Executive Summary

A Domestic Abuse Related Death Review (DARDR) concerning the death of Siobhan (pseudonym)

(September 2020)

Author – Jackie Dadd

Date completed – March 2024

The Domestic Abuse Related Death Review Panel and the members of the South Cambs Community Safety Partnership would like to offer their sincere condolences to the family of Siobhan, who have lost their loved one in tragic circumstances.

Contents

1. The review process

1.1 This review is into the death of Siobhan, a 32-year-old Irish female traveller, who was found hanging by her 13-year-old child at her home address in South Cambridgeshire during September 2020. The Police investigated the circumstances and submitted a report to the Coroner with a finding that the death was non-suspicious and the cause was suspected suicide by hanging. The Coroner's inquest took place and recorded the death as such.

The Police referred the matter to the South Cambs CSP on 7th September 2020 and following a meeting with representatives from a number of authorities and voluntary sector, a decision was made to undertake a Domestic Abuse Related Death Review as the definition in Section 9 of the Domestic Violence Crime and Victims Act (2004) had been met.

South Cambs CSP commissioned Sancus Solutions to Chair and Author the review. A scoping period was agreed and two panel meetings were held. During the second panel meeting, following the scoping of agency records, it was agreed by those present that they did not feel there was sufficient evidence of domestic abuse to continue with the review. The relevant forms and reports were submitted to the Home Office DARDR QA Panel for their deliberations.

On 26th October 2022, the QA Panel responded to South Cambs CSP by letter, informing them that they felt this case would benefit from a DARDR with an investigation into what interaction there was with services and consideration of how they interact and engage with the Traveller community.

South Cambs CSP then commissioned a new Chair and Author to complete the review based on the information previously provided.

In accordance with Home Office guidelines to ensure confidentiality, pseudonyms have been used throughout this report which have been chosen by the Author with the advice of the Community nurse who knows the family members:

Siobhan – A female Irish traveller, 32 years old at the time of her death.

Stevie – Siobhan's eldest child with Rowan. 13 years of age at the time of death.

Jo – Youngest child of Siobhan. One year old at time of death. Father is Tommy.

Sinead – Mother of Siobhan, a female Irish traveller.

Brian – Father of Siobhan, a male Irish traveller.

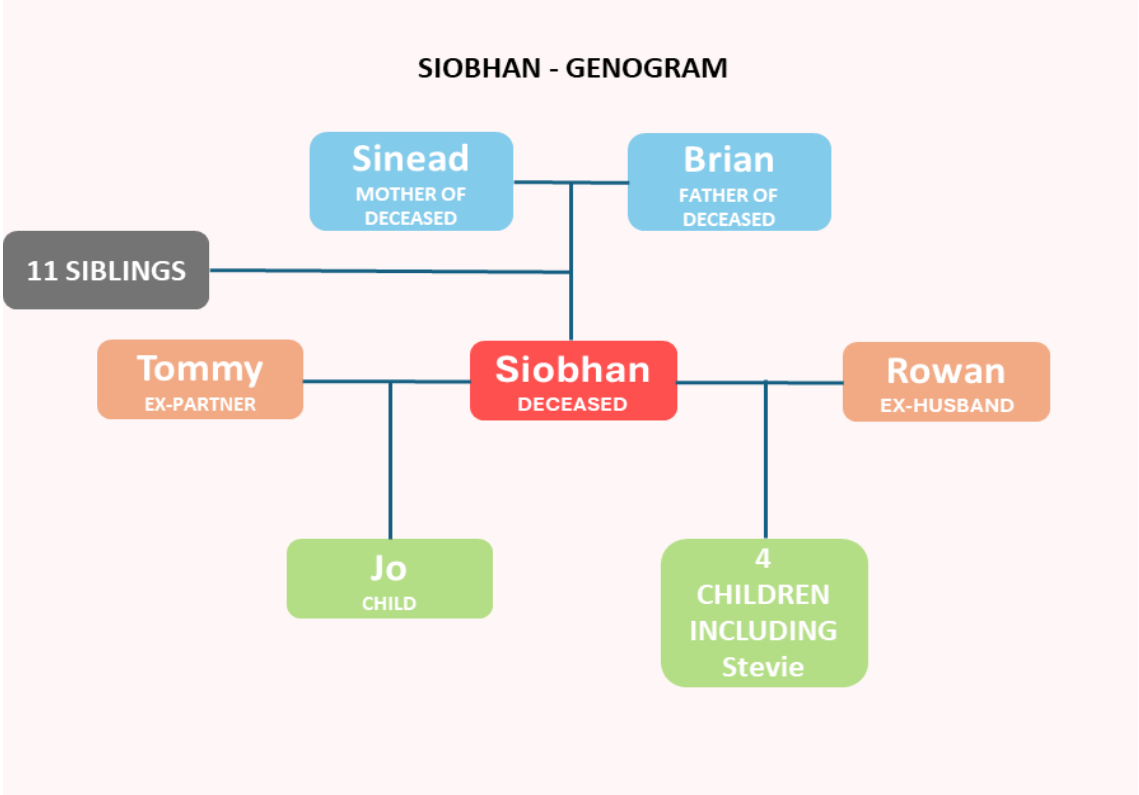
Rowan – Ex-husband to Siobhan and father to the three eldest children including Stevie. English Romany traveller. Deceased in 2013 having taken his own life.

Tommy – Ex-partner to Siobhan and father to Jo. Irish traveller. Age unknown.

Niamh – Wife of Tommy. Irish Traveller. Age unknown.

Joseph – Brother-in law married to Siobhan's sister. Irish traveller. Age unknown.

Address – Name of Location provided as South Cambridgeshire/Cambs area.



A decision was made by the initial Chair that no IMRs would be requested based on the information from the scoping documents. This was reviewed by the new panel but due to the lack of recording of domestic abuse in the chronologies and scoping documents, it was felt that IMRs were not necessary. Summary reports were requested to respond to the agreed Terms of Reference.

2. Review panel members

The following agencies/organisations/voluntary bodies have contributed to the Domestic Abuse Related Death Review by the provision of reports and chronology. Individual Management Reviews had not been initially requested. Relationships within the community are built over a considerable amount of time and so it was agreed that to maintain trust in the Irish Traveller community, the Gypsy and Traveller Liaison Officers from the South Cambs District Council and from the Community Nurse and Health Visitor would not sit on the panel but provide information and guidance with their specialist skills and knowledge in this area. Their input and advice have been included throughout this report as specialists within this area.

The Review Panel, who have contributed and discussed the contents of this report are comprised of the following: -

Name	Area of responsibility	Organisation
Vickie Crompton	Domestic Abuse and Sexual Violence partnership manager	Cambridgeshire County Council
DCI Jenni Brain	Public Protection	Cambridgeshire Police
Kathryn Hawkes	Communities Manager	S. Cambs District Council
Tracy Brown	Safeguarding Lead	Cambridge University Hospitals - Addenbrookes
Linda Katte	Deputy Designated Safeguarding People/MCA Lead	NHS Cambridgeshire and Peterborough Integrated Care Board
Angie Stewart	Chief Executive Officer	Cambridge Women's Aid
Rachel Robertson	Advanced Practitioner Safeguarding and Domestic Abuse Lead/AMHP	Cambridge and Peterborough NHS Foundation Trust (CPFT)
Claire Saggiorato	Designated Nurse Safeguarding Children	NHS Cambridgeshire and Peterborough Integrated Care Board
Joseph Davies	Suicide Prevention Manager	Public Health Department – Cambridgeshire County Council
Elizabeth Clarke	Service Director	Cambridgeshire Children's Social Care

All members of the panel have complete independence from any subject in this review. The Review Chair and the Panel gave due consideration for the content of the DARDR and it was agreed that reports, chronologies and other supplementary details would form the basis of the information provided for the overview. Thanks goes to all who have assisted and contributed to this review with their valued time and cooperation.

Two separate panel meetings have been held since the return from the Home Office. Delays occurred in collating this information as Sanctus Solutions could not provide the documentation that had already been submitted during scoping previously in 2020 and therefore, each agency was asked to review their archived records for their initial chronologies and scoping documents.

The completed report was handed to the South Cambs Community Safety Partnership on 25th March 2024.

3. Contributors to the review

The following agencies have contributed to the review:

Agency	Contribution
Cambridgeshire Police	Panel member, chronology
Cambridge and Peterborough NHS Foundation Trust (CPFT)	Panel member, chronology
South Cambs district Council/CSP	Panel member, oversight, verbal interview
Cambridgeshire and Peterborough Public Health	Verbal interview, panel member
Cambridge University hospitals - Addenbrookes	Panel member, chronology
Metropolitan Housing Trust Ltd	Scoping
Cambridgeshire Children's Services	Scoping
S. Cambs district housing dept	Scoping, panel member
Cambridgeshire and Peterborough DASV Partnership	Panel member, oversight
Cambridgeshire Children Social Care	Panel member, summary report

4. Author of the Overview report and Chair

The chair of the review panel and author of this report is Mrs Jackie Dadd, an independent consultant who is also independent of the organisation and agencies contributing to this report. She has no knowledge or association with any of the subjects in this report prior to the commissioning of this review. She is a retired Detective Chief Inspector with Bedfordshire Police with vast experience of safeguarding and domestic abuse related issues and has been involved in the DARDR process since its inception in 2011. She has completed the Home Office online training, the Continuous Professional Development accredited AAFDA DARDR Chair training and is a member of the AAFDA DARDR network, regularly attending the monthly forums for CPD and discussion. Mrs Dadd has completed a large number of DARDRs with several having been published.

The remit from South Cambs CSP for this report was to utilise the information already gathered by the previous Chair and ensure the observations from the QA Panel were met, however, further information has been sought to provide wider context and a more informed review.

5. Terms of Reference

On receipt of the response from the Home Office that they wished for the DARDR to be conducted, it was agreed that the Terms of Reference would primarily (but not solely) focus on the areas highlighted by the Home Office:

1) Has domestic abuse in any form been the causation or a contributory factor to Siobhan taking her own life?
2) How effective are services and agencies provisions to domestic abuse within the Irish Traveller community in Cambridgeshire?
3) How did services interact with Siobhan and how do they engage with the Irish Traveller Community within Cambridgeshire?
4) What other barriers affect the Irish Traveller community within Cambridgeshire and in particular, would have had an adverse effect on Siobhan?

The full Terms of Reference are below:

- Has domestic abuse in any form been the causation or a contributory factor to Siobhan taking her own life?
- This is to be reviewed as a suicide based on the investigation by appropriate authorities. The purpose is to establish if DA was the cause or a factor in the death of Siobhan.
- To establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims.
- Ensure the review seeks to involve family and friends in the process and takes account of who the family may wish to have involved as lead members. Identify any other people the family think may assist or be relevant in the review process.
- Identify barriers that affect the Irish Traveller community within Cambridgeshire and that may have affected Siobhan
- How effectively do professionals engage with the Irish Traveller community in Cambridgeshire and did they interact effectively with Siobhan?
- Were procedures sensitive to the ethnic, cultural, linguistic, and religious identity of the deceased and his wife? Was consideration for vulnerability and age necessary? Were any of the other protected characteristics relevant in this case?
- Is there sufficient support available locally for victims of domestic abuse in the GRT community of Cambridgeshire and how accessible are they?
- Identify and highlight good practice for wider sharing

6. Summary chronology

Siobhan was one of eleven siblings to their parents, Sinead and Brian. Brian was in poor health and Sinead took the role of head of the family. There were a number of health problems within the family including mental health and alcohol abuse. All of Siobhan's siblings married within the Irish Traveller community but Siobhan was married to an English Romany Gipsy, Rowan (not necessarily married in law but long-lasting relationships are referred to as wife/husband in the Traveller Community). They majority of the family lived on a private site owned by Sinead and Brian in Cambridgeshire.

Siobhan and Rowan had three children together, the two eldest were boys, with the youngest being a girl, Jo who was born in 2007. There were Police reports of DA where Siobhan was the victim in the period of 2010-2013 relating to Rowan but no prosecutions were brought. During 2012, Siobhan had attended the accident and Emergency Department on twelve occasions with chronic stomach pains that had been a medical issue since 2008.

In October 2013, Siobhan's husband, Rowan died by suicide after he had been found hanging in a touring caravan on a plot in London whilst touring. It cannot be ascertained whether Siobhan was still in a relationship with him at this time but Siobhan told professionals that he had been suffering with his mental health and depression.

This had come out of the blue to Siobhan and she was referred to the Mental Health Team early in 2014 where records state that she was suffering from prolonged and intense grief with her moods being fluctuating and unpredictable. Due to her not attending an appointment with the Community Health Team, she was discharged from their service although she did contact them on a further two occasions where they recorded her wish to move nearer her family and that she was frustrated with the housing system.

In 2015, Siobhan had two separate incidents with different members of her family where the police were called and Siobhan was recorded as the victim. She did not support the Police with either investigation and no prosecutions were brought. A Domestic Abuse Risk Assessment (DASH) was only completed for the incident involving her parents as Cambridgeshire Police did not complete these for siblings at that time. It was graded as medium.

In 2017, Siobhan attended the Emergency Department at the hospital with a scald to her left knee and thigh from hot water spilt from the kettle where she stated she had dropped it. The hospital staff had difficulty whilst treating Siobhan and security had to be called. Siobhan left the hospital with a cannula still in place as she refused to have it removed.

In 2018, Siobhan was in a relationship with another Irish traveller, Tommy, who was 'married' to someone else in the community. This was frowned on by the Traveller community and Siobhan began to become ostracised from the wider network although her parents supported her.

There was an investigation into Siobhan's brother-in-law, Joseph, following an allegation where he was shouting at Siobhan and revving his car engine in what looked like he was going to drive at her. This offence was incorporated into the wider offence of Stalking which he was charged with along with his wife (Siobhan's sister).

This was due to him contacting the Police on several occasions near to the end of the year providing unfounded intelligence on Siobhan to try and get her into trouble with allegations surrounding her driving, child neglect and drugs. It is thought that this may have been a 'backlash' to Siobhan having the relationship with Tommy but this was never officially ascertained and was rumour in the community.

Siobhan attended the ED on four occasions with three being due to abdominal pains and then one as identified pregnancy. She left prior to treatment on two of those occasions. She did not attend an ultrasound or her 16-week appointment. This child was Tommy's, but the relationship had ended by this time.

The GP referred Siobhan to the District Nurse Service. They attempted to phone her twice but there was no answer and they were unable to leave a message. Siobhan was therefore discharged. The entry does not outline the reasons for the referral. This was the last entry CPFT had on their records in relation to Siobhan.

Siobhan had sought assistance at the Traveller drop-in Centre in the area where she sometimes attended with her mother, Sinead, in order to apply and be successful in moving to a house near to her parent's site as she had decided she wanted to bring her children up in a house but needed to be near her family for support.

Early 2019, Siobhan attended a hospital in London in relation to her pregnancy and stomach pain. Records state that she was abusive and 'very difficult', not wanting to receive care. When she was seen a month later by a nurse in Cambridgeshire, she stated that she had been in pain at the time and that she had been responding to a rude and racist midwife. She denied being overly aggressive.

Two days later Siobhan attended the hospital reporting that she had been assaulted by being hit in the head and the side by a metal pipe. The attack was at her husband's grave by Niamh, the wife of Tommy. There was no additional evidence as the witnesses did not want to speak to the police and the case was filed. Siobhan stayed in hospital for monitoring and was aggressive towards staff and stated she was being treated 'like a dog.' Security was called.

A month later, Stevie, Siobhan's child was assaulted by the child of Niamh. There was no additional evidence and the case was filed with no further action by the police.

During the summer of 2020, a domestic argument took place between Siobhan and her then, new current partner when she accused him of cheating on her. She denied any violence when the police attended and did not wish to complete any paperwork. This partner lived in a separate county to Siobhan and she saw him infrequently.

A report was made to the Police for the harassment of Stevie who was receiving death threats over the phone. It was believed to be from the child of Tommy and Niamh but there was no evidence of this.

Siobhan had been seen alive by her 13-year-old child, Stevie during the morning. The exact time is not known. Jo, her youngest child at 18 months old was also in the house. About 15.30hrs, the same day, having not seen her mum for some time, Stevie went up to Siobhan's room where she found that a baby cot was blocking the door. Managing to get the door slightly open, she found her mum hanging from the loft hatch.

Jo ran to the neighbours who contacted an ex-partner who was working near-by who went into the address and called 999 for an ambulance. The ambulance attended and declared life extinct. They did not attempt CPR or move Siobhan. The Police arrived and found that Siobhan had appeared to have hung herself using some washing line that was wrapped around a curtain pole. The curtain pole was then put across the gap of the loft hatch. Underneath Siobhan was a baby cot. One foot was inside the cot with the side of her foot resting on it and the other foot was over the side of the cot hanging off the floor.

Siobhan's death was treated by the police as non-suspicious with no evidence of third-party involvement.

Following the death of Siobhan, a Child Protection referral was raised over Stevie having found her and also having lost her father in similar circumstances previously. The outcome was a s17 single agency investigation for Social Care to support the children and consider long term plans.

All five children went to live with their grandparents following Siobhan's death.

7. Key issues arising from the review

Lack of communicative measures for those with educational needs or illiteracy

Siobhan was illiterate, which is common within the GRT community and Irish Travellers. This was identified as an area that is not overly considered by organisations and led to a lengthy discussion by the panel in which it was felt that all organisations could improve.

Communications are predominantly by letter or text and for applications, people are signposted to websites where they have to complete an on-line application. When a person comes into contact with someone for the first time, it is rare that they are asked of their ability to read or write and often, people will not offer to disclose this due to embarrassment or potentially previous humiliation and therefore, will be handed leaflets with information that they are not going to be able to read.

Illiterate persons can sometimes find it difficult to recall information and use of family members and other innovative methods of communication may enhance engagement,

provide additional support and assist with appointment attendances. (recommendation refers)

Building relationships with 'hard to reach' communities

A detailed discussion took place in relation to the term 'hard to reach' and whether the phrase 'hard to engage' would be more appropriate. Representatives from all organisations commented on the reticence to enter traveller sites due to both anecdotal information and previous incidents. Apart from the South Cambs District council GRTLO, the sites are only visited if there is a specific incident/reason. The relationship is not built and therefore, as found during Covid when the Council went to the sites to offer vaccinations, the trust and relationship was not there so although they reached them, they could not engage with them.

The fact that Siobhan had moved to a house away from a site, isolated communication even further and created an additional barrier. It has been identified that a number of organisations have a lack of understanding of the needs within this community which can also harm relationships when they are communicating with them. The drop-in centres for the GRT community are a valuable space to foster relationships and provide a safe space for females, as it is they who predominantly attend, to disclose domestic abuse if they feel able. (recommendation refers)

8. Conclusions

Siobhan was an Irish traveller and part of a large family who had lived nearby to and been supported by her parents her whole life. Police records comment that there was a record of domestic abuse (no detail provided as outside of review scope) prior to her husband taking his own life in 2013. His death enhanced her mental health difficulties whilst she was raising their three children on her own.

Siobhan had a long-term medical condition that caused her constant pain in which she had to attend hospital a number of times each year. Health professionals on the panel commented on how this can have a detrimental effect on your mental health and behaviour, particularly when it is long-term.

Siobhan had a child from a married male in the Irish Traveller community which caused her to be ostracised from the community apart from her family. With harassment over a few years on both her and her child that was believed to have been from his family Her relationship with her family at times over the years had been troublesome with reports to the police of her parents threatening her and then the charging of her sister and brother-in-law for stalking where there had been a period of time of malicious reports to the police about Siobhan which were unfounded.

The panel discussed all of these circumstances and it was agreed, along with the Public Health Suicide Prevention Manager that all of the above carry a heightened risk of suicidal

tendencies which is recorded as higher within traveller communities than others. The Panel was satisfied that because of the work already being done, there was no need for a specific recommendation regarding suicide prevention within the GRT community. That said, it was felt that there were non-specific areas of work that the G&TLO could become more involved with, including, as an example – the regular refresh of the Cambridgeshire Suicide Prevention Strategy.

Barriers faced that are recorded as either anecdotally or reported by the Irish Traveller Community were discussed and explored by the panel. It was found that some of these did not directly affect Siobhan and are therefore mentioned in the report as being identified and considered by South Cambs CSP in relation to their response but not discussed in the report in depth. These areas included immunisation of children, home education, professionals' presence on traveller's sites and obtaining bank accounts. This was to ensure the focus remained on the DARDR principles and did not become a needs gap analysis.

The panel felt that South Cambs CSP area had a number of provisions tailored to the needs of the GRT Community which showed best practice. The practical help provided by their GRTLO and the relationship built to be able to engage both on the sites and at the drop-in centre bridges a communication gap between the community and professionals, however, reliance is on that person remaining in the role for. This is also assisted by the Traveller Health team and their attendance at the drop-in centre and evidenced by the knowledge of the family, the specific practical assistance provided to Siobhan and the relationship built previously with Siobhan's mother to enable an approach in relation to this DARDR. Good practice is also acknowledged by a recognised female Gypsy professional delivering and running the suicide prevention line and counselling service.

Wider provisions, knowledge and succession planning are required to ensure that if an individual leaves an organisation, the relationship and communication with the GRT community is not fragmented or lost.

Domestic abuse has been identified in the past history of Siobhan by her late husband, her sister and brother-in-law and on one occasion, her parents. The panel borne in mind that although Siobhan was asked and denied domestic abuse by professionals on occasions, she was a private person and may not have necessarily disclosed it in those circumstances. The fact that she did contact the police on occasions when she was abused by her family does show that she was prepared to report abuse.

Owing to the lack of evidence of recent domestic abuse, although taking into account this is based on professionals' recordings and it is not known what may have been occurring but unreported, with the information available, the panel does not feel that domestic abuse was evidently a contributory factor to Siobhan sadly taking her own life.

9. Lessons to be learnt

4.2.1 Improved cultural competency across organisations

The Police do not have strong community links within the GRT community and there is not regular liaison. The only contact, for which they reach out via county council colleagues is in response to when issues arise and therefore, do not maintain contact as a matter of course to provide a constant connection.

South Cambs CSP employ a GRTLO, who provides a great conduit to the Community within the area as does the Traveller Health Team. These are individual professionals who have remained in their role for some years and steadily built trust and relationship to a degree with members in the community. They are the 'go to' for all agencies when any issues arise and have a wealth of knowledge.

However, when you then consider succession planning, these individuals should not be relied on to be the sole contacts and provide all of the knowledge. They must be utilised to cascade learning across organisations and provide introductions to other professionals within the community. Without this, as has been experienced from agencies within this review, if a person in a specialist role leaves that employment, a wealth of knowledge, a built and trusted relationship and a gap in provisions is created. (Recommendation refers)

4.2.2 Language used by professionals in relation to the GRT Community

On Siobhan attending hospital for a medical issue in which security had to be called due to her aggressive behaviour, the first point on a list in her medical notes of concerns was the word 'Traveller.' This was discussed at length by the panel with differing opinions with some finding this a derogatory comment. However, others stated that it should be taken as a positive point that the fact she was a traveller had been recognised but it required context around the word. Are there specific adjustments or specialist knowledge required would have assisted others when reading this. Other notes do refer to Siobhan being from the Traveller community and needing a point of contact for appointments as due to her travelling she had not attended on occasions. This is more appropriate recording.

Another phrase to describe Siobhan that was used on a separate occasion was 'chaotic.' The dictionary description of this is -

Chaotic – meaning disorderly, disorganised, topsy-turvy, disrupted

This word can be taken negatively and has been used to describe Siobhan's behaviour whilst in hospital. It was discussed that although the comments written by professionals will have been made within time constraints, care must be taken about what is written and the manner in which it is written so that it is not read in isolation at a later date and taken out of context if this was not the intention. (Recommendation refers)

Methods of communication with the GRT Community

As outlined at 1.8.4 of this report, illiteracy is prevalent within the GRT Community and with the ever-reducing face to face appointments and the increased use of technology, the panel accepted that methods of communication, although adapted for differing languages and for the blind, were not adapted for those who are illiterate and would not be able to read a leaflet given to them or a text sent to them.

This was the case with Siobhan when she was provided information from CPFT following an appointment over her mental health and then did not attend the following appointment or utilise any of the services that had been provided.

This can immediately cause a barrier to people seeking help as they may feel embarrassed to ask for help with reading when they have been give the information in this format with an assumption that they will be able to read it as it is not common practice for the agencies on this panel to ask the question. Practical assistance to a person who may be already confused with bureaucracy would assist and ensure that someone the contact to another provider is made for someone with multi-complex needs who may feel to overwhelmed to make the contact themselves. (Recommendation refers)

10. Recommendations

National

There were no national recommendations identified within this review.

Local

1. **CPFT to consider an extension to those roles, already held within the Trust, which ensure health equalities and engagement opportunities for GRT communities.**
   This will provide wider expertise and knowledge in this area to cascade around the workforce and provide a holistic response to challenges faced when treating and communicating with the GRT community.

2. **CPFT to communicate to all staff as appropriate, the range of local partner agency provision to support staff to engage with the GRT community.**

   This will ensure that appropriate advice and pathways are provided and that awareness and understanding is raised about the needs of the GRT community.

3. **The following authorities and provisions in Cambridgeshire to have either a bespoke G&TLO or trained personnel with specialist knowledge of the Traveller community to help bridge the relationship between the Traveller community and professionals and cascade the knowledge across their agency:**
   Police
   Children's Social Care and Education
   South Cambs District Council
   Cambridge University Hospitals
   CPFT
   This will increase awareness of specific needs within the community and ensure that all agencies are working holistically, rather than reliant on a sole person from one organisation for all matters in this area. It also addresses the demand on organisations if they were to employ bespoke personnel.

4. **The following authorities and provisions in Cambridgeshire are to implement a process within their working practices whereby they provide practical help to those within the GRT Community and others who may have educational needs with applications and agency processes:**
   Police
   Children's Social Care and Education
   Cambridgeshire Public Health
   CPFT
   This will address some of the practical needs of those who cannot read or write in navigating their way through local government and agency processes. This may assist breaching the gap between the GRT Community and professionals.

5. **The following authorities and provisions in Cambridgeshire to provide awareness and implement ways of alternative communication for those with educational needs or illiteracy.**
   Police
   Children's Social Care and Education
   CPFT
   Cambridge University Hospitals
   Cambridgeshire Public Health
   This will assist with contacting those who cannot read or write and do not attend appointments as they are sent via letter. It will also increase those who are seen and prevent their cases being closed as they do not respond.

6. **The ICB to seek assurance from health providers that their training includes narrative surrounding documentation and use of terminology 'Traveller within the record so that it is provided as informative with context and not misconceived therefore preventing unconscious bias.**
   This will allow the inclusion of the fact that the person is a Traveller without any negative connotations as the narrative surrounding it will provide context to the fact that it is recorded.

7. **The current drop-in centres held by CCC Traveller Health Team (Public Health*) are to be continued as a valuable communication, support and relationship building opportunity with the GRT Community.**
   They have been proven as an invaluable asset to the GRT community in assisting them with practical help with outcomes that would not be possible without this facility. It is also a pivotal relationship building tool for the authorities within Cambridgeshire with the GRT community which would leave a gap in provisions.

Addendum – Recommendations have been made that have been directly identified through either contact/communication with Siobhan or that have arisen due to services within South Cambs CSP area. The panel are aware of a myriad of barriers that have anecdotally been commented upon on the internet and on a larger research scale outside of the area but have not included these due to lack of local evidence and not within the requisites of a DARDR.