Record of Inquest

Following an investigation commenced on the Second September 2021
And an inquest opened on the Third March 2022
And an inquest hearing at The Old Court House, Hatfield held from Twenty-Sixth June 2023 until Sixth July 2023, heard before Samantha BROADFOOT KC of Cambridgeshire and Peterborough coroner's area and the undermentioned jurors:

The following is the record of the inquest (including the statutory determination and where required, findings)

1 Name of Deceased (If known)
Kellie SUTTON

2 Medical cause of death:

1a Features consistent with hanging.
1b
1c

II

3 How, when and where and for investigations where section 5 (2) of the Coroners and Justice Act 2009 applies, in what circumstances the deceased came by his or her death.

See attached.

4 Conclusion of the Jury as to the death

Unlawful killing.

5 Further particulars required by the Births and Deaths Registration Act 1953 to be registered concerning the death

(a) Date and place of birth: 07/07/1987 Welwyn Garden City	
(b) Name and Surname of deceased: Kellie SUTTON	
(c) Sex: Female	(d) Maiden surname of woman who has married:
(e) Date and place of death: 26/08/2017 Lister Hospital, Coreys Mill Lane, Stevenage SG1 4AB	
(f) Occupation and usual address: Trainee Beauty Therapist 8 Pollards Close, Welwyn Garden City AL7 3BY	

Signature

Signature of Jurors

[redacted] .....
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Annex A – Record of Inquest Box 3 and Box 4: Determination Sheet - Questionnaire

Short Form **Question 1 Short Form Conclusion:** Are you satisfied on the balance of probabilities that Kellie Sutton's death was (a) Unlawful Killing; or (b) Suicide; or (c) Accidental Death	**Answer:** (a) Unlawful Killing
Supplementary Narrative **Question 2 Basic facts of Kellie Sutton's death :** Do you agree with the following statement which is intended to summarise the basic facts of Kellie Sutton's death: '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.'	**Answer 'yes' or 'no'. If 'no' please provide your alternative form of wording.** YES

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Question 3 Was there any failure or inadequacy in the response to the 999 call by Hertfordshire Constabulary on 9th July 2017 which contributed to Kellie Sutton's death? **Answer 'yes' or 'no' in the box opposite.**	**NO**
If your answer to the question above is "no", was there any failure or inadequacy in the response to the 999 call by Hertfordshire Constabulary on 9th July 2017 which *may have* contributed to Kellie Sutton's death? **Answer "yes" or "no" in the box opposite.**	**YES**
If yes, please give an explanation for your answer below:	Had further investigation or action been taken on the 9th July 2017, it may have led to further interventions that could have altered the final outcome on 23rd August 2017. This is in addition to the admitted failings recognised by Hertfordshire Constabulary. These failures include: • Body worn video capability; • The need for greater professional curiosity and judgment relating to the DASH process • House to house not being completed • Checks were not completed in relation to the children so that the appropriate assessments and referrals could be made

SBKC

Question 4 Was there any failure or inadequacy by the police between 9th July 2017 and 23rd August 2017 to use measures such as issuing a DVPN and/or applying Clare's Law which contributed to Kellie Sutton's death? **Answer 'yes' or 'no' in the box opposite.**	**NO**
If your answer to the question above is no, was there any failure or inadequacy by the police between 9th July 2017 and 23rd August 2017 to use measures such as issuing a DVPN and/or applying Clare's Law which *may have* contributed to Kellie Sutton's death? **Answer 'yes' or 'no' in the box opposite.**	**YES**
If yes, please give an explanation for your answer below:	Numerous opportunities were missed at several levels to recognise the significance of the responses in the DASH 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, which may have altered the final outcome of the 23rd August 2017.
Admitted failings insofar as not already referred to elsewhere: _____	

SBKC