Regulation 28: REPORT TO PREVENT FUTURE DEATHS

NOTE: This form is to be used **after** an inquest.

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** Chief Constable for Hertfordshire Constabulary
1	**CORONER** I am Samantha Broadfoot KC, Assistant Coroner for the Coroner area of Cambridgeshire and Peterborough.
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INVESTIGATION and INQUEST** On 02 September 2021 I commenced an investigation into the death of Kellie Marie SUTTON. Kellie died on 26 August 2017 in Lister Hospital. She was 30 years old. The investigation concluded at the end of the inquest on 06 July 2023. The medical cause of death was 1a) features consistent with hanging. The jury recorded a short form conclusion of unlawful killing and a narrative conclusion as follows: After being subjected to months of controlling and coercive behaviour and domestic abuse by her then partner, on the morning of 23rd August 2017 Kellie Sutton hung herself from the door handle of her living room at her own home using a belt as a ligature. She was treated at the scene by ambulance staff and HEMS before being conveyed to the Lister Hospital. Her injuries were not survivable and she died at 2.30pm on 26th August 2017 in the hospital. The jury found that there were certain failures or inadequacies by Herfordshire Constabulary which *may have* contributed to Kellie Sutton's death, but not that they did: see Annex A - Determination sheet.
4	**CIRCUMSTANCES OF THE DEATH** Kellie Sutton had experienced a series of relationships from a young age with abusive men in the past. She had 3 children. Kellie met her final partner in March 2017 and he moved in to her home at 8 Pollards Close, Welwyn Garden City, AL7 3BY where she lived with two of her children in a shared custody arrangement. There was extensive and detailed witness evidence gathered by the police for criminal proceedings which demonstrated that Kellie's partner was abusive towards her: both physically violent on at least several occasions and by his controlling and coercive behaviour towards her, which included shouting, threatening, phoning constantly if she was out, isolating her from her family and friends and holding her bank card. She lived in fear of her phone battery dying because if he couldn't get hold of her he would "go mad" and would become violent. In March 2018, i.e. after her death, Kellie's partner was convicted of controlling and coercive behaviour in an intimate relationship, contrary to s76 of the Serious Crime Act 2015, the offence taking place between 1 March 2017 and 24 August

2017. He was also convicted of one count of assault occasioning actual bodily harm, the offence taking place on 3rd June 2017 and one count of common assault which occurred on 9 July 2017.

I am satisfied from the evidence, which included text messages from Kellie to friends and from Kellie to her partner that Kellie was very unhappy in this relationship but did not feel able to extricate herself from it, even though her friends were telling her he was abusive.

On 9 July 2017 a neighbour called the police on the basis that Kellie was being "beaten up by her partner". The police came very quickly and spoke to Kellie and her partner separately but the couple told them that they had just had a verbal argument. A risk assessment in the form of the DASH book was completed which resulted in 6 ticks and the police took the view that this was a 'standard risk' case and the matter was closed as a non-crime incident. The police did not speak to the neighbour who called 999 and who was in possession of significant further information about the incident, including that one of the children had witnessed it. In a witness statement for the inquest the police accepted, at a senior level, that the response fell below the expected standard in a number of respects, including body worn video capability, the failure to check up on the children and that they showed a lack of professional curiosity and judgment relating to the DASH process and house to house inquiries not being completed.

The controlling and coercive behaviour continued. Over the night of 22/23 August 2017, there were a series of exchanges both verbally and by text message which continued after Kellie's partner left for work at 650 a.m. This showed a series of increasingly distressed messages from Kellie culminating in her threatening to hang herself to which he had responded with words to the effect of 'do everyone a favour'. Very shortly thereafter she stopped answering the phone, he rushed home and found her hanging from the door handle in the living room, at about 810 a.m. Despite him administering CPR to her and the ambulance arriving shortly thereafter, tests showed that she had suffered irrecoverable brain injury from lack of oxygen and brain stem death was confirmed on 26 August 2017 when she was pronounced dead.

The inquest jury found that although they were not satisfied that the lack of further investigation or action on 9 July 2017 did contribute to Kellie Sutton's death, they found that it may have led to further interventions that could have altered the final outcome on 23 August 2017. The jury also found that numerous opportunities were missed at several levels to recognise the significance of the responses in the DASH and that this in turn led to a failure to consider implementation of appropriate protective measures, which could have included issuing a DVPN and/or applying Clare's law. However, they concluded that they could not be satisfied that these failings did contribute to Kellie Sutton's death, although they may have contributed to her death.

During the course of the inquest the court heard evidence from an expert in the field of violence against women and girls about the harms of controlling and coercive behaviour and abuse, the feelings of entrapment by victims meaning it was very common for a victim to be unable to extricate themselves and the higher incidence of suicide in victims of abuse: one third of all suicides in England and Wales are preceded by domestic abuse. The court heard that an understanding of controlling and coercive behaviour was key to any risk assessment and that it was important to understand that no physical assault was required.

The evidence at the inquest indicated a lack of awareness of the link between domestic abuse and suicide. Whilst officers did have an awareness of the 'harm' from others through domestic abuse, a heightened awareness of the risk of 'harm' by taking one's own life was relevant to a risk assessment and the consequential steps which may be required.

The evidence at the inquest also appeared to reveal a lack of understanding by front line officers of the circumstances in which a DVPN could be applied for, and whether it was necessary for an individual to have been subject to arrest prior to triggering a referral to the DAISU.

	I am of the view that this lack of understanding, notwithstanding training which had been provided, was evident and created a risk of future deaths. The court heard about the lack of systems available at the time to easily identify serial perpetrators of abuse. However, I accept the evidence from the Constabulary about the changes that have already been made and further developments that are on-going. Accordingly this element does not form one of my elements of concern.
5	**CORONER'S CONCERNS** During the course of the investigation my inquiries revealed matters giving rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows: 1. There was a lack of understanding of controlling and coercive behaviour, what it is, and the impact on victims. 2. There was a lack of awareness of the link between domestic abuse and suicide. 3. There was a lack of understanding by front line officers of the circumstances in which a DVPN could be applied for, and whether it was necessary for an individual to have been subject to arrest prior to triggering a referral to the DAISU.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisation has the power to take such action.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by June 24, 2024. I, the coroner, may extend the period. Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise you must explain why no action is proposed.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons: Family of Kellie Sutton. I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any person who I believe may find it useful or of interest. The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest.

	You may make representations to me, the coroner, at the time of your response about the release or the publication of your response by the Chief Coroner.
9	**Dated: 30th April 2024**  **Samantha BROADFOOT KC** **Assistant Coroner for** **Cambridgeshire and Peterborough**