merseyside's nine Directors of Public Health and their teams, serving a population of 2.6 million

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

14.9.1 No agency has identified barriers to information sharing in England. Although An Garda Siochana declined to share information for the purposes of the DHR, operationally, the relationship between Cheshire Constabulary and An Garda Siochana was positive, and operational information was shared. As identified at paragraph 5.5, Cheshire Constabulary received a brief statement, late in the DHR process, which did not give any detail.

14.9.2 The panel identified that Tasmin's movement between three different areas in England did cause some issues for agencies. For example, the Warrington MARAC was unaware that Tasmin had previously been discussed at both Cambridgeshire and West Lancashire MARACs. This was because after being heard at West Lancashire MARAC, Tasmin had no further contact with West Lancashire agencies, and there were no incidents in West Lancashire. Services there, did not know Tasmin had gone to live in Warrington (she had in fact gone to live in Ireland first) and therefore a MARAC-to-MARAC transfer from West Lancashire to Warrington was not made. Some of the information that Tasmin disclosed whilst in Warrington in 2021, was the same as she had previously disclosed, for example, Sean's alleged links to a proscribed organisation. It may have been helpful to understand what action had been taken previously. Following consultation with Safelives, a single agency recommendation has been formulated for the new Warrington IDVA service to take forward.

14.10 **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?**

14.10.1 Tasmin did not share very much detail with her family about what happened in her relationships in Ireland. When she fled to England in crisis, her family provided a home for her and supported her in practical ways.

14.10.2 During late 2018, in Cambridgeshire, Tasmin's family were aware of interactions with An Garda Siochana, which caused upset. They described the phone calls, telling Tasmin that she had to go back to Ireland to give evidence, as bullying. Tasmin's family were aware of some issues in her brief relationship with a man in Cambridgeshire and ensured that he left the family home and did not come back.

people. The Collaborative also has a strategic influencing role within the Liverpool City Region Combined Authority and the Cheshire & Warrington sub-region.

Tasmin's family were complementary of the support provided by Cambridgeshire Constabulary, for example, in providing personal and house alarms.

14.10.3 Following the further abuse in Ireland and her return to Warrington in 2020, Tasmin disclosed limited information to her family. Particularly, after moving out of the family home to her own flat, Tasmin's family were only aware of what she shared with them. Whilst this was her choice as an adult, her family wish that agencies could have shared information with them. Her mum said: "had we known we could have done something".

14.10.4 Tasmin's flatmate disclosed to the police that he had been in a relationship with Tasmin for a couple of months before her death. Her parents were unaware of this relationship until they met the flatmate when they went to the flat after Tasmin's death. Tasmin did not disclose the relationship to any professional that she worked with. The flatmate told the police that he was not aware that Tasmin suffered from any mental health or substance misuse issues.

14.10.5 Tasmin's employment in England, during the timescale of the review, was for very brief periods, and the review has not engaged with employers for that reason.

14.11 Were there any examples of outstanding or innovative practice?

14.11.1 The panel acknowledged the efforts of many professionals to keep Tasmin safe. The following innovative practice was identified.

14.11.2 <u>Cheshire Constabulary:</u>

On being informed that there were no provisions for visually recorded evidence in the Irish criminal justice system, the officer who obtained Tasmin's statement, provided a statement to evidence Tasmin's demeanour and her physical and emotional reactions whilst speaking about the alleged offences. It was the officer's opinion that this was in keeping with what they would expect to see from a victim recounting a traumatic memory. Furthermore, that her account remained consistent throughout.

14.12 What learning did your agency identify in this case?

14.12.1 Warrington and Halton Teaching Hospitals NHS Foundation Trust

Identification of domestic abuse and coercive and controlling behaviours.
The effect of Tasmin's situation on her mental health.

Opportunities to refer to safeguarding, social services, and DA specialists.

14.12.2 Cheshire Constabulary

The DASH should have been completed when Tasmin reported domestic abuse to Cheshire Police in September 2020, and a VPA should have been submitted, as per the Cheshire Police Domestic Abuse Procedure. From the information known to police at that time, Tasmin's case would have fit the criteria for referral to MARAC, which would have ensured that she was offered specialist domestic abuse and rape and sexual abuse support, and that a risk management plan was in place and reviewed to reflect changes in circumstances.

Following Tasmin's disclosure, no vulnerability marker was put in place.

The offences committed in Ireland were not recorded on separate Niche occurrences. As the Garda confirmed that they had recorded the offences, there was no requirement for Cheshire Police to record criminal offences to comply with National Crime Recording Standards. The information, in relation to this, was recorded on the Niche occurrence enquiry log as a 'concern for safety' occurrence and so was not immediately evident on viewing Tasmin on Niche. As there was also no VPA or MARAC referral, Tasmin's domestic abuse history would not be instantly visible to control room staff or response officers attending to concern for safety incidents. Whilst it was known that Tasmin had previously attempted suicide and that there had been involvement with mental health services, unless the Niche occurrence enquiry logs were reviewed, officers would not have had a clear picture of the domestic abuse that Tasmin had suffered, the associated risks from Sean, or the risk of suicide. On occasions when officers attended further concern for safety incidents, VPAs were not submitted. Whilst mental health services were made aware of suicide attempts, consideration was not given to ensuring that agencies were sighted on the information concerning domestic abuse, the impact of this on her mental health, and suicidal ideation. On an occasion when a VPA was submitted, the details of Tasmin's 'boyfriend' were not obtained.

No VPA was submitted, despite a vulnerability marker being in place following MARAC instructing attending officers to 'SUBMIT VPA'.

14.12.3 North West Boroughs Healthcare NHS Foundation Trust [now part of Mersey Care NHS Foundation Trust]

There is no evidence that supports frequent communication between agencies, both external and internal. There is a lack of a clear plan of co-ordinated risk

support for Tasmin, particularly in relation to Victim Support and cross-border communication with police agencies.

All agencies and teams should work together to develop clear treatment and protection plans when multiple organisations and agencies are involved. Particularly, where an individual does not meet the criteria for sec 42 co-ordination of enquires.

A multi-agency meeting was an opportunity for Talking Matters / CGL to share that Tasmin had not been referred to services.

Organisations and agencies should proactively use established MDTs, complex case reviews, MARAMs, and information sharing pathways to co-ordinate care and share risks.

Tasmin would have likely benefitted from psychological assessment and talking therapy. The Assessment Team were under the impression that Tasmin had self-referred to Talking Matters and was on the waiting list, but they had never received a referral from Tasmin.

IAPT services require the service user to be motivated to engage with their services; therefore, it is often beneficial for service users to self-refer. However, secondary services should refer directly to IAPT on the service user's behalf, if appropriate.

Guidance on when service users should be directly referred to IAPT, should be agreed between the services. Complex service users should be discussed in complex case meetings, and the most appropriate psychological therapy offer can be stepped up or down as appropriate.

Not all adult safeguarding concerns were fully explored and discussed with the Trust or local authority safeguarding team.

As part of their assessment, staff members should exhibit professional curiosity when exploring adult safeguarding concerns. This may include discussions with the internal safeguarding team, even when the service user is deemed to have capacity and understands the consequences of their actions

Weekly reflective practice to discuss safeguarding concerns. The Trust's Safeguarding Adults and Children teams provide a duty system (Monday to Friday, 9 am – 5 pm) and should be consulted when complex cases present increased risk of abuse/harm/neglect.

The mental health assessment completed by the Warrington mental health liaison team practitioner, was not robust in using all available information, and the completed uploaded assessment was not updated to the Warrington General Hospital notes. All practitioners should follow the local SOP to ensure that assessments are robust, and that documents are uploaded in a timely manner.

Regular supervision with practitioners, reviewing quality of review and clinical curiosity

14.12.4 **Refuge Warrington IDVA Service**

This service is due to be taken in-house to Warrington Borough Council. The council has made a commitment to ensure that learning and recommendations, relevant to IDVA services in Warrington, are implemented.

When COVID restrictions eased, the service resumed face-to-face support. They have offered, and continue to offer, face-to-face appointments to every client they support. The team are carrying out joint visits with police / social care, and they attend housing, solicitors, and other appointments with clients.

The service manager has discussed in team meetings, staff making all attempts to establish contact with the referrer before closing the case. Staff are to notify them of the outcome, with the client records being updated and confirming the referrer has been notified. The service to share with referrers, any outcomes of risk assessments when they do have contact with clients.

The service and deputy manager are carrying out thorough inductions with all new staff, including delivering a training day to both new and existing staff members on their roles and responsibilities. The training covers how to refer to local services and expectations for following up on referrals. The role of the duty worker, including timeframes of contact, recording, information sharing, updating referrers on outcome of contact, completing initial assessments, and how to complete DASH risk assessments. The training covers: timeframes for contacting clients after the case has been allocated to an IDVA; case work; MARAC guidance; safeguarding and completing referrals; referrals to support services, such as mental health / drug and alcohol services; civil orders; and guidance on Claire's Law.

The service attends daily huddle meetings every morning. These meetings are held between Refuge Warrington Domestic Abuse Service, Warrington Children's Services, and the police, to discuss domestic abuse cases involving children and adults. The IDVA who attends, will discuss any actions with the team. They will then feedback to partners, at the daily huddle meetings, any updates, including outcomes of referrals received into the service, for example, if a case has been

allocated or not, the named IDVA in the case, and any issues with obtaining alternative contact details for clients.

During periods where there is an increase in referrals, more staff are placed on the duty system to contact clients within the timeframes, as per Refuge's casework management policy.

Refuge has added a section on its case recording system, specifically on suicide attempts. This section directs the staff to report when a client has reported a suicide attempt, when the incident happened (with full details), and that this has been reported to a senior manager.

Refuge's head of safeguarding is undertaking a charity-wide safeguarding review and has identified the need to strengthen their existing collation of safeguarding activity and data. By strengthening the data, Refuge can develop highly responsive and effective safeguarding processes, systems, and practice. Refuge's case recording system enables staff to record safeguarding referrals that are made for children and adults.

14.12.5 **Warrington Adult Social Care**

Information was not always shared with agencies as appropriate, or there were significant delays to this, and conflicting information was shared between agencies.

Disclosures made by Tasmin were not always acted upon.

Cultural issues within clinical services, relating to reluctance to make referrals to adult safeguarding due to believing individuals with capacity do not meet the threshold.

14.13 **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?**

14.13.1 The panel thought it was important to remember the timing and context of Covid-19 restrictions.

- On 16 March 2020, the Prime Minister, Boris Johnson, made a televised statement, saying: "now is the time for everyone to stop non-essential contact", referring to it both as "advice" and a "very draconian measure".
- It was not until 23 March 2020 that Mr Johnson told people they "must" stay at home, and said that "we will immediately" close some businesses.

- This had been referred to as the start of lockdown by Government ministers, including Messrs Hancock and Johnson.
- Legally, the main restrictions in England actually began at 1 pm on 26 March, when The Health Protection (Coronavirus, Restrictions) (England) Regulations 2020 came into force.

14.13.2 From 25 March 2020 to 21 September 2020, Tasmin had no contact with services in Warrington. She was living in Ireland during this time. No agency contributing to the review, has identified a direct impact from Covid-19 in relation to the provision of services to Tasmin.

14.13.3 Warrington Adult Social Care report that the large volume of safeguarding adult alerts sent by NWAS, created pressure on the Council's First Response Team. NWAS and the local authority are working together to create a more robust screening and referral process. No further recommendation is made.

14.13.4 The Refuge Warrington IDVA service reported that in March 2021, the service was very busy – with IDVAs carrying above their normal workload of cases. This was partly because, in that period, cases were open for longer than necessary due to awaiting court dates – as many cases were not being listed for court. As a result of this, additional funding was granted for two further IDVAs.

The other impact on the IDVA service, was that most IDVAs were working from home. Much of the support that was provided by Refuge Warrington Domestic Abuse Service, was done via the telephone. If Tasmin had asked for a face-to-face appointment, the IDVA would have found a safe place to meet. There is no evidence that this was offered by the IDVA or that Tasmin knew that this was an option. The service is now offering face-to-face support to all clients and is accommodating all clients who wish to meet with a member of the team (face to face), unless there is a significant reason not to.

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

14.14.1 The panel identified two recommendations, from previous reviews in Warrington, that it thought especially relevant.

14.14.2 **Warrington Community Safety Partnership should seek assurance from its constituent partners and third sector agencies that they commission that an appropriate mechanism is in place to ensure that domestic abuse and safeguarding policies are embedded in practice.**

The panel thought that this review provided evidence that safeguarding and domestic abuse policies had not been followed on some occasions, and that further work and assurance was necessary.

14.14.3 **Warrington Community Safety Partnership and Warrington Safeguarding Adult Board should consider the feasibility of developing a co-ordinated case management / information sharing approach to the care of high intensity service users who, for whatever reason, engage in risky behaviours that are not captured by other safeguarding processes. The two boards are best placed to collaborate and facilitate discussion around this, with a view to agreeing and implementing a multi-agency protocol.**

This previous recommendation has already been discussed at paragraph 14.6.12. There is evidence that this previous recommendation has now been implemented. No further recommendation is made.

14.14.4 **Warrington and Halton Teaching Hospitals NHS Foundation Trust**

Domestic abuse training identified in two previous DHRs:

Action taken
Following the two previous reviews, the Trust appointed a temporary dedicated domestic abuse trainer and overhauled domestic abuse training. All staff had training relevant to their role, including training on how to complete DASH risk assessments. The Trust now has an IDVA on site, who is available to advise staff and work directly with clients. An identified post holder with the Trust safeguarding team is responsible for supporting staff with DASH risk assessments.

15 CONCLUSIONS

15.1 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.

15.2 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.

15.3 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.

15.4 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.

15.5 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 13 of the report and is deliberately repeated here.

15.6 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

15.7 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"

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

15.9 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.

15.10 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.

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

16 LEARNING

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

16.1 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

16.2 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

16.3 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

16.4 **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

16.5 **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

16.6 **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

17 RECOMMENDATIONS

DHR Panel

17.1.1 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.

17.1.2 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.

17.1.3 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.

17.1.4 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.

17.1.5 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.

17.1.6 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.

17.1.7 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.

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

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

17.2 Single Agency Recommendations

17.2.1 All single agency recommendations are shown in the action plan at Appendix A.

Appendix A Action Plan – Tasmin DHR – Warrington Community Safety Partnership

Action Plan currently being completed.

End of overview report 'Tasmin'