Overview report

A Domestic Homicide Review (DHR) concerning the death of Siobhan (pseudonym)

(September 2020)

Author – Jackie Dadd

Date completed – March 2024

The Domestic Homicide 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.

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Preface

The key purpose of any Domestic Homicide Review (DHR) is to examine agency responses and support given to a victim of domestic abuse prior to their death and to enable lessons to be learnt where there may be links with domestic abuse. For these lessons to be learnt as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each death, and most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future. The victim's death in this case met the criteria for conducting a DHR according to Statutory Guidance1 under Section 9 (3)(1) of the Domestic Violence, Crime, and Victims Act 2004. The Act states that there should be a "review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by-

(a) a person to whom he was related or with whom he was or had been in an intimate personal relationship, or

(b) a member of the same household as himself, held with a view to identifying the lessons to be learnt from the death".

The Domestic Abuse Act 2021 and the Home Office defines Domestic Abuse as:

Behaviour of a person ("A") towards another person ("B") is "domestic abuse" if—

(a) A and B are each aged 16 or over and are personally connected to each other, and

(b) the behaviour is abusive.

Behaviour is "abusive" if it consists of any of the following—

(a) Physical or sexual abuse

(b) Violent or threatening behaviour

(c) Controlling or coercive behaviour

(d) Economic abuse

(e) Psychological, emotional or other abuse

and it does not matter whether the behaviour consists of a single incident or a course of conduct.

"Economic abuse" means any behaviour that has a substantial adverse effect on B's ability to—

(a) Acquire, use or maintain money or other property, or

(b) Obtain goods or services.

For the purposes of this Act A's behaviour may be behaviour "towards" B despite the fact that it consists of conduct directed at another person (for example, B's child).

Controlling behaviour is:

A range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.

Coercive behaviour is:

An act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim. The term domestic abuse will be used throughout this Review as it reflects the range of behaviours encapsulated within the above definition and avoids the inclination to view domestic abuse in terms of physical assault only.

Recommendations will be made at the end of this report, however, there has been an ongoing action plan introduced by the panel, parallel to this Review to ensure that the areas that can be immediately addressed have not incurred unnecessary delay.

A glossary is available at appendix B at the end of this report which will provide explanation to the acronyms used throughout.

Section 1 - Introduction

1.1 The commissioning of the Review

1.1.1 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 Community Safety Partnership (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 Homicide Review as the definition in Section 9 of the Domestic Violence Crime and Victims Act (2004) had been met.

South Cambs CSP initially 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 DHR QA Panel for their consideration.

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 DHR 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, Mrs Jackie Dadd, to complete the Review based on the information previously provided.

1.1.2 Contributors 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	Summary report, panel member
South Cambs District Housing Team	Scoping, panel member
Cambridgeshire and Peterborough DASV Partnership	Panel member, oversight

NHS Cambs and Peterborough Integrated Care Board (ICB)	Scoping, panel member
Cambridge Women's Aid	Scoping, panel member
Sancus Solutions	Initial Chair and Author

1.1.3 Review Panel

The following agencies/organisations/voluntary bodies have contributed to the Domestic Homicide Review by the provision of reports and chronology. Individual Management Reviews had not initially been 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 and independence from the subjects of the Review, 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.

1.1.4 – 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	South 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
Liz Clarke	Service Director – Quality Assurance and Practice Improvement	Children, Education & Families – Cambridgeshire County Council

1.1.5 - 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 DHR and it was agreed that reports, chronologies and other supplementary details would form

the basis of the information provided for the overview. Thanks go to all who have assisted and contributed to this Review with their valued time, expertise and cooperation.

1.1.6 – Author of the Overview report

The chair of the Review panel and author of this report is Mrs Jackie Dadd, an independent consultant who is 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, having been the Force Lead for domestic abuse, stalking and harassment and serious sexual offences and has been involved in the DHR process since its inception in 2011.

She has completed several training courses including the Home Office online training, the Continuous Professional Development accredited AAFDA DHR Chair training, the Domestic Abuse and Suicide accredited course, and is a member of the AAFDA DHR network, regularly attending the monthly forums for CPD and discussion. Mrs Dadd has recently completed the new Home Office DHR Chair training to obtain the qualification of a level three ONC certificate.

Mrs Dadd has completed and published several DHRs.

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.

1.2 Purpose of the Review

1.2.1 - The purposes of a DHR are to:

a) 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.

b) 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.

c) apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate.

d) 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.

e) contribute to a better understanding of the nature of domestic violence and abuse; and

f) highlight good practice.

1.2.2 - DHRs are not inquiries into how the victim died or into who is culpable; that is a matter for coroners' and criminal courts, respectively, to determine as appropriate. DHRs are not specifically part of any disciplinary inquiry or process. Part of the rationale for the Review is to ensure that agencies are responding appropriately to victims of domestic abuse by offering and putting in place appropriate support mechanisms, procedures, resources and interventions with an aim to avoid future incidents of domestic homicide and domestic abuse. The Review also assesses whether agencies have sufficient and effective procedures and protocols in place which were understood and adhered to by their staff.

1.2.3 - The death of Siobhan was presented to the Coroner as potential suicide. The outcome of the Coroner's inquest was that the cause of death was suicide by way of hanging. This Review will ascertain whether domestic abuse could have been the cause or a contributory factor to this. It is not to apportion blame, but to view the circumstances through the eyes of Siobhan.

1.3 Timescales

1.3.1 – Cambridgeshire Police made a referral for the consideration of a DHR to the South Cambs CSP following the death of Siobhan and identifying domestic abuse in her history.

1.3.2 – A decision was then made by South Cambs CSP, in accordance with the December 2016 Multi-Agency Statutory Guidance for the conduct of Domestic Homicide Reviews to commission a DHR and the Home Office were notified.

1.3.3 – An initial scoping and panel Review took place in which the finding was that there was insufficient evidence of Domestic abuse to submit a DHR. The response from the Home Office was that they requested a DHR and outlined some factors that they wished to be explored.

1.3.4 - Mrs Jackie Dadd was commissioned to provide an independent author for the already existing research for this DHR on 9th February 2023. 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. A further two panel meetings then took place representing the same agencies as the initial panel, with some new representatives due to changes in staff. The completed report was handed to the South Cambs Community Safety Partnership on 25th March 2024.

1.3.5 – Table outlining timeline of Review

07/09/20	Police referred incident for consideration of DHR to South Cambs CSP

November 2020	Decision to commission a DHR made by South Cambs CSP and partners
November 2020	Home Office notified of decision to commission DHR
January 2021	Helen Collins of Sanctus Solutions commissioned as Chair and Author
09/03/21	First panel meeting
11/11/21	Second panel meeting
January 2022	HO notified of decision not to progress DHR
26/10/22	HO QA panel response letter outlining requirement for DHR
09/02/23	New Author commissioned for DHR – Jackie Dadd
20/09/23	Third panel meeting
05/03/24	Fourth panel meeting
25/03/24	Completed report handed to South Cambs CSP by Author

1.4 Terms of Reference

On receipt of the response from the Home Office that they wished for the DHR 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 can be found at appendix A at the conclusion of this report. The panel were agreed that this should not be a Needs Gap Analysis as this would detract from the DHR and require wider parameters.

1.5 Confidentiality

This report has been treated as Official Sensitive and dissemination kept to those outlined at 1.9.

The pseudonyms used in this report were chosen by the author with the advice of the Community Nurse who knows the family members, to ensure confidentiality and to protect the identity of those referred to throughout the report. Full details are found at 1.6 of this report. The panel did not feel that the identity of any sex would breach confidentiality.

The Safer Peterborough Partnership and Author have ensured that the collation of information and the information contained within this report complies with the Data Protection Act 2018 and the General Data Protection Regulation (GDPR).

1.6 Subjects of the Review/family and friends' involvement

1.6.1 - In accordance with Home Office guidelines to ensure confidentiality, pseudonyms have been used throughout this report for any person specifically referred to as follows:

Siobhan – A white, 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. Grandparent to all of Siobhan's children.

Brian – Father of Siobhan, a male Irish traveller. Grandparent to all of Siobhan's children.

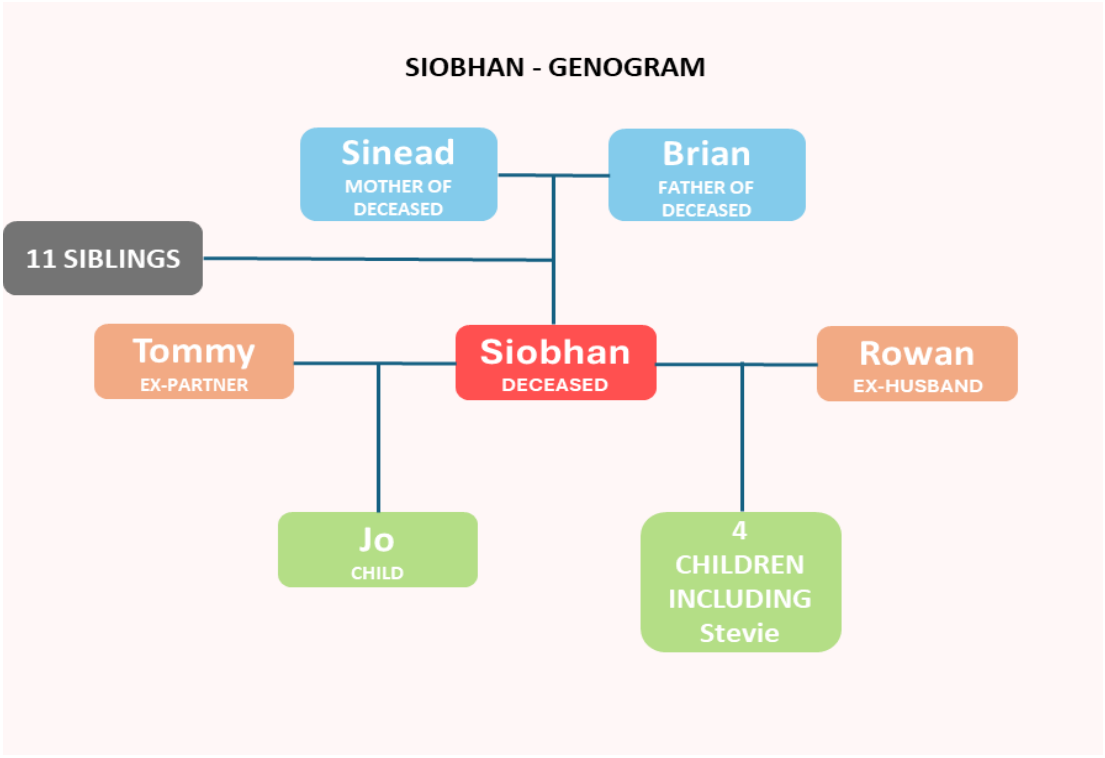
Rowan – Ex-husband to Siobhan and father to the three eldest children including Stevie. A white English Romany traveller. Deceased in 2013 having taken his own life.

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

Niamh – Wife of Tommy. A white female, Irish Traveller. Age unknown.

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

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



1.6.2

1.6.3 – At the outset of the Review, the family of Siobhan were approached on a number of occasions utilising an already built and trusted relationship with the local Gypsy and Traveller Liaison Officer and the Community Nurse and Health Visitor on the Traveller Health Team with Sinead, the mother of Siobhan. This was identified as the most appropriate introduction to the DHR. A delay took place due to Covid lockdown which prevented them meeting with the family. A sibling was also spoken to along with the mother, Sinead, and the family made the decision not to engage with the Review.

Options had been offered to the family, including face to face meetings, written statements and third party mediated sessions, including AAFDA support for the process. All were declined. They did not wish for a copy of the report and had been offered a face-to-face meeting where someone trusted would read it through with them and discuss it, but they declined.

Sinead had been approached once more in 2023 by the same Community Nurse, once the Home Office had requested the DHR continuance, but again declined to engage or attend a panel meeting with all previous offers re-iterated. No friends were identified that could be spoken to.

The pseudonyms used in this report have been chosen by the Author with the advice of the Community Nurse who knows the family members, to ensure confidentiality.

1.7 Parallel Reviews

1.7.1 - The Coronial process took place once a decision had initially been made that a DHR was not going to take place and found that the cause of death was suicide by way of hanging which was consistent with the post-mortem findings. Toxicology results showed no excess of prescribed or non-prescribed drugs but showed blood ethanol as 144mg/100ml which is far in excess of the legal limit for driving and is associated with drunkenness.

1.8 Equality and Diversity

1.8.1 - The Review gave due consideration to each of the nine protected characteristics under Section 149 of the Equality Act 2010 and found four to be relevant to this case. Those being sex, age, race, maternity and pregnancy, and disability. The relevant legislation that provided the context for the panel was The Disability Act 2016 and The Equality Act 2010.

It was considered that Siobhan's sex was relevant to the Review as 3-10 women a week die by suicide where they have suffered domestic abuse and in 2017, eighty-three per cent of victims reporting coercive control to the police were female.[1] Women's Aid report statistics showing that 31% of Irish women have experienced psychological violence by a current or former partner.[2]

1.8.2 - Race was also considered to be a relevant characteristic within this Review due to Siobhan being an Irish Traveller. The UK Government website states that 66% of people in the UK wrongly viewed Gypsy Rome Traveller (GRT) not to be an ethnic group in a 2018 YouGov poll.[3] It describes the community as those with a nomadic habit. It also states, as found many times during research that the capture data surrounding the GRT community is from a small number due to lack of responses to surveys and willingness to participate in Reviews. However, there are enough sources to provide a good picture of inequalities that these Communities face.

The Irish Traveller community is documented as having different needs, cultural responses to professionals and ways of life that are often not understood or are misinterpreted. All these were areas that were examined by the panel.

There are lessons to learn regarding culture and language, but these are not listed within the Equality Act 2010 as 'protected characteristics.' These are outlined later in the report. The panel also needed to understand barriers that are faced by the GRT community that may link to the lack of reporting of domestic abuse from this community.

1.8.3 Age – Siobhan's age was deemed relevant to this Review as The Irish Times reported that 50 per cent of Travellers die before their 39th birthday and that females' life expectancy

[1] Office for National Statistics, 2017

[2] Women's Aid facts – Women's Aid Annual Impact report 2022

[3] Gov.UK – Ethnicity facts and figures – 29/03/22

is 15 years less than that of other 'general' females[4]. Siobhan was 32years old at the time of her death.

1.8.4 - Disability was considered for a number of reasons. Siobhan had a medical condition which caused permanent pain in her stomach. She attended hospital for treatment on a number of occasions. The University of Bedfordshire submitted to the Government inquiry in relation to Health that the health status of Gypsies and Travellers is much poorer than that of the general population.[5]

Siobhan not being able to read or write and the negative impact this had on her when trying to obtain assistance from authorities and complete applications was deemed relevant. However, the Disability and Equality Act 2010 does not recognise illiteracy as a disability, nor do the social security regulations. It is commented on within this report and worthy of mention as a disability as the definition states:

'A disability is any condition of the body or mind (impairment) that makes it more difficult for the person with the condition to do certain activities and interact with the world around them.'[6]

Not being able to read or write had a similar effect on Siobhan and the panel considered whether or not this may have been a barrier to identifying and utilising local support provisions. The Irish Traveller Movement report that many members of the Irish Traveller community may have literacy difficulties, particularly older group members. The report also states that an analysis of standardised test results showed that 62.1% of Travellers surveyed were in the lowest 20% quartile in numeracy and 67.4% were reading at below the lowest 20% quartile.[7]

According to European Union research[8], Irish Travellers suffer some of the worst discrimination and poverty of any ethnic group in Europe which is causing a mental health crisis in their community. The panel gives due consideration as to whether this is recognised within services and whether services are available and adaptable to the community.

1.8.5 Siobhan had five children, all of whom were under 16 years of age at the time of her death with the youngest being just over the age of one year. The Office for National Statistics estimates that around 1% of children are likely to experience the death of their mother before they reach the age of 16 years. This data research was completed up until 2000 with nothing more recent. Siobhan died at the young age of 32 years. Data supplied from 28 police forces showed that over 50% of police recorded violence against the person offences against women in age groups between 20 and 44 years were domestic abuse related.[9] The panel considered what opportunities were taken and available to identify any

[4] The Irish Times 25 June 2007
[5] publications.parliament.uk 20/17/19 - Health
[6] Ref- Disability and health overview. CDC Centres for control, disease and prevention
[7] Survey of Traveller Education Provision (2006)
[8] FRA – EUROPEAN UNION AGENCY FOR FUNDAMENTAL RIGHTS FRA, 2020
[9] Home Office statistics - ONS 2023

domestic abuse that Siobhan may have been suffering during her pregnancies, in particular, the pregnancy of her youngest child.

1.9 Dissemination

Recipients who received copies of this report prior to publication:

Panel Members (listed in 1.1.4)

Relevant members of South Cambs CSP

DASV Strategic Board

Cambridgeshire Police and Crime Commissioner.

Domestic Abuse Commissioner.

The family members did not wish for a copy of this report.

1.10 Contextual background

Siobhan's death is one of 14 suicides that has been reviewed as a domestic homicide in Peterborough and Cambridgeshire since 2018. Of these Reviews, this is the only Review that involves a person from the Traveller community.

The South Cambs Community Safety Partnership (CSP) have the statutory responsibility for DHRs within their area. At the time this Review was initiated, they oversaw all of the DHRs in the South Cambs area. In April 2021, the Domestic Abuse & Sexual Violence partnership (DASV) began a centralised DHR process for the whole of Cambridgeshire and Peterborough to coordinate DHRs on behalf of the six local CSPs. They are able to analyse issues across Cambridgeshire and Peterborough for wider implementation and uniformed processes.

Suicide rates in all districts within Cambridgeshire and Peterborough are statistically similar to England for the three-year period 2017-19. However, all have seen an increase in suicide rates from 2015-17 to 2017-19.

The DASV worked alongside Public Health to review the correlation between suicide and domestic abuse in which the outcomes have been shared with key stakeholders working on suicide prevention in Cambridgeshire and Peterborough. The joint Cambridgeshire and Peterborough Suicide Prevention Strategy 2022-2025 was published in January 2023.

The World Health Organisation undertook a multi-country study using population-based surveys. This showed that women with experience of physical or sexual violence were nearly

4 times more likely to attempt suicide than women without such experiences, but it provided no associations for men[1]. In addition:

1. Domestic Abuse is a factor in around 12.5% of female suicide attempts
2. 25% of those in Domestic Abuse services have felt suicidal due to the abuse
3. Domestic Abuse victims are 8x more at risk of suicide than the general population
4. 50% of Domestic Abuse victims who attempt suicide will undertake further attempts within a year
5. 20% of DA Victims attempting suicide are pregnant
6. A third of female suicides are subject to domestic abuse
7. "Suicidal acts…… are more likely where feelings of defeat and entrapment exist alongside beliefs that neither rescue or escape are possible" Williams (2001)

Section 2 – The Facts

2.1 Background information

2.1.1 – Information provided in this section has been obtained from CSPs records and knowledge of the family from professionals who worked with Siobhan and her mother at the Travellers drop-in centre. The chronology may not be exact as some information is not documented and is provided by historic knowledge of professionals.

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 struggles and alcohol abuse. All of Siobhan's siblings married within the Irish Traveller community but Siobhan was married to an English Romany Gypsy Traveller, Rowan (not necessarily married in law but long-lasting relationships are referred to as wife/husband in the Traveller Community). The majority of the family lived on a private site owned by Sinead and Brian in Cambridgeshire.

Siobhan and Rowan had four children together, with the eldest child being Stevie, 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 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.

10 **Intimate partner violence, suicidality, and self-harm: a probability sample survey of the general population in England - The Lancet Psychiatry** Intimate partner violence, suicidality, and self-harm: a probability sample survey of the general population in England - The Lancet Psychiatry

2.1.2 This had come out of the blue to Siobhan and she was referred to the Mental Health Team early in 2014 from the Advice and Referral Centre (ARC) and passed to the senior social worker for triage where she was given an appointment for an assessment.

In this assessment, it was noted that Siobhan was suffering from prolonged and intense grief following the suicide of her husband in October 2013 and was experiencing unpredictable and fluctuating changes in her mood. She felt that she had little control over her emotional state.

Her medication was to be reviewed at a specific appointment. She was written a letter informing her of the details and who to contact out of hours. She was also sent information from CRUSE on bereavement by suicide. Her mother was given contact details of who to contact if Siobhan's mental health deteriorated or she had concerns for her mental state, and her GP was updated. In depth notes were made of the discussion with Siobhan in which she had expressed that nothing offered ever helped her.

A further appointment was made which Siobhan did not attend for unknown reasons and a letter was sent to her GP discharging her from secondary care.

In June, the same year, Siobhan called the Out of Hours line sounding very distressed. She disclosed that she wasn't able to talk to her family as they like to see her happy and was not comfortable for them to see her upset. She was scared that if she showed her emotions to anyone, they would think she was a bad mother. She stated that she loved her children and tries to be happy for them but was still struggling to come to terms with her husband's death.

She had no thoughts of harming herself and was trying to move house nearer to her family and had asked the council to move her. The nurse stated that she would contact the GP to send a letter to support the application.

In 2015, there were two separate incidents with different members of her family where the police were called and Siobhan was recorded as the victim of the incidents. 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.

2.1.3 In 2018, Siobhan was in a relationship with another Irish traveller, Tommy, who was 'married' to someone else in the community. This was frowned upon by the Traveller community and Siobhan began to become ostracised from the wider network although her parents continued to support 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). He had been 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 Emergency Department on four occasions with three being due to abdominal pains and then one as an identified pregnancy. She left prior to treatment on two of those occasions and 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.

2.1.4 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, 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.

2.2 Circumstances of the death of Siobhan

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 the 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 hanged 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 of her feet 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.

The Coroner's inquest found the cause of death to be Suicide by way of hanging.

2.3 Individual Management Reviews (IMRs)

2.3.1 – 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 still not necessary.

2.4 Summary reports

Relevant selected agencies were asked to provide chronologies of their interaction with Siobhan and other agencies, and some, more generic reports on provisions available within the area to the Traveller community to ascertain any gaps, good practice or barriers they have previously, or currently, experience.

2.4.1 – South Cambs District Council Gypsy and Traveller Liaison Officer (G&TLO)

This information was gained during a verbal interview between the author and the individual who has been employed in this role for several years. The role will be referred to as G&TLO. All observations within this section are from a professional who has worked in, and closely with, the GRT community for a number of years. They have provided insight from conversations with those in the community they have worked with.

This role ideally requires the same person to perform it over a long period of time – such longevity helps build up trust within the Traveller community. The role assists individuals with practical needs, advice and guidance and is a conduit between the community and the departments within South Cambridgeshire District Council.

Within South Cambridgeshire, there are fourteen private traveller sites and two Council sites which vary in size from having one plot up to one site having 350 mobiles. Some sites are owned by one family or there can be mixed sites in which a family would own a piece of land split into plots. There is only one Irish Traveller site within Cambridgeshire.

A drop-in centre for travellers is held on a Wednesday in South Cambs which is to support their community and provide help and guidance in a myriad of areas. It is populated by health nurses, the G&TLO, family workers for children's centres and other professionals and is well attended by the community with different people each week. The G&TLO assists with accommodation and benefits amongst other things.

Siobhan's mother frequently attended the drop-in centre and Siobhan attended with her on some occasions. Siobhan was assisted by the G&TLO with getting her two sons into the Catholic school and also received help with obtaining a move into the house that was to be her last home. This help was in the form of liaising with other departments, filling in forms and ascertaining the needs of Siobhan as she couldn't read or write and the bureaucracy of dealing with Council departments was too overwhelming. These issues were commonly seen within the Traveller community as illiteracy is common and there can be a mistrust of Social Care as they "didn't understand travellers as they could not articulate" and "they were of the understanding that the children would be taken away if Social Services were involved." The cultural traditions were not understood outside of the community - what they should and shouldn't do. If something was incorrectly portrayed or misunderstood, even if it was the slightest thing, then this would be spread through the community and be believed.

If any disclosure of domestic abuse occurred, or if bruises, for example, were seen on a child during the drop-in, then appropriate referrals would be made, regardless of the trust that

had been built. The Traveller community are very private people, particularly when they are on site and do not let others in as they believe it will dilute their culture. They feel they need to preserve what they have. Siobhan was a very private person and didn't disclose much of her life to anyone she spoke to at the centre, disclosing the minimum of information required to seek assistance.

Observations from this professional are that the Traveller community is a 'man's world' where it is not questioned where they are or what they are doing. This is the opposite of how females are treated – they are expected to account for their movements at all times.

Illiteracy is a common issue in the Traveller community as many children have home schooling from parents who are also illiterate as they do not want the children to be educated in mainstream schools. South Cambs District Council received funding for equality and diversity in order to bridge the gap between schools and the children in this community which assisted with communication and saw an increase in children attending school at that time but the funding has now been cut and the effects of this have been seen with a decline in attendance and in the willingness to communicate.

The Traveller community is the largest ethnic minority community in South Cambridgeshire. It takes a lot of work over a long time to build trust and a relationship with the community and the understanding that 'one size does not fit all.' The G&TLO has acted as a conduit for many organisations including Social Care due to the relationship with the GRT community that has been forged over a lengthy period.

2.4.2 – Cambridge University Hospitals

Some entries are taken directly from patient records to reflect language, terminology and considerations utilised to describe Siobhan and her behaviour.

2012 – An Emergency Department (ED) management plan states that Siobhan had twelve attendances to the Emergency Department within 2012 with acute and chronic abdominal pain which was thought to be pancreatitis or possibly gastritis. Siobhan frequently didn't attend outpatient appointments. She did attend an outpatient endoscopy but could not tolerate the procedure and a plan was suggested to have tests done under a general anaesthetic at one stage. In 2008 she attended for an endoanal ultrasound on her back which again she did not tolerate. A CT scan in 2008 showed pancreatitis of unknown aetiology with multiple cysts inside the pancreas and a dilated bile duct. The report stated:

I gather that this lady is from a Traveller community which can sometimes be chaotic. She frequently requests Entonox.[10]
Management plan:
"Every attendance should be assessed on its own merits.

[10] **Entonox** - Entonox is a mixture of a gas called nitrous oxide and oxygen. It is also called gas and air. You can breathe in Entonox to control pain and anxiety during some medical tests.

If this lady attends within hours please ask the pain team to come down immediately.
Avoid Entonox as this may make trapped wind worse.
Try non-opiate analgesia first including Buscopan, Voltarol etc.
If opiates are considered necessary start with Oramorph.
Try to establish with the patient how she is managing her pain, what investigations she thinks need to happen and whether she is prepared to turn up for tests and appointments.
It may be that this lady is Travelling around in which case she needs a permanent point of contact to send letters to.
GP has been contacted and Oramorph removed from repeat prescription.
She has been referred to the pain clinic" (notes made in 2008)

2017 – Siobhan attended the ED for a scald to her left thigh and knee from hot water spilled from kettle. Siobhan was recorded as being very agitated. She was asked on many occasions to stop shouting and banging on the wall of the cubicle. Her sister was present and was helping to calm her down. Siobhan received water, wet dressings and an ice pack that was requested. Her leg was dressed as per the Doctor's instructions but Siobhan removed the dressings and threw them onto the floor. The Doctor (Dr) explained to her that she could go home once it was re-dressed but Siobhan started to remove the dressings again, shouting, threatening to report nurses and 'lump' them. It was explained to her that these dressings are to help the burn and she was provided medication. Siobhan then refused to leave the department, refusing to let staff remove her cannula and refusing to give up the Entonox. Security was called. The ED Dr deemed Siobhan to have capacity, but she continued to refuse to allow staff to remove the cannula but allowed them to re-dress her leg. Siobhan left department with cannula in situ with security present. Police were informed that Siobhan had a cannula in situ and was displaying drug-seeking behaviour but the Police stated that it is not something they would attend.

2018 – During the course of the year, Siobhan attended the ED on four occasions due to abdominal pains and then an identified pregnancy - she left prior to treatment on two of those occasions. Siobhan did not attend an ultrasound nor the 16-week appointment for unknown reasons. Siobhan was very clear on what medical intervention and what medication she did and did not wish to have when she spoke to medical professionals.

2019 – Records show that Siobhan received midwifery treatment from the Queen Elizabeth hospital in Woolwich following abdominal pain. Records state: 'Since admission she has been very difficult, abusive and not wanting to receive care. She has been smoking and using Entonox in the room.' Her niece was present with her, to whom she had also been abusive.
Concerns in Addenbrookes notes from the information from the Queen Elizabeth hospital were recorded as:

- Traveller
- Known to have pancreatitis but has not attended any follow up appointments
- Very frequent attender at ED, has ED management plan as demands Oramorph/Entonox
- Known to be taking Citalopram, and prescribed Oramorph 10mg prn since 13/5/18
- Fragmented maternity care, DNA 16/40 appt
- Unclear whether social care involved with family

- Possibly illiterate (?), requested all information goes to her father and he will pass on to her.

February
06/02/19 – Siobhan attended a routine antenatal appointment with the community midwife in which it was recorded that she was friendly and polite throughout. Siobhan reported in her appointment at Lewisham hospital previously, that she was in a lot of pain at the time and the midwife was dismissive of her pain and made assumptions about her Traveller status, just from her accent.

Siobhan stated that there was a huge clash of personalities and voices were raised between herself and the midwife. Siobhan denied any substance misuse as she was a strict catholic, but at the time was feeling very desperate because of the pain. She denied banging walls or being overly aggressive, but stated she was just responding to a rude and racist midwife.

Siobhan denied domestic violence at all and stated she was single as the father of the baby is now back with his wife. Siobhan was in the process of moving to a house in another area of Cambridge. There were no concerns and it was noted that Siobhan was friendly and polite, as she was at booking.

08/02/19 - Siobhan reported that she had been assaulted by being hit in the head and side by a metal pipe. Siobhan stated that during the afternoon, she was assaulted by an unknown female. She was kicked in the back and thinks she then fell forwards. There was no loss of consciousness. She could recall events pre and post assault. Following this, she reported back pain but predominant pain was in her lower abdomen.

Siobhan's main concern was for her unborn baby.

On asking Siobhan directly about the event, she stated she was visiting her husband's grave and she was also with her sister at the time.
She reported that two women approached her, she believes that one of the women was the ex-wife of her current baby's father. Siobhan reported that the women attacked her, she was kicked and also hit with a metal bar. Her sister was also there and was trying to protect her. There were other people there but they left when the women started to attack her. Siobhan remained in hospital, with several entries made on her notes. Records state: 'Siobhan has passed urine on the floor again which I have politely asked her not to do this due to hygiene. Siobhan started to raise her voice and become aggressive, said that we are treating her like a 'dog'.'

Security was called and she was asked to put her clothing on her bottom half to protect her dignity prior to their arrival but she refused and then stated she did not want them in her room as she was a Roman Catholic and shouldn't be seen unclothed by men.

12/02/19 – Following a referral to Children's Social Care, a strategy meeting was held to discuss whether a section 47 should be raised. Concerns were raised as follows:

- Siobhan was a very frequent attender at A&E in London with aggressive and

demanding behaviour for morphine and Entonox. Other Trusts had management plans due to her aggression

- Siobhan has pancreatitis but does not attend appointments or follow advice.
- Her children did not attend school and they had not seen the GP for two years
- Siobhan's husband hanged himself and this has left significant trauma
- They had insufficient information on current relationship however it is believed she had an affair with Tommy.
- The wife of Tommy was part of the assault against Siobhan and she has previously driven a car at Siobhan's children in a threatening manner
- It was felt there was a high risk that she will attempt to assault Siobhan again
- Siobhan was known to not be truthful when dealing with professionals
- There was insufficient information on Siobhan's mental health
- Siobhan had a long and prolific history of shoplifting since 2008 and police intelligence suggested that she uses her children to help her when she goes shoplifting
- Clarification is needed on her morphine use due to risk to unborn baby.

All members of the strategy meeting agreed that a section 47 assessment should be commenced. The Social worker and traveller liaison representative arranged a joint visit for the same week. Siobhan's whereabouts were not known but she had spoken to the traveller liaison representative that morning and told her she was moving to another area of Cambridge. A plan was put in place.

22/02/19 – Siobhan was spoken to and reported feeling safe at home and denied domestic abuse.

04/05/19 – Previous notes state that Siobhan is documented as having Bipolar Disorder and PTSD. She was medicated post her husband's death but had not taken any for two years. Siobhan suffered from post-natal depression after her first two previous pregnancies.

05/08/20 – Siobhan attended A and E with abdominal pain and staff found her difficult to manage. She accused staff of being racist since she had arrived and was rude to the point that two members of staff had to be with her and her not seen alone. She was not willing to answer questions to assist with her treatment and was demanding Entonox. She was rude and aggressive to staff when this was refused. There was no concern over her medical condition as she was walking up and down the apartment.

The above are selected notes from Siobhan's medical records. Through her pregnancy from January to birth in May 2019, there is a recording every week and often multiple times within the week of contact with Siobhan. A vast number of these report non-compliance and aggression from Siobhan in some form and describes her as 'difficult to deal with' on one entry. Security have had to be called on more than one occasion when she had been admitted.

Good practice/Reflective considerations

The local health trust is promoting the use of My chart which is the electronic patient portal to support with patient information, appointments and letters. My Chart has the ability to recite for those who are unable to read or require additional support.

Reasonable adjustments:

Interpretation services: available in over 100 languages and BSL Double appointment: available for those using communication aids, interpreters and carers Accessible information: Written information can be provided in various formats e.g. braille or large text, Patient Assistance: Access to support with communication and information needs via accessibility@addenbrookes.nhs.uk or 01223 256998 and will include providing provisions for those who have difficulty with reading and writing.

Deaf blind relay BSL (British Sign Language) Lip speaker Sign support English Text into audio translation Visual frame signing Translations into various languages including audio to text, e-text, easy read etc. They currently do not have the ability to on demographic data collection to identify GRT ethnicity. The trust adheres to the NHS spine definitions.

2.4.3 – Cambridgeshire Police

There were reports of DA where Siobhan was the victim in the period 2010-2013 where no prosecutions were made. These related to her deceased husband.

27/12/14 – A report was received by the police that Siobhan and her friend had left three under 10's alone at home at night. Officers attended and there was no adult present. Siobhan returned whilst officers were still there. Due to evidential difficulties the investigation was filed. A Safeguarding referral for the children was made and a crime report of neglect due to concerns expressed for the children was recorded.

15/01/15 – Siobhan reported that while she was having a verbal domestic with her sister-in-law, her brother intervened to try and get her out of the caravan and poked her in the eye.

A crime report was raised for assault. Siobhan would not support the investigation and it was filed due to insufficient evidence.

24/05/15 - Siobhan contacted the police to report being fearful for her life after being threatened by her parents. However, on police attendance, she was abusive and refused to engage in the investigation process.

A medium risk DASH was raised retrospectively. There was insufficient information for a crime to be raised.

04/05/18 – An Investigation into Siobhan's brother-in-law, Joseph, took place following an allegation where he was shouting at Siobhan and revving his car engine and looked like he was going to drive at her. A crime investigation was recorded into a Public Order offence.

This offence was incorporated into the wider offence of Stalking which he was charged with, and which involved his wife (Siobhan's sister).

19/11/18 – Anonymous information was received stating Siobhan had someone else pass her driving test and was now driving illegally. The informant was thought to be Joseph.

07/12/18 – The police were contacted by Joseph to state his children have messaged him saying Siobhan is locking them in the toilet. A welfare check took place and no concerns were raised.

12/12/18 – Joseph contacted Police to state Siobhan was dealing in drugs. No immediate concerns were raised and he was advised to inform Social Services.

17/12/18 – Joseph contacted the Police with allegations of Siobhan taking drink and drugs in front of her children, driving them around whilst under the influence and using them to shoplift. The veracity of the information was questioned due to numerous calls made by Joseph around that time.

08/02/19 - Investigation into a female attacking Siobhan with a metal pole to the upper body and head and saying that she would kill Siobhan once the baby was born. The female is the ex-partner of the person Siobhan was in a relationship with at the time.

Siobhan supported police action, but none of the witnesses were willing to assist. Siobhan agreed to the filing of the investigation without the suspect being interviewed to prevent repercussions for herself.

12/02/19 - Concerns were raised by social care around the Mental Health and behaviours of Siobhan and the impact they will have on her unborn baby. A strategy request was made from Social Care and Midwifery.

S.47 Single Agency approach was agreed in the strategy meeting. At the case conference it was agreed for the children to go on to a Child in Need (CiN) Plan.

July 2019 – There were two separate incidents of allegations against Siobhan of making off without payment and shoplifting. There was no support from the companies and the investigations were filed.

August 2019 – An assault with no injury was reported on Stevie believed to be by the child of the ex-partner of Tommy. No additional evidence and investigation filed.

21/02/20 - Damage was caused to Siobhan's car and front door. Siobhan claimed to not know what had happened, but it was possibly something to do with families feuding over an ex-partner.

Siobhan did not wish to complete any paperwork or make a complaint. There was no CCTV or witnesses and the investigation was filed.

12/07/20 – A domestic argument took place when Siobhan accused her current partner of cheating on her. In response, he hid her bank cards. Initially, it was reported that he had been violent to Siobhan, but she denied this when the police arrived and refused to complete any paperwork.

25/08/20 - Crime investigation into the harassment of Stevie who was receiving death threats over the phone. This was believed to be from the child of Siobhan's ex-partner, Tommy.

06/09/20 – A Child protection referral was made after the death of Siobhan as concerns were raised over Stevie having found her and also having lost her father in a similar way in 2013. The outcome was a s.17 single agency investigation for Social Care to support the children and consider long term plans.

Good practice/Reflective considerations:

In April and June 2021, two additional safeguarding functions were introduced in Cambridgeshire to support frontline decision making. The Early Intervention Domestic Abuse Desk (EIDAD) went live in June 2021. Their involvement begins from the point that a call is received by the Force Control Room (FCR) and is identified as domestic related. When identified as a domestic abuse incident, the EIDAD will commence research which will involve identifying previous domestic related incidents, warning markers for parties at the address and any previous MARAC involvement. This information is then formulated into a research package which is then sent directly to the attending officer. Officers can also consult with the team directly from the scene.

2.4.4 Cambridge and Peterborough NHS Foundation Trust (CPFT)

In September 2021, a full-time post was financed to support CPFT staff with domestic abuse cases. They have written policies specific to this area and have created a page on the CPFT intranet for staff to enable them to find links to support agencies and information on how to ask patients questions about whether they are experiencing domestic abuse.

They have integrated DA champions who are staff working on wards and in the community who have an interest in DA work and are the first port of call for other staff to come to for guidance. They are supported monthly in a group by the safeguarding team.

Record keeping has been updated with a domestic abuse template within the safeguarding mode and plans are being made to install a pop up when staff open a patients record to prompt staff with 'Have you asked about domestic abuse?'

There are several Mental Health service provisions within Cambridgeshire including the following:

CPFT Liaison Psychiatry Service (LPS) - LPS are dedicated seconded psychiatry teams based in general hospitals, providing rapid access to assessment of acute mental health needs. They provide a plan which may include advice, signposting and/or referrals to community mental health teams and partner agencies and/or treatment of mental health problems, for example medication review. LPS covers the emergency department and medical wards in general hospitals.

CPFT First Response Service (FRS) - The FRS supports people of all ages experiencing a mental health crisis. FRS provides 24-hour, 7 days a week, 365 days a year access to mental health care, advice and support. By calling 111, and selecting the MH option, a person will be put through to a member of FRS who will speak to them and discuss their current mental health needs. Support may involve telephone support or a face-to-face assessment and if appropriate referrals onto other CPFT services.

The Sanctuary - This service can be accessed via FRS. It is a joint service partnered with Mind. This service supports people in mental health crisis. The team will see how best they can support individuals and decide if a safe space or a visit would be helpful.

CPFT Psychological Wellbeing Service (PWS) - This service provides help to people aged 17 and over (no upper age limit), who are experiencing common mental health problems such as depression and anxiety disorders, including: generalised anxiety disorder (GAD); social anxiety; post-traumatic stress disorder (PTSD); health anxiety; panic; phobias and obsessive-compulsive disorder (OCD). The main treatment offered is Cognitive Behaviour Therapy (CBT). This is now known as NHS Talking Therapies, which Siobhan declined.

Liaison and Diversion Services (LaDS) – The LaDS services identify people who have mental health, learning disability, substance misuse or other vulnerabilities when they enter the criminal justice system, predominately in police custody and courts. The service can then support people through the early stages of criminal system pathway, refer them for appropriate health or social care or enable them to be diverted away from the criminal justice system into a more appropriate setting, if required. LaDS work with children (over the age of 10 years) and adults, providing triage, assessments and sign posting, support with attending first appointments, time limited primary care treatments and court reports with the aim of improving overall health outcomes for people and supporting people in the reduction of re-offending or diversion where appropriate. The team consists of experienced mental health nurses, mental health social workers and support workers.

Chronology

2014

March - Siobhan reported that her husband had hanged himself. She stated that it had ‘come out of the blue’ and there was no indication that he was suffering from any mental health problems or depression.

2016

On her request, Siobhan was sent a copy of a report completed by the senior social worker from about a year and a half before to accompany an eligibility for work form that was being completed on her behalf.

2018

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.

Areas for consideration:

1. In 2020, what services were provided and were there any barriers/gaps in relation to supporting and treating adults and children from the Irish Traveller community?
    - Adults: The notes demonstrate that Siobhan did access mental health services but declined to engage in any form of talking therapy or treatment. It is clear that she is part of a hard-to-reach community who finds it difficult to engage with services to access the support and treatment she required. No additional service provision for the GRT community was designed with these challenges in mind.
    - Children: CCS provided a health visitor, midwifery and school nurse services at that time.
      08.09.20 - A Strategy meeting was held following the death of Siobhan and a CPFT practitioner from Health MASH attended.
      15.10.20 - The allocated Social Worker contacted to ask if any support was required from the 0-19s services.
      20.10.20 – The Social Worker emailed CPFT and stated the children would benefit from a health/wellbeing assessment /support. The Social Worker was signposted to CHUMS and STARS for emotional health and wellbeing support as a more appropriate service rather than 0-19s for support around loss and trauma.
      26.11.20 – A growth review and general health assessments were completed by 0-19s service. The two older children declined counselling when offered.

2. In 2023, are services more effective or has there been any progress? (in relation to question 1)
    - Adults: CPFT has a Trust wide Equality Diversity and Inclusion Team. There is also a dedicated lead for engaging difficult to reach communities to ensure health equalities. In addition, there is a strategy and lead for suicide prevention.
    - Children: CPFT provide health visitor, midwifery, school nurse and CAMH services.

3. Are any additional measures in place to engage children from the Gypsy, Roma, Traveller (GRT) community?
   There are no additional measures in place at this time. However, the Trust is developing strategies to engage with all hard-to-reach communities.

Best practice/Reflective considerations

Siobhan accessed CPFT mental health services and from the information held, there does not appear to have been any identified barriers, however, she did not engage with services and the reason for this is not known.

The area of Cambridgeshire and Peterborough have a large GRT community and prior to this DHR Review CPFT were unable to provide data on the numbers of adults and children from the GRT community accessing CPFT treatment and support services, and were therefore as an organisation, unable to fully evaluate its effectiveness in engaging and providing treatment and support for the GRT community. As a direct result of this Review, CPFT's electronic record keeping system has been modified to includes GRT to the patient's demographics ethnicity 'options' list.

On the occasions that Siobhan contacted services in an upset state, there was a lack of inquisitiveness and questioning of the children's emotional state and wellbeing. There is no record of the fact that Siobhan could not read or write or if CPFT were aware. Although there is good practice shown of offering support and information about who to call in a crisis, CPFT wrote that information and sent it in letter form. They could have written a letter of support for housing to expedite matters and provide practical help with matters that were causing Siobhan stress.

There was not an assertive effort to contact Siobhan by the District Nurses and no effort was made to use existing relationships with professionals.

Following the death of Siobhan, collaborative working was evident between CPFT and Children's Services to provide support to her children and use of specialists within the Traveller Community were utilised showing best practice.

2.4.5 Cambridgeshire Public Health

The previous Suicide Prevention strategy that ran from 2017-2020 listed gypsies and travellers as a high-risk group. This continued into the renewed strategy for 2022-2025[11] where the community has been mentioned as a high-risk group and identifies that data, both nationally and locally is severely lacking for suicides in the GRT community. However, from the data available, it is shown that Irish Travellers are six times more likely to die by suicide than the general population. It is also stated that in studies that do consider the mental health of the GRT community, concerns such as acceptance, life prospects and access to services are suggested as risk factors.[12]

The current strategy also states that research has shown that those bereaved by suicide are 65% more likely to die by suicide than by natural causes, regardless of whether the person who died by suicide was a blood relative or not.

[11] Suicide Prevention Strategy - Cambridgeshire County Council

[12] Thompson, R.M. et al., 2021. Mental health support needs within Gypsy, Roma, and Traveller communities: a qualitative study, Mental Health and Social Inclusion

Cambridgeshire Public Health have recently added Gypsy, Roma, Traveller on their Real-time Suicide Surveillance data collection to provide more informed data on the local area in the future.

People in contact with mental health services are at a particularly high risk of suicide compared to the general population (approximately a 10-fold risk)[13], but they have the greatest opportunity of intervention as a system as they have engaged with local care services. It correlates domestic abuse and suicide, advising domestic abuse specialists including IDVAs should receive training in suicide mitigation.

Best Practice/Reflective considerations:

The Public Health Lead Nurse for Travellers is part of the Suicide Prevention Strategy Implementation Group and feeds back to the Suicide Prevention group about issues affecting the GRT community.

Public Health have provided an Adult Literacy Skills programme which is ongoing with funding from Cambridgeshire skills. This will continue but oversight of the Traveller Health Team may change in the near future.

A two-year project which funded Traveller Health Education Liaison Officer posts has just concluded. This supported GRT community members in accessing alternative options or support to gain access to mainstream schooling. There is no funding to continue this project.

2.4.6 Cambridgeshire Public Health – Traveller Health Team

This information was gained during a verbal interview with the author from the memory and knowledge of the individual who has been employed in this role for several years as a Community Nurse and Health Visitor and is part of the Public Health Traveller Team.

All observations within this section are from a professional who has worked in and closely with the GRT community for a number of years and has had disclosures and insight provided from conversations from those in the community that they have worked with.

The Traveller Health Team attend weekly drop-in centre for travellers at two separate locations, one on a Monday and one on a Wednesday. This is an opportunity for them to provide advice to anyone with health concerns who does not wish to go to the Doctor's, check on the health of young children, encourage parents in relation to immunisation, pregnancy checks etc. Food bank vouchers can be provided. Siobhan attended and was provided food bank vouchers and assistance with household bills on a few occasions.

The Traveller Health Team maintains the same professionals in post where at all possible to provide continuity of service and to enable them to build a relationship, trust and be able to have historical knowledge of those who attend over a period of time. This also assists with risk assessing and advice as vital information may not be repeated by attendees and may be

[13] . Department of Health and Social Care, 2021. Suicide prevention in England: fifth progress report. Available at: https://www.gov.uk/government/publications/suicide-preventionin-england-fifth-progress-report

lost. Without this prior knowledge of professionals, risk assessments may not be as informed and accurate.

Barriers have been identified that are specific to the Traveller community in relation to their lack of understanding of systems and their fear of authority. This can be problematic to families where their culture is to be spontaneous which leads to missed appointments and then discharge from services. This correlates with the low immunisation rate in children from the Traveller community as appointments would rarely be made solely for this purpose. The lack of practical help available due to illiteracy is a common problem. Siobhan herself needed assistance with completing forms and, apart from the drop-in centre that provided help in this area, this support is not provided with pathways and websites are referred to for assistance.

Siobhan's mother, Sinead regularly attends the drop-in centre and has done so for a number of years and Siobhan would come with her every now and then and received help on each occasion.

Advice and processes are not always suitable for the Traveller community. Families are predominantly large which provides a barrier if a mother is wanting to flee with her children as there are few refuges or safe havens that can accommodate larger families.

All of the team have attended 'STOP' suicide training which is refreshed periodically due to the recognised links between suicide and domestic abuse.

Best practice/Reflective considerations

There are regular regional meetings of the Traveller Teams so that they can share information on trends and patterns recognised and any issues that are identified that may transfer across several sites. It is also an opportunity to share working practices and evaluate the services that are being provided.

This service is paramount to maintaining contact with the Traveller community as they do not trust professionals on the whole and they do not generally involve the Police in 'their business' unless a life is at risk.

There is a general level of acceptance of violence against both men and women in the Traveller community that is not always recognised as domestic abuse. The Team tries to gently integrate National initiatives utilising the drop-in centre to try and raise awareness in this area.

The drop-in centres have representatives attending from the following organisations:

Cambridgeshire County Council Public Health

- Cambridgeshire County Council Traveller Health team
- Community Development worker
- Adult literacy worker
- Senior advocacy practitioner

South Cambs District Council G&TLO

Cambridge City Council Family worker from Child and Family team

'Healthy You' Health Practitioner

Healthwatch

Cambridgeshire County Council Targeted Service support.

2.4.7 Metropolitan Housing Trust

The Metropolitan Housing Trust owned the property that Siobhan and her children lived in for the last few years of her life.

19/02/19 – A clear note was on the computer system indicating that Siobhan could not read or write.

February 2019 – September 2020 – Revenue documents from the computer system show constant financial arrears in both rent and other bills connected to the property. A number of attempts to contact Siobhan by text message, phone calls and voicemails were unsuccessful. It states in June 2019 that a support worker is assisting her with obtaining benefits but it is not known who this is or the organisation they represented.

2.4.8 Department of Work and Pensions (DWP)

Siobhan was in receipt of Employment Support Allowance from 4th December 2015. A Work Capability Assessment was completed on 9th March 2016 and she was found to have Limited Capability for Work or Work-Related Activity and was placed in a support group. A medical report was written in relation to this. It was recorded that Siobhan had never been employed and was currently living in a caravan with her children and parents. Siobhan got upset during the assessment and very irate as she does not like talking. Her mother assisted with answering questions.

Siobhan advised them of a change to her address in both 2018 and then 2019.

There was no further contact until January 2021 when a payment was returned from the bank as the account had been closed.

2.4.9 Cambridgeshire and Peterborough Domestic Abuse Violence Partnership

The DASV network are recruiting front line staff from across all partner agencies who will act as 'Champions' to cascade and share information with colleagues in their agency/service. The Network meetings will take place quarterly and focus on a different subject area in relation to domestic abuse each time.

The aim of the DASV Champions role is to use existing and develop new links to promote discussion and best practice around the issues of domestic abuse and sexual violence affecting users of the service.

Champions are expected to:

- Proactively raise discussion about domestic abuse and sexual violence.
- Help address local barriers and identify improvements.
- Act as a person with some expert knowledge to provide support to peers when working with adults, children and young people and families affected by domestic abuse or sexual violence.
- Inform colleagues of updates and projects including feeding back from the quarterly awareness sessions

In January 2022, around 100 professionals attended over three sessions where the presentations were made by One Voice 4 Travellers. The professionals represented organisations including Adult Social Care, Children's Social Care, Education (including schools), Health (including mental health), Housing, specialist DA workers and voluntary organisations. One Voice 4 Travellers is funded by the Cambridgeshire Office of the Police and Crime Commissioner (PCC) for specialist work with the GRT community within Cambridgeshire.

One Voice 4 Travellers are a "By & For" service who work with the Gypsy Traveller Community Across the Eastern Region.

In Cambridgeshire & Peterborough they are funded by the Office of the Police & Crime Commissioner to provide 15 hours specialist Domestic Abuse Outreach to the Gypsy Traveller Community.

They support those who may be subjected to domestic abuse to make informed choices about their lives and being able to recognise what outcome those decisions may have, such as making a move from living in a caravan to living in bricks and mortar to allow them and their children to live safe and free from possible threat or abuse.

In 2022/23 they supported 58 victims of Domestic abuse in this area, 15 of whom lived in South Cambs. The types of abuse suffered were:

- Coercion and control (31)
- Financial abuse (37)
- Physical violence (11)
- Emotional abuse (52)

This service has been funded by the OPCC in various forms since March 2020 and continues to be funded until March 2025.

All IDVAs and specialist domestic abuse staff receive suicide prevention training from MIND.

2.4.10 Integrated Care Board (ICB) (previously the Clinical Commissioning Group – CCG)

At the time treatment was being provided for Siobhan, the Integrated Care Board was known as the Clinical Commissioning Group. This was changed in 2022.

Main health providers have been contacted to ascertain what training is provided in relation to the GRT community within their organisations and whether there are specialist liaison officers or personnel with specialist knowledge in relation to this community group within their organisation.

It was found that those who did not deliver any specialist training around the GRT community and did not have liaison officers based within them, had previously accessed support from the Liaison Nurse in Cambridgeshire. They acknowledge that they have treated patients from the GRT Community and believe that they have developed knowledge and skills in their dealings over a number of years.

One Health provider reported that the Adult Safeguarding team keeps a check of ethnicity and have only had one white Roma case in the financial year of 2022/23. The data capture does rely on either self-reporting or 'eTrack' being accurate. They have had two After Action Reviews (AAR) in 2023 involving two Irish Travellers meaning that the capture throughout is quite small. They have a lead for Equality, Diversity, Inclusion and Armed Forces that they can also ask for advice.

During their training, they talk about vulnerabilities. The Safeguarding policies also reflect the vulnerability of the GRT client group and the protected characteristics. In September 2022 staff had Gypsy, Roma, Traveller Cultural Awareness Training delivered on teams via Healthwatch and it was put on the Healthwatch Network website for staff.

2.4.11 South Cambridgeshire District Council

The Council employs a Gypsy and Traveller Liaison Officer to build relationships with the GRT Community in the area, assist them with Council matters and support with applications. This role acts as a conduit for many agencies in the area who do not have contacts. The G&TLO is welcome on the different sites within Cambridgeshire and attends the drop-in centre to provide practical assistance in applications for housing and school entry, amongst other things. The current G&TLO has worked in this role for several years and took a couple of years before starting to be able to build relationships.

The G&TLO has attended NAGTO conferences (National Association of Gypsy and Traveller liaison officers), Traveller Movement conferences, Government events and ACERT (GRT education conferences. All of these are to widen the knowledge in a number of areas and be informed of national trends that could affect South Cambs. Training has also been provided specific to GRT in areas of domestic abuse, safeguarding, LGBT and Gender training, Mental Health, Healthwatch and Finance and Budgeting.

Policy and Performance staff have received GRT training from the charity Friends, Families and Travellers. Housing staff also attended this. Events are held every year during Gypsy,

Roma and Traveller Heritage month explicitly intended for all officers and members and are typically one or two 60-minute webinar sessions. Although this is not specialist training, it is intended as a primer for all staff.

An awareness session for staff, partnered by Cambridge City Council was held in the summer of 2023 and was available to all staff from either council and for shared services. A recording was uploaded onto the private YouTube channel for wider dissemination.

HR do not receive specific learning in relation to the GRT community but it is incorporated within the compulsory Diversity and Inclusion e-learning. In terms of housing needs, South Cambs council are working with specialist consultants to carry out a Housing Needs Assessment and will provide specialist advice as part of this.

The Council is committed to ensuring that they are accessible and serve all communities within South Cambridgeshire. During Covid, in order to assist with vaccinations, there was a medical team sent to sites with the G&TLO to offer immediate vaccinations without attending the vaccination centres, but the engagement with this was low. However, this should be seen as good practice and a positive service offered by the council.

Good practice/Reflective considerations

The website is under review and aims to bring the reading age down to nine years by Autumn 2024. There is also easy read information available on/via the website. There are website disclaimers if you need alternative formats, of which a number are available. Although there has been a move to digital services, there will always be a contact centre available to avoid digital exclusion.

South Cambs District Council have translation and interpretation and sign language services and offer face to face appointments to those who need or request them.

2.4.12 Cambridgeshire Children's Social Care

Section 47 refers to a provision within the Children Act 1989. If Children's Social Care receive information or have concerns about a child's welfare, they have the legal duty to conduct a thorough assessment to determine whether the child is suffering, or likely to suffer significant harm.

Cambridgeshire Children's Social Care had contact with Siobhan and her family from 2009 onwards.

2009 – Aware of an allegation by Siobhan that Rowan had slapped her across the face.

2012 – 2 x referrals. The first was from the hospital re: Mum presentation (no further details known). The second was from the school as the child had a bruise to her face. A s.47 took place and the concerns were unsubstantiated.

2013 – 2 x referrals received. A core assessment was completed after the death of Rowan.

2014 – 3 x referrals received. The referral in December was in relation to abuse and neglect. A s.47 and a Child and Family assessment found it to be unsubstantiated. The closure record states: 'family come from a travelling background; the children are receiving an appropriate standard of care.'

2019 – A referral was received by the hospital owing to challenging and concerning behaviour by Siobhan. Referral information included 'children appear to experience a large friend and family network generated by traveller culture.' The children were classed as 'Children in Need (CiN) from January until July when they were then closed to Children's Social Care and stepped down to Early Help (now known as Targeted Support).

In September, a police referral was made to the MASH following Siobhan calling the police because her child had been assaulted by other children at a local swimming pool. Jo was observed to be in a hot car which was the purpose of the referral. Siobhan was spoken to as part of MASH but no specific action was needed and the family were open to Early Help at this time.

They remained in receipt of Early Help support until November 2019.

2020 – A referral was received in February following a smashed car and front door at Siobhan's house. The children were said to not be present when this occurred. The police report recorded that 'neighbours unwilling to speak to the police due to occupants being from a 'traveller community'

Education

Checks with Education show that the two oldest girls (born in July 2007 and July 2008 respectively) were Elected Home Educated (EHE) from February 2017. There are a significant number of records about oversight and tracking of the EHE of the girls in 2018 and 2019 but it would appear that Siobhan disengaged from the support. The Child and Family Assessment of Dec 2020 simply makes reference to the absence of school delivered education after year 6 as something that is 'cultural'. Again, it is not acknowledged or probed that the grandparents who the children now live with are both illiterate.

Family and support following Siobhan's death

Records show violence from Siobhan's husband, Rowan, dating back to 2009. There is also other information of violent behaviour of males within Siobhan's wider family, and although there is no record of this being specifically towards Siobhan, there was violence in the family which Siobhan and potentially her children were exposed to. This is an area that required further exploration and discussion (violent/abusive /coercive males in the family network) in considering the impact and risk on the children when placing them with the grandparents.

It is acknowledged that there was an appropriate referral and response after Siobhan died in Sept 2020. The children were opened to Children's Social Care and an assessment was completed. The outcome of this was a 'step down' to Early Help who were then involved until Summer 2021. The assessment does not fully consider the cumulative history and experiences for these children. The level of potential trauma is not explored fully. The

analysis includes that having their Grandmother, Sinead, caring for them is positive because they are living with family. There is not the depth of consideration of moving back to a fixed site after living externally from the community, nor much detail as to how Sinead will manage the emotional impact of all of the children now having lost both biological parents in tragic circumstances. On review, the threshold was met for Child In Need. However, we also have to consider the balance of engaging families effectively. As the threshold was not met for significant harm at this time, there can be consideration made for offering support that the family would accept. There is evidence that Sinead was willing to work with Early Help.

Good Practice/Reflective considerations

When the children were closed to Children's Social Care with a referral to Early Help, the manager oversight recorded that the children were being home educated but it was 'unclear how they are receiving education as the mother does not read or write.' This does not appear to have been followed up.

The lack of engagement on Elected Home Education after Siobhan's death is perhaps indicative of the wider challenges of what support the family wanted.

2.4.13 National research on provisions and services

On the website of 'The Traveller movement,' there is a clear pathway to a section on domestic abuse where it explains how to recognise this within your relationship. Women's Aid is utilised to provide advice for women on safety planning and refuge. There are videos that can be watched by survivors from the Traveller community to resonate with those seeking help or viewing the site. There is an interactive map that provides locations for help across the country and Cambridge Women's Aid contact details are provided as support within the local area.

A project by Friends Families and Travellers[14] took place for a year beginning in June 2016 where they held a 'Healthy relationship focus group' to explore and increase the knowledge of Gypsy and Traveller communities around healthy relationships and domestic abuse. During this, they outlined barriers to accessing services as:

- Feel that mainstream services are not accessible to Gypsies and Travellers.
- Mistrust of statutory agencies such as Police and Social Services
- Fear of being judged due to lack of awareness of their culture on the part of services
- Sense of fatalism and low expectations
- Literacy and isolation may play a part

At the end of the three-hour focus group session the participants had created a power and control wheel relevant to their experiences and had a better understanding of the recognition that some behaviour towards them was domestic abuse and not to be accepted.

[14] Friends Families and Travellers June 2016 gypsy-traveller.org

The Office of National Statistics (ONS)[15] conducted qualitative research exploring the lived experience of Gypsy and Traveller communities, relating to education and employment in 2022 and found that there was a lack of awareness and sensitivity in schools to Gypsy and Traveller culture and that opting to home educate gave them more flexibility to travel as they struggled to obtain authorised absences from school for this.

Section 3 - Analysis

3.1 Family and friends' involvement and perspective

3.1.1 – No family or friends of Siobhan have been identified as wishing to partake in this Review.

3.2 Terms of reference areas

3.2.1 - Has domestic abuse in any form been the causation or a contributory factor to Siobhan taking her own life?

Professionals who work closely with the GRT Community have commented during this Review that domestic abuse occurs within relationships of Irish Travellers but it is kept private and not spoken about to professionals or those outside the Community. This is also repeated on numerous sites on the internet but is by and large anecdotal, with comments on Irish Travellers, and the sites do not provide academic research or figures to authenticate this assertion.

The Police refer to historic domestic abuse incidents between Siobhan and her husband, Rowan who died in 2013. His death had a detrimental effect on Siobhan's mental health. Siobhan had a relationship with a married man, Tommy, and became pregnant with her youngest child. Her relationship with him did not continue and there are police reports of a number of different incidents both throughout her pregnancy and after the birth of the child against both her and her child Stevie of assaults and harassment. Although these are believed to have been committed by Tommy's wife and children on differing occasions, no prosecutions were brought as there was no evidence to prove this. This will undoubtedly have had a detrimental effect on her mental health and fear for her and her family's safety - these events brought scrutiny from Social Services which was a great fear of hers. These offences are not recorded as domestic abuse as they do not form part of the definition.

During her last pregnancy, it was recorded that Siobhan was questioned in regard to domestic abuse on each occasion she attended an appointment (good practice) and she always denied this.

[15] Office for National Statistics (ONS) 7 Dec 2022 Gypsies' and Travellers' lived experiences, education and employment, England and Wales:2022

There is recorded history of domestic abuse in Siobhan's life in 2018, with charges being brought against her brother-in-law and sister for stalking, but these were not treated as domestic abuse at that time. Due to changes in the recording and how Cambridgeshire police now deal with domestic abuse, these incidents would now be recorded as Domestic Abuse / Familial Abuse.

There was an incident that Siobhan reported to the police of threats toward her from her parents and she was then involved in a domestic incident between a partner and herself where no offences were identified just a couple of months prior to her death.

3.2.2 - How effective are services and agencies provisions to domestic abuse within the Traveller community in Cambridgeshire?

Within both Cambridgeshire and Peterborough, 'One Voice 4 Travellers' work with, and support, members of the Gypsy Roma Traveller communities who are deemed to be in a state of need, hardship or distress caused by, or associated with, violence. The Author made contact with them but was not able to ascertain their interactions with other agencies or Siobhan. From speaking with other professionals and based on information provided within this report, it would appear that 'One Voice 4 Travellers' are commissioned to complete specific projects and do not work outside of this remit or alongside other provisions which can sometimes affect the collaborative approach and wider knowledge of what is being provided to individuals.

There are records of professionals asking Siobhan if she was subject to domestic abuse on occasions when she went to the hospital for appointments including during a routine ante-natal appointment which is good practice. On these occasions, Siobhan always stated there was no abuse.

Questioning of organisations within Cambridgeshire including the panel representatives indicates that very few organisations attend Travellers sites and engage with the communities. This could be due to a lack of liaison officers within organisations or potential fear of attending sites. There is also the consideration of how Siobhan's behaviour when she is being aggressive is interpreted; whether this is attributed to her being an Irish Traveller and this, in turn, overshadowing whether it could be due to the physical pain she was in for example. This cannot be ascertained but must be balanced with the fact that no medical staff should feel threatened during their work or feel in danger and, if they do, then contacting security is the correct procedure to follow.

A discussion took place by the panel into whether there was recognition of DA in the offences and actions committed by Tommy's family against Siobhan's family. The majority of members felt that this was too far removed to be classed as domestic abuse, which is also in accordance with the Home Office Crime Recording Rules. However, there were members who felt that it may have been classed as domestic abuse due to being 'personally connected.' This highlights some of the potential subjectiveness of words included in the act for example 'intimate' and the confusion that it can sometimes cause in agencies when they

are training their staff to identify domestic abuse. However, the overarching agreement was that the vulnerability and risk should always be assessed and identified, no matter how it is classified. It was felt this was not always the case with Siobhan.

3.2.3 - How did services interact with Siobhan and how do they engage with the Irish Traveller Community within Cambridgeshire.

When looking at how services engaged with both Siobhan and how they engage with the Irish Traveller community in general, it must be taken into consideration if there are any barriers that impede this and prevent trusted relationships with authorities being built.

The records of CPFT show that Siobhan voiced her concerns over people thinking that she wasn't a good mother if she showed her emotions. This was an area that was highlighted in a report from 2005 by Cambridgeshire and Peterborough Mental Health Trust where they completed a small study for improving mental health services for Travellers in Cambridgeshire.[16] Barriers to care were identified and recommendations to improve the service were made. The barriers identified are still be highlighted within this report including: 'There was an expectation that health workers would have no time and a lack interest or understanding. This fear of hostility was fuelled by experiences of discrimination. A health worker not conforming to this stereotype was viewed as an exception. CPFT have increased their staffing for both adults and children in relation to 'hard to reach' communities but accept that no additional measures are in place at this time to engage with children from Traveller communities.

The panel debated in detail whether the phrase 'hard to reach' was reflective of the GRT community in Cambridgeshire or whether it should be considered as hard to engage. An example of this is the pro-active attempt at engagement during covid where all recognised sites were attended with medical practitioners to offer the vaccination there and then but there was not much uptake. This could have been through lack of trust or lack of trust in the vaccine as the reasons were not asked or identified. (recommendation refers)

This also highlights a barrier and potential isolation from the community for Siobhan as she and her children lived in a house away from the sites. This may not be the only area in which she potentially faced this separation.

The drop-in centres are a valuable enterprise to provide advice and practical assistance to the GRT community whilst building trust and relationships. Due to the differing professionalisms that attend there are numerous areas and bureaucracy that can be assisted with which is often a barrier. Through attending with her mother, Siobhan managed to obtain practical assistance on different occasions to gain her children entry to school and also to obtain a house which she may not have been able to by herself. The continuation of the drop-in centres is currently in the consultation period. (recommendation refers)

[16] Improving mental health services for Travellers in Cambridgeshire – Cate Treise & Geoff Shepherd February 2005

Children's Services held information on Siobhan and her wider family from referrals that had been made to them but there appears to be evidence of Social Workers not exploring circumstances and information in depth as they were seen as 'traveller culture.' It is not clear what the children have been exposed to but there are several records held of violence by males within Siobhan's family and this does not appear to have been a consideration or explored in regard to their welfare.

It is noted that in 2014, following a referral, when Siobhan failed to attend an appointment that CMHT closed her case which shows a misunderstanding and intolerance of the lifestyle of her community. However, the panel accepted that this was in 2014 and procedures for all patients have now changed with contact made on more than one occasion to attempt appointment attendances.

3.2.4 – What other barriers affect the Irish Traveller community within Cambridgeshire and in particular, would have had an adverse effect on Siobhan?

The Financial Times reported on how gypsies and travellers are fighting financial exclusion [17] as they struggle to obtain insurance for their homes, vehicles and life insurance once it is known that they live on a Travellers site. Due to a vast majority having difficulties with reading and writing, they do not always have bank accounts and find it difficult to gain employment, with many being self-employed through no choice of their own.

Siobhan did have a bank account and was assisted by the South Cambs G&TLO to obtain a house as was her wish, but she still struggled financially, having rent arrears and being a single mother to four children. She had difficulties with obtaining benefits, not knowing what and how to apply for them, even with help from a support worker due to her own lack of education and illiteracy. DWP records show that Siobhan had not gained employment throughout her life.

A vast number of Traveller children are now being withdrawn from school by their parents to be home educated. Each local authority is responsible for elective home education based on Government guidance[18] . There is no legal duty on parents to inform the local authority that a child is being home educated. If a child never attends school, an authority may be unaware that he or she is being home educated. It outlines measures that can be taken if it is found that a child is not receiving the necessary education required whilst 'home schooling' but this is very difficult to monitor, particularly on Travellers sites where quite often, professionals will not enter.

The author spoke to a Head Teacher from a high school in Cambridgeshire and some of the issues that this legislation presents are that the majority of home-schooling is not held accountable for their learning and do not have to complete GCSEs and gain qualifications. Also, it has already been stated within this report with the issue of illiteracy within the Communities and therefore, the parents and grandparents may not be able to tutor their

[17] Financial Times, 21 July 2022 – How Gypsies are fighting financial exclusion – Robert Wright
[18] Dept for Education – Elective home education April 2019 – Departmental guide for local authorities

children or check their progress. The question needs to be asked as to whether this is facilitating further isolation from other communities if they are not attending school or education facilities and if this is then detrimental to them accessing employment in later years without qualifications. However, it is noted that with the help of the South Cambs G&TLO at the drop-in centre, Siobhan enrolled her two eldest children in a catholic school and this issue did not directly affect her. However, a lack of education affected Siobhan as outlined throughout this report with figures showing that people who identified as Gypsy or Irish Traveller were three times more likely to have no qualifications.[19]

The Traveller Health team suggested that advice and processes are not always suitable for the Traveller community. One of these being that the families are predominantly large due to multiple children and to flee your home with all your children causes issues with finding accommodation and can be a barrier to them leaving. The Author spoke with different Counties IDVA Services and Women's Aid to ensure this was not a localised issue and they confirmed that there are few places available that can accommodate large families, especially when the children are all young and would need to be in the same room as their parent and not split into two rooms. There is also a barrier for victims fleeing within the Traveller community due to the connections they have across the Country and traveller's sites. The victim fleeing can be recognised in a place that was deemed to be safe and they will be aware of this when professionals may not and this fear is another reason for not fleeing.

Although not specifically domestic abuse, this may be one of the reasons that Siobhan may have felt that she couldn't leave the area when she was isolated from the community and receiving harassment.

Section 4 – Conclusions and Recommendations

4.1 Conclusions

4.1.1 Siobhan was an Irish traveller and part of a large family who had lived nearby and had 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

[19] Census 2021 from the Office for National Statistics (ONS)

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 DHR 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 G&TLO 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 DHR. 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.

4.2 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 G&TLO, 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 'sometimes 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)

4.2.3 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)

4.3 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
   CPFT
   Cambridge University Hospitals
   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 DHR.

Appendices

Appendix A

Terms of reference

- 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? 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

Appendix B

Glossary

AAFDA: Advocacy After Fatal Domestic Abuse

CSP: Community Safety Partnership

CCG: Clinical Commissioning Group

CPFT: Cambridge and Peterborough NHS Foundation Trust

DA: Domestic Abuse

DHR: Domestic Homicide Review

DASV: Domestic Abuse and Sexual Violence partnership

DHR: Domestic Homicide Review

GP: General Practitioner

G&TLO: Gypsy and Traveller Liaison Officer

GRT: Gypsy Roma Traveller

ICB: Integrated Care Board

IDVA: Independent Domestic Violence Advisor

IMR: Individual Management Review