# Enfield Community Safety Partnership

# Review into the death of Eve

(October 2020)

Confidential Draft

4 February 2026

Amended 30 October 2026

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# 1. INTRODUCTION

This domestic homicide review was commissioned by Enfield Community Safety Partnership following the suicide of Eve, a local resident who was 50 years old. While it was clear that Eve had taken her own life, it was decided to undertake a domestic homicide review because it appeared that she may have taken her own life because of domestic abuse.

The Multi-agency Statutory Guidance for the conduct of Domestic Homicide Review (s.2.18) states "*Where a victim took their own life (suicide) and the circumstances give rise to concern, for example it emerges that there was coercive controlling behaviour in the relationship, a review should be undertaken, even if a suspect is not charged with an offence or they are tried and acquitted. Reviews are not about who is culpable.*"

In order for lessons to be learnt as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each case, and most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future.

The panel wishes to express their condolences to Eve's family and friends. The panel would also like to thank all those who have contributed to this review.

## 1.1. Timescales

Enfield Community Safety Partnership was notified of Eve's death by AAFDA (Advocacy After Fatal Domestic Abuse) in December 2020. Owing to the tardiness of the police investigation and the then procedure in Enfield (i.e. it was the practice at the time for the Metropolitan Police Service to recommend a domestic homicide review), a review was not confirmed until August 2021. The Partnership reviewed the circumstances against the criteria set out in the Multi Agency Statutory Guidance for the conduct of Domestic Homicide Reviews (2016) and recommended to the Chair of the Community Safety Partnership that a domestic homicide review (suicide) should be undertaken. The Chair ratified the decision to commission a review in August 2021 and the Home Office was notified the same month. The commencement of the review was further delayed because of the police investigation, followed by the family's request for a Victims' Right to Review (VRR).[1] In February 2022 the Victims' Right to Review (VRR) concluded that the decision for 'no further action' was correct. Nevertheless, Eve's family pursued a second Victims' Right to Review (VRR) and ultimately in April 2022, after many email exchanges and changes to the officers overseeing the Victims' Right to Review (VRR), the second review (VRR) concluded that the case should be put to the Crown Prosecution Service (this took place in June 2022). The Crown Prosecution Service asked for further information from the Metropolitan Police Service in August 2022 and November 2022. In February 2023, the Crown Prosecution Service rejected the charge of manslaughter. Thus, Eve's family asked for a Victims' Right to Review (VRR) of the Crown Prosecution Service. This was completed on 22 October 2024. Although the domestic homicide review had commenced in terms of seeking individual management

[1] The Victims' Right to Review (VRR) Scheme gives victims the right to ask for a review of a police decision not to charge a suspect. For further information see https://www.met.police.uk/advice/advice-and-information/victim-support/victims-right-review-scheme/ accessed online 18 August 2025

reviews, the chair was asked not to conduct interviews with professionals and Eve's family until the Victims' Right to Review (VRR) process was completed (February 2025).

In all, the investigation and challenge took place over a four-year period. There were over 300 emails involving at least 16 different police officers who were involved in various capacities, including reviewing the case, communicating with the family, and handling the investigation.

## 1.2. Confidentiality

The findings of this review remained confidential and were only available to participating professionals, their line managers and members of the domestic homicide review panel until after the report was approved by the Home Office Quality Assurance Board.

To protect the identity of the family members, the following anonymised terms and pseudonyms have been used throughout this review:

Eve – deceased aged 50

Jake – Eve's partner

# 2. METHODOLOGY & TERMS OF REFERENCE

The review was conducted in accordance with the Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (2016) under s.9 (3) Domestic Violence, Crime and Victims Act (2004).

## 2.1. Time period

This report examined the contact and involvement that agencies had with Eve and her partner (Jake) between May 2019 and the time of her death in October 2020. The panel decided on this time frame because this included the period when Jake first contacted Eve and they rekindled their relationship. The panel agreed, however, if any agency had relevant information outside of this period, this information should be included in the individual management review or information report.

## 2.2. Family engagement

Eve's family was supported by Advocacy After Fatal Domestic Abuse (AAFDA). The family and their advocate worked hard to ensure a review was undertaken concerning the circumstances of Eve's death. The independent chair was introduced to Eve's family by their advocate.

Eve's family provided a wealth of information, much of which is within the body of the report. They had the opportunity to contribute to the terms of reference, review the completed draft and choose a pseudonym.

The panel considered whether or not to approach Jake for his thoughts about his relationship with Eve. He had however denied any coercive controlling behaviour when he was interviewed by the police. Furthermore, a review of the charging decision was still underway as part of the Victims' Right to Review (VRR) Scheme.

## 2.3. Agencies and other contributors to the review

Individual management reviews and chronologies were requested from:

i. General Practitioner

Information reports and chronologies were requested from:

ii. IAPT (Improving Access to Psychological Therapies)[2]

iii. Metropolitan Police Service

iv. Sussex Police

An interview was conducted with:

v. Eve's independent counsellor

All the authors of the individual management reviews and the information reports were independent of the case i.e. they were not involved in the case and had no direct management responsibility for any of the professionals involved.

## 2.4. Key lines of enquiry

The review addressed both the 'generic issues' set out on page 31 in the Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (2016)[3] and the following specific issues identified in this particular case:

- What knowledge or information did your agency have that indicated Eve was a victim of abuse, harm or domestic violence and how did your agency protect her? How did your agency assess her risk? What referrals did your agency make?
- If your agency had information that indicated that Eve might be at risk of abuse, harm or domestic violence was this information shared? If so, with which agencies or professionals?
- What knowledge or information did your agency have that indicated Jake might be violent, abusive or controlling and how did your agency respond to this information?
- Did Covid19 have an impact on the support that was offered or given to Eve? Did professionals have face-to-face contact with her?

[2] The NHS's Improving Access to Psychological Therapies (IAPT) programme officially changed its name to NHS Talking Therapies in January 2023 as part of a national rebranding effort to be clearer and more accessible for the public. The name change was decided after a public consultation and was implemented across all NHS services throughout 2023.

[3] https://www.gov.uk/government/publications/revised-statutory-guidance-for-the-conduct-of-domestic-homicide-reviews

## 2.5. Specific issues for individual agencies

All agencies were asked to address the key lines of enquiry above but in addition to this, there were some specific issues to be addressed by the following agencies.

- Metropolitan Police Service

Eve's family asked to understand the Metropolitan Police Service procedure and timeline for investigating the death of a person who takes their own life when there has been domestic abuse in the relationship. This should include information about:

- The current Metropolitan Police Service policy on investigating suicides when there is a history of domestic abuse. It should outline any changes that have been implemented since Eve's death in 2020
- The timeline for seizing items such as mobile phones for interrogation
- The rank, training[4] and experience of investigating officers

In this particular case, Eve's family wanted to know what offences were considered as part of the investigation i.e. coercive controlling behaviour, harassment etc. The family also asked the Metropolitan Police Service some very specific questions which are set out in s.6.4.

- General Practitioner

The GP individual management review (IMR) was asked to provide a comprehensive overview of any significant interactions Eve had with her GP between 2015 and 2019. This should include a detailed account of the care she received from May 2019 up to the time of her death. Additionally, it should include any information received from Eve's counsellor regarding her state of mind in the days leading up to her death. Was this information acted upon, and were there areas where practice could be improved?

The following questions should also be addressed:

- Do GPs routinely ask about domestic abuse?
- Was Eve ever seen on her own during her appointments?
- If not, what steps were taken to create opportunities for confidential conversations?

- Counsellor

Did Eve disclose that her partner was abusive and if so, were any referrals made or suggested?

## 2.6. Review panel

The review panel met 6 times and all meetings were held via MS Teams (December 2021, April 2022, June 2024, April 2025, July 2025 & September 2025). All the members were independent of the case i.e. they were not involved in the case and had no direct line

[4] Training i.e. in domestic abuse and coercive control as well as in investigating cases involving domestic abuse and coercive control

management responsibility for any of the professionals involved in the case. The review panel comprised:

- Independent Chair and Author
- Community Safety Project Manager (Strategy & Governance, London Borough of Enfield
- Designated Professional for Adult Safeguarding, Enfield Directorate
- Detective Sergeant, Specialist Crime Review Group, Metropolitan Police Service
- Domestic Abuse and Sexual Safety Coordinator North London NHS Foundation Trust[5]
- Head of Community Safety, London Borough of Enfield
- Head of Community Services, Solace Women's Aid
- Independent Domestic Abuse Practitioner & Psychotherapist
- Health & Wellbeing Board Partnership Manager, Mental Health, Learning Disabilities & Health Protection Lead, Public Health Department, London Borough of Enfield

## 2.7. Author of the overview report

The chair and author of this review has been a freelance consultant for 26 years. She specialises in violence against women and girls, safeguarding children and vulnerable adults with a particular focus on domestic abuse. She has undertaken research on domestic abuse for Community Safety Partnerships and conducted audits and practice reviews for Local Safeguarding Children Boards. She has chaired and authored over 30 serious case reviews/domestic homicide reviews. She has a Master of Business and Administration (MBA) from Bradford University School of Management (2000) and a Master of Laws (LLM) in Child Law from Northumbria University (2011). She is independent of, and has no connection with, any agency in the Enfield area; she has never been employed by any agency in Enfield. She has completed two previous domestic homicide reviews for Enfield Community Safety Partnership (2019 & 2021).

## 2.8. Parallel reviews

Eve's inquest was listed for 24 May 2022 but was postponed when the case was referred to the Crown Prosecution Service for review in May 2022. A pre-inquest hearing took place in September 2025, the inquest listed for December 2025 was again postponed and a new date is yet to be set.

[5] At the time of Eve's death, North London NHS Foundation Trust was known as Barnet Enfield and Haringey Mental Health Trust (BEHMHT)

## 2.9. Equality and diversity

Eve was White British and her ex-partner is White British – neither were practicing Christians. All aspects of equality and diversity were considered throughout this review process. This review focussed particularly on age, disability and sex – where applicable they are discussed throughout the report. To ensure the review process considered issues around domestic abuse and suicide, the panel included representatives specialising in domestic abuse and those specialising in mental health and suicide prevention. A specialist psychologist from 'Woman's Trust' was invited on to the panel. Woman's Trust is a specialist mental health charity that provides free counselling and therapy for women who have experienced domestic abuse. The thoughts and views of all the specialists are reflected throughout the report.

## 2.10. Dissemination

In addition to the organisations contributing to this review (listed in paragraph 2.3), the following will receive copies of the learning from this report:

- Barnet, Enfield and Haringey Mental Health NHS Trust Integrated Safeguarding Adult and Children Committee
- Police and Crime Commissioner (Mayor's Office)
- The Office of the Domestic Abuse Commissioner
- Enfield Safer and Stronger Communities Board (Community Safety Partnership)
- NHS North Central London Integrated Care Board
- British Association for Counselling and Psychotherapy (BACP)

# 3. THE THOUGHTS OF EVE'S FAMILY

The family raised a number of concerns about the police investigation into Eve's death. They clearly fought hard to have her experience recognised by the Metropolitan Police Service and Crown Prosecution Service – and with support from AAFDA (Advocacy After Fatal Domestic Abuse) succeeded in having a domestic homicide review commissioned.

The Chair of the review met with Eve's parents and brother together with their AAFDA (Advocacy After Fatal Domestic Abuse) support worker in February 2025. They described Eve as strong woman with lots of fire in her. She was feisty, generous and kind – she was always helpful and giving. She was a confident, caring and strong-willed woman who did not have mental health problems.

Eve was fearful of Jake. He shouted at her, verbally abused her and threatened her and her family. There were times when she sat in the dark to avoid his detection – and avoid his "*mind games, lies, persistence and proximity*". There was an occasion when he phoned her

from outside her flat and berated her for two hours. Sometimes she went back to live with her parents for her own safety – she felt safer there as Jake could not reach her there.

Eve described to her family how every time she tried to leave Jake, he convinced her to stay. He "*talked her around*" by promising to change, using manipulation and persistence to persuade her.

Jake would turn up at Eve's property uninvited and she would let him stay to avoid any "*aggro*". During this time Eve's mood deteriorated. She had never been depressed in the past (except as a response to life events such as divorce and post-natal depression). Eve's family thought that Jake was not supportive concerning Eve's low mood – indeed, they felt he was the cause of it.

## 4. THE FACTS

In mid-October 2020, Eve hanged herself. Her front door was ajar and she was found a short while later by her father, who had arrived to finish some decorating they had started the previous day. Her father attempted to resuscitate her but she was pronounced dead at the scene.

## 5. BACKGROUND AND CHRONOLOGY OF SIGNIFICANT EVENTS

Jake and Eve knew each other from secondary school when they were young. According to Eve's father, they started a relationship during which Eve became pregnant (aged 16). She subsequently had an abortion. They were approximately 19 years old when their relationship ended.

Subsequently, Eve had been married twice and she had two adult children who were both at university at the time of her death. From information gathered during the investigation into her death, there had been domestic abuse in a previous relationship – however, in that situation Eve had been able to recognise the domestic abuse and extract herself from the situation. At the time of her death, Eve was at the end of divorce proceedings with her second husband.

Eve was not known to many agencies. She was not known to the Metropolitan Police Service but she had three contacts with Sussex Police. The first was in 2015 when Eve was employed as a cleaner by an elderly woman. She had a disagreement with the woman's son. Ultimately, the police investigated and this culminated in both parties being served with a Police Information Notice (PIN) asking them to end any further contact.

Her two other contacts with Sussex Police both concerned criminal damage to her car. These incidents occurred in 2016 and 2019 and neither appeared to be relevant to this review. Jake was known only to the Metropolitan Police Service as a victim of theft in 2017.

In May 2019, Jake reconnected with Eve via Facebook. They met in Covent Garden a few days later. At that time, Eve lived in Sussex where she had a cleaning business and she travelled back to Enfield at the weekends. It appeared that Eve wanted to move back to Enfield. Therefore, her parents arranged for the tenants to leave a property they owned.

Eve took over the flat in mid-September 2019 and finally moved in in mid-October 2019. It appeared that Jake also moved in with Eve.

In February 2020, Jake went on a golfing holiday to Portugal. Whilst he was away a tree was damaged by wind in the front garden of Eve's flat. Eve told Jake about the tree and he told her to leave it until he returned. In the meantime, her father and brother cut it down to avoid any further damage. When Eve told Jake about the tree, he was angry with her father and he was verbally abusive towards Eve. It led to a "*massive*" argument whilst Eve was driving him back from the airport. Jake felt that her father and brother were interfering in her life. According to Eve's brother, Eve was "*upset and fearful*", she stopped the car and asked Jake to get out. She was shaking and nervous about what he might do to her father and brother, as he was also being offensive and using threatening terms towards them.

The relationship between Jake and Eve's family deteriorated over the next couple of months. In mid-April, Eve went to her GP and described feeling very low, anxious and frightened. Then at the end of April 2020, Eve's father wrote a letter to Jake basically asking him to slow their relationship, give Eve some space and leave her flat. Even when he found alternative accommodation, he still visited Eve regularly. She clearly had difficulty asking him to leave and also felt guilty about keeping secrets from her father as she did not tell him that Jake still visited and often stayed overnight.

On 17 May 2020, Eve's daughter overheard an argument between Eve and Jake whilst they were speaking on the phone. She went into Eve's room because she was concerned about the noise and tone of the argument. Jake had called Eve from his car which was parked outside Eve's flat. He spent two hours on the phone being abusive, and during the call he was also threatening towards Eve's father. The following day, Eve's brother went to Eve's flat. There he found Eve and Jake clearly in the middle of another argument. Eve's brother told Jake to stop verbally abusing, upsetting and bullying Eve. He told Jake that he needed to get help "*with his issues*".

The following day (18 May 2020), Eve moved back into her parent's home because she was scared of Jake, his behaviour, the things he was saying about her and the threats to her family. She said Jake often came to her flat in the evening and sometimes stayed the night because she felt scared to ask him to leave. This was despite her adult daughter also living at the flat.

Between 20 May and 28 May 2020, there were various WhatsApp message exchanges between Jake and Eve's brother. Jake initially blamed his behaviour on Eve's mental health problems. Later he said he was going to get help for himself. He also tried contacting Eve's daughter "*trying to manipulate her*" into contact with him. According to the family, Jake continued to text/Facebook message and WhatsApp Eve – "*he would not leave her alone*". Throughout May 2020, Eve had telephone contact with her GP concerning her depression and anxiety.

Eve met with Jake on 14 June 2020. She told her parents that she would be 10 minutes but returned three hours later, confused about what Jake had said to her – none of which

(according to her family) sounded "*sincere*". Eve started seeing a private counsellor on 16 June 2020. Eve had weekly appointments and this continued until her death in October 2020.

On 26 June 2020, Eve moved back to her own flat. During July 2020, Eve tried writing various messages to Jake explaining that she wanted to end the relationship. She worried that it might make him angry and it did not appear that she ever sent the messages.

At the beginning of August 2020, they went on holiday together with his two children. Eve said that during the week, Jake was verbally offensive towards her, he criticised her for embarrassing him because she was not sociable or talkative enough. On 10 August, Eve spoke to her GP and said that she was aware that her relationship was not going well and she thought she should finish it. She said that she thought the trigger for her low mood may be her partner.

On 20 August 2020, Eve sent Jake a message which ended by saying "*We are over. I now know that I need my own space to sort myself out without you putting pressure on me to do things your way. It's the only way I'm going to be able to get through this. Don't try and change my mind. We'll have to sort out the stuff we have of each other's in a few weeks. Don't contact me*."

According to her family, Eve's Internet search history demonstrated her state of mind. For example, in early September 2020, she looked up depression, suicide, coercive controlling behaviour and narcissism. The following week, she searched the Internet for "*hanging yourself using a belt*" and "*how to suffocate yourself*".

On 18 September 2020, Eve had a review of her depression with her GP. She explained that her partner was very controlling. She found it difficult to think of any examples but was aware that she was anxious all the time about seeing him and how he might be. On the same day, Eve used her phone to read about a woman who was recovering from rape.

According to her search history, at 9.18am on 20 September 2020, Eve looked up "*how to make a hangman's noose*" and then wrote a suicide note at 10.17am.

After Eve's death, her daughter found the deleted suicide note on Eve's iPad that Eve had written on the morning of 20 September 2020 explaining that she could not see "*a path out of my hell*". The panel deliberated on whether to include Eve's entire suicide note and consulted her family to understand their wishes. Ultimately, it was decided that the note not only revealed Eve's innermost thoughts and the profound impact domestic abuse had on her, but also demonstrated a clear causal link between the domestic abuse she was suffering and her suicide.

[My daughter] I truly love you and [my son] with all my heart ❤ you are both my world

But I can't live like this anymore. Jake is a fucking narcissistic arsehole and has ground me down to the bare bone. He's fucked with my head and I can't see my way out. He's befriended [friend] and [friend] so I can't even turn there for support without fear of it getting back to him. No one apart from you and the close family will ever see him for what he is cause he's so clever. He makes [ex-partner] look like a fucking pussy cat!

I've no place to run to and I'm tired of this all. Everything Jake says he twists, and he twists everything I say so I can't remember stuff. He says I only have him. I know that's not true but I hate him, he's a vial sack of shit and this is the only way I can get him out of my life.

Love you all forever and I'm proud of what you have both achieved so far in your amazing lives and will continue to do.

You both are my best achievements …. The rest of my life I've fucked up once too many times and for that I will be paying the price. I've never wanted to hurt any of you and I know that that's exactly what I've done in unimaginable amounts and I hope that one day you'll be able to forgive me. I know you don't but never take your mental health for granted. Look after yourselves and surround yourselves with beautiful likeminded people not people that think they're better than you and treat you like shit and spit you out when their done and leave you to struggle on your own but still tell themselves that they are wonderful, perfect freaks …. Jake!!!! The world is full of cunts like Jake but please stay clear of them.

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Love you forever and then I love you more
Mumma xxxxxxxxxx
Look after each other like you always have. You are the best kids and the best friends and that will never change. Love ya both ❤❤ and I'm sorry

Look after nanny and grandad and [my brother] and pud and they'll look after you both. Sorry to let you down but I can't see a path out of my hell

Eve's daughter arrived back at the flat unexpectedly (possibly disrupting her suicide attempt). Eve told her daughter that Jake had dinner with her and had stayed overnight. She said that she did not ask him to leave to avoid any "*aggro*". Her daughter contacted Jake via email to arrange for him to collect his possessions from Eve's home.

Following this, Eve blocked Jake's phone number, she cleared his belongings into the shed and she started staying with her parents again instead of her flat. Eve (with her daughter's help) deleted all pictures of Jake and all his messages. On 23 September 2020, Eve's brother and father moved everything of Jake's out of the shed (Eve was away working in Sussex). After this date, Jake sent an email to Eve's daughter and on 29 September a WhatsApp message to her son. Neither responded to him. On 8 October 2020, Eve returned to her flat

and found that Jake had dropped off a receipt with a note saying "*lots of love*" or words to that effect. The following day, her GP records stated that she had had several days of thinking that she would be better off dead.

On 11 October 2020, Eve again looked up "*how to hang yourself*" and various ways to have a painless death. On the day of her death, she re-read the story of surviving rape and looked up whether or not a divorce settlement would go to your children if you died before it was paid. She edited her suicide note on her phone (leaving her previous one saved in her iPad memory). Eve missed calls from her daughter and her father, and was then found by her father having hanged herself.

Eve took her own life in mid-October 2020. She left a note for her children which said

"*I love you* [daughter] *&* [son] *with all my heart and I'm sorry* ❤ *I'm so proud of you both, you are amazing people and I'm so proud to have brought you both into this world and I know you both are going to make a difference, and the world a better place. I can't live like this please forgive me. I'm so lonely and in pain. I love Nanny, Grandad and* [my brother] *very much too and I'm sorry to let everyone down but I can't see a way of this hole that I'm in. Love you all for ever* ❤❤❤❤❤ *look after pud* 🐾 *and promise me you'll look after one another too*" ❤❤❤❤❤❤❤

# 6. AGENCY INVOLVMENT AND ANALYSIS

## 6.1. GP Practice

Eve was registered with a GP Practice in Sussex from 2015 until April 2020. Her records from this GP Practice showed that she started a new relationship in June 2019. She also had Carpel tunnel syndrome which had an impact on her ability to work as a cleaner.

On 17 April 2020, she had a telephone consultation with a GP [Dr A] at the Practice in Enfield. Eve registered as a temporary patient. She described feeling anxious and worried about the future. She was self-employed and had lost her job as a cleaner due to 'lockdown'. Eve described not sleeping well and feeling low and "*not herself*", she was more tearful and said that normally she would go out and get on with things but could not do that because of lockdown. She said she was staying in London with family, including her daughter and her partner. At the time she said she was possibly staying for good but she was not sure and therefore she had not changed her GP.

Eve was offered cognitive behaviour therapy (CBT) which she declined because she preferred to take medication. She had tried medication before and it had worked. She was prescribed an antidepressant which would take about 4-6 weeks to work. She was asked to book a review appointment for 2-3 weeks. She was also told to call back or call 111 if her mood worsened or she had "*dark thoughts*".

Eve registered at the GP Practice the following week. On 21 April 2020, she had a telephone consultation [Dr B] in which she stated that she was feeling "*hopeless*", was not sleeping or eating well and was having panic attacks – her concentration was poor and she described

fleeting thoughts of deliberate self-harm but had no plans. Eve had not yet collected her antidepressant prescription. It was noted that she "*lives with adult daughter and partner – supportive*". She was prescribed diazepam 2mg (six tablets) to try for a few days, as she was very anxious. The plan was to review her in a week or sooner if she was not coping.

Eve had a telephone appointment with a GP on 1 May 2020 [Dr C]. Although her mood was still low, her records showed that she had started to feel better. The doctor signposted Eve to online cognitive behavioural therapy (CBT) and suggested that she self-refer to IAPT (Improving Access to Psychological Therapies) [6]. She had no suicidal thoughts and the plan was to review her in 10 days but she could make another appointment if her symptoms worsened or she had thoughts of harming herself.

On 8 May 2020, Eve again spoke via telephone to her GP [Dr C]. She said that she remained anxious, her sleep was poor as was her concentration. She said that she was living in Enfield but working in Sussex. In Sussex she was staying at friend's houses but because of lockdown, this was unable to continue. She had lost her cleaning work because of Covid19 and was finding it difficult to get other work. She was encouraged to apply for benefits/tax credits. She was again advised to self-refer to IAPT (Improving Access to Psychological Therapies).

Eve spoke to her GP [Dr C] via telephone again on 15 May 2020 by which time she had contacted IAPT (Improving Access to Psychological Therapies). Her GP records stated that she was sleeping more but her mood had not improved, but she had no thoughts of self-harm and no suicidal thoughts. Eve was told to book another review in a couple of weeks but to phone the Surgery, 111 or 999 if her mood deteriorated in the meantime.

Her records showed that by her telephone appointment on 29 May 2020 [Dr C], Eve had had a session with IAPT (Improving Access to Psychological Therapies). When Eve next spoke with her GP [Dr C] via telephone on 19 June 2020, it was noted that she had had four sessions of cognitive behavioural therapy (CBT) with IAPT (Improving Access to Psychological Therapies) over the phone. Eve said she found it hard to do cognitive behavioural therapy (CBT) over the phone. The plan was to review Eve again in two weeks.

NOTE:

Eve was not receiving cognitive behavioural therapy (CBT) counselling, she was accessing Guided Self-Help with IAPT. The sessions were 30 minutes in length. Psychological Wellbeing Practitioners often deliver low-intensity interventions, which can include guided self-help, psycho-educational groups, and computerised cognitive behavioural therapy (CBT). They focus on helping individuals develop coping strategies and manage their symptoms – whereas, counsellors offer more extensive, exploratory support for a broader range of emotional and psychological problems

[6] The Improving Access to Psychological Therapies (IAPT) programme began in 2008 with the intention of transforming the treatment of adult anxiety disorders and depression in England – see https://www.england.nhs.uk/mental-health/adults/iapt/ - accessed online 18 August 2025

On 13 July 2020, Eve told her GP [Dr C] via a telephone consultation that she was continuing on the antidepressant although she was not feeling "*back to normal yet*". She had finished receiving treatment from IAPT (Improving Access to Psychological Therapies) which had only been some help. She also told the GP that she had restarted her relationship with her "*old partner*" and the following week she told the Practice nurse that she would like to restart her contraception.

Eve had an appointment via video call with her GP [Dr C] on 10 August 2020. She said she was feeling a "*bit numb*" on the antidepressants. She explained that she had just returned from holiday with her partner and his children. She said she was aware that their relationship was not going well and she thought she should finish the relationship. Eve suggested that her partner may have been the cause of her low mood. Her notes recorded that she was not suicidal nor did she have thoughts of self-harm. Eve's GP noted that the medication might support Eve and the difficulties she was having in her relationship but noted that medication would not be a solution. Her notes showed that Eve was given information about RELATE and their counselling service – but clearly stated that RELATE was just for Eve to find support with her situation (rather than as couples' counselling).

Eve asked for another appointment on 7 September 2020, but her usual GP [Dr C] was away, so an appointment was booked for the next available time on 17 September 2020. The doctor called later than was originally booked causing Eve to miss the appointment on 17 September. She therefore had a telephone consultation with her GP [Dr C] on 18 September 2020. She said she did not feel she was "*getting anywhere*". She had been speaking to a private counsellor once a week. She had not accessed RELATE, as she did not remember it being mentioned. She told the GP that she had had several days of thinking she would be "*better off dead"* – although she was clear that she had no plans or active thoughts of self-harm or suicide. She described "*on-going*" issues with her partner who she felt was very controlling.

The GP asked her to describe instances of his behaviour but Eve struggled to think of any examples. Although she did tell the GP that she thought that her partner was checking her phone. She described feeling generally anxious about seeing him and "*how he will be"*. She was asked to think about some clear examples of behaviour that were worrying her so they could talk about them. She said there was no history of physical violence. Eve said that her private counsellor thought that Eve's relationship issues were central to how she was "*feeling and managing"*. Eve described how she worked away in Sussex all week but did not find things much better when she was away from him. The GP offered to send Eve a link to a domestic abuse helpline but she declined in case Jake saw her phone, so the GP suggested that she call a domestic abuse helpline while she was in Sussex. This would give her the opportunity to note down some of the issues in her relationship and discuss them freely. Again, the GP noted that medication might not necessarily resolve the issues in Eve's relationship. The GP suggested increasing Eve's dose of antidepressant but Eve wanted it reduced. The GP recognised that the dosage would need to be monitored closely as Eve was having thoughts of "*wishing to be dead*". The outcome was that the dose remained the same and to be reviewed in 10 days.

**This was again a missed opportunity not only to refer Eve to Solace Women's Aid but also to refer her to the Mental Health Crisis Team. Her mood was not improving and she was still having periods of feelings she would be "*better off dead*".**

Eve had another telephone consultation with a GP [Dr D] in early October 2020. Again, she described (in a questionnaire) that she had had several days of thinking she would be better off dead. The GP gave Eve three options for her treatment.

i. To increase her medication
ii. To remain on the same dose and continue with psychological therapy
iii. Reduce her medication and increase the dose back up if her symptoms worsened or stop the medication if there was no difference.

Eve chose to reduce her medication with a plan to review her in 2 – 3 weeks. However, there was no reference to the previous consultation with Dr C about reviewing the domestic abuse and signposting her to help. There was no follow-up on this matter.

Three days after her previous appointment, the GP received a letter from Eve's private counsellor.

> *Dear Dr. [redacted],*
>
> *My name is [redacted] and I am a BACP Accredited Counsellor*
>
> *I have been seeing Eve weekly for counselling for three months now and supporting her with her depression and relationship issues.*
>
> *As part of my continuing support for her I would like to speak with you to share some of my concerns around her depression and how this is impacting her on her thoughts and her life.*
>
> *Please advise me of a time convenient to you.*
>
> *With kind regards*
>
> [redacted]

It was received in Eve's notes a few days later and was reviewed the following day by her usual GP (Dr C) who was on-call. According to Eve's notes, as the letter did not raise anything urgent, the doctor planned to call Eve's counsellor on the Monday, but by that time Eve had taken her own life.

### 6.1.1. Analysis of GP Practice involvement

It was clear from reviewing Eve's records that Covid19 had a detrimental impact on Eve's contact with her GP Practice. Her first contact with her GP Practice in Enfield was in April 2020 which coincided with the beginning of the first 'lockdown'. Therefore, all of her appointments were telephone consultations except one video call and one face-to-face appointment with a nurse. There appeared to be little thought about whether she was able

to speak freely over the phone or whether Jake may have been present and thus have an impact on how openly Eve could talk. Furthermore, as her consultations were via telephone, none of the GPs were in a position to read any of Eve's 'non-verbal' signs such as her facial expression, posture, eye contact or her physical appearance i.e. whether she was well-kept.

An opportunity was missed to provide Eve with information about Solace Women's Aid when her GP discussed the possibility of Eve seeking advice from RELATE. The GP should also have referred her to the Mental Health Crisis Team (secondary mental health). Normally an IRIS[7] Independent Domestic Abuse Advisor (IDVA) would have met Eve at the GP Practice but this service was suspended during at the time due to lockdown.

Although the GP Practice was IRIS accredited, it was uncertain whether the GPs were up-to-date with their training on domestic abuse. For example, there was no indication in the individual management review that a 'domestic abuse alert' had been placed on the front page of Eve's notes. Had there been, her circumstances would have been obvious to all professionals accessing her records. Such an alert would have enabled all the GPs who came into contact with Eve to understand her situation and provide her with better and more targeted support.

The lack of an alert on Eve's records showed in her final contact with the GP Practice in early October 2020. The telephone consultation was with [Dr D] – not her normal GP. Despite Eve stating that she had had several days of thinking she was better off dead, her anti-depressant was reduced and the domestic abuse discussed at her previous appointment went unnoticed. In fact, the GP gave Eve the choice of whether she wanted to increase or reduce her antidepressant – it was not documented why it was considered appropriate for a patient with mental ill-health to decide on their own treatment.

## RECOMMENDATION

i. IRIS should undertake a review to ensure the GP Practice is up to date with training on domestic abuse. This review should include whether:
   - Domestic abuse alerts are routinely and appropriately placed on patient notes
   - Multi-agency communication and referrals are routinely used
   - Victims of domestic abuse are prioritised for face-to-face appointments

ii. Currently, MOPAC (Mayor's Office for Policing and Crime) funds Violence Against Women and Girls services in London by commissioning crime prevention and reduction services, and by collaborating with London boroughs through the London Crime Prevention Fund to address violence against women and girls. Enfield Community Safety Partnership should formally write to the Deputy Mayor for Crime and Policing at the Mayor's Office for Policing and Crime (MOPAC) to raise concerns about the increasing financial pressures on local partners to sustain core domestic abuse services, including IRIS and Independent Domestic Abuse Advisor (IDVA)

[7] IRIS is a specialist domestic violence and abuse (DVA) training, support and referral programme for General Practices – for further information see https://irisi.org/about-the-iris-programme accessed online 18 August 2025

provision. The letter should request that the Deputy Mayor undertakes a review and realignment of the current funding formulas to ensure they reflect the growing demand and adequately support the Government's ambition to halve violence against women and girls by 2030.

## 6.2. Barnet, Enfield and Haringey Mental Health Trust

Eve self-referred to IAPT (Improving Access to Psychological Therapies) on 8 May 2020 (a year after rekindling her relationship with Jake). The telephone screening was completed on 12 May 2020. Her presenting issues concerned "*not feeling safe to drive*" and she referenced lockdown being difficult and having lost her confidence and feeling like she was starting over again. She stated that she was isolated from her friends, as she did not like the computer. She was not confident in accessing social media. She stated she was taking antidepressants but they made her drowsy. She said that she had not experienced any previous trauma and explained that her support systems were her immediate family. She stated her goals were to be working and to be socialising.

Eve described feeling "*Quite bleak, don't recognise myself anymore. Cut myself off from most people. Now living with my family, isolated self from friends - not keeping in touch, don't like the computer because I'm not confident to access social media or job searches so I'm not doing it. Done it to myself, don't know how to get out of the rut. Can't concentrate, can't watch TV, bored, when partner not around, taking toll on him. Daughter – taking a toll on her she's doing finals. …. No desire to do anything, it's not me because I'm naturally outgoing and bubbly.*"

She explained that she "*had a dip about 8 years ago, when she left her first husband*". At the time she had counselling and cognitive behavioural therapy (CBT) and found it helpful. She did not take drugs or smoke and had an occasional drink of alcohol. She just wanted to be "*back to me again*" – a confident person, working and socialising because she had lost herself somewhere. She requested therapy over the phone rather than via computer.

The screening did not identify any risk to herself or others – and no risk from herself or others. The "*conceptualisation of main problem*" by the practitioner was:

> Client has been experiencing low mood over the last 6-7weeks due to losing her job because of lockdown. She has lost interest in doing things and is not able to concentrate when doing things such as watching TV. She has isolated herself from friends and feels even more isolated during lockdown. She feels she now has to "*start again*" because lockdown rules have relaxed but does not know where to start to "*get out of this rut*".

Eve was offered six sessions of guided self-help therapy [8] over the phone or via a video call on computer. Eve stated her preference was telephone. At the time, central guidance stipulated that appointments during lockdown should not be 'in person'.

During her first session on 26 May 2020, Eve focussed on her anxiety when driving. She did not mention any issues with her partner or domestic situation during this session. Nor had she yet disclosed any relationship issues to the GP.

In subsequent sessions (2 June & 9 June) discussion took place around the 'vicious cycle of depression' together with three key areas of activities – routine, necessary and pleasurable, in order to identify activities and grade them from least to most difficult.

During her fourth session on 16 June 2020, Eve stated "*that it would be easier not to be here*". She said she had no plan to act on these thoughts and rated her intention as "*maximum 1*". The focus of her fifth session on 30 June 2020 was on 'active and passive relaxation'. Her sixth and final session on 10 July 2020 covered 'relapse prevention' including goals for the future, difficulties that may arise and how to cope with them.

### 6.2.1. Analysis of IAPT (Improving Access to Psychological Therapies) involvement

There was little information in the IAPT (Improving Access to Psychological Therapies) records. The focus of the sessions appeared to be on her lack of confidence, her social isolation and her difficulties with driving. Unlike the GP or her private counsellor, Eve did not open up about her relationship with Jake. There was no evidence that she was directly asked about her relationship. Furthermore, when Eve explained during her fourth session "*that it would be easier not to be here*" this did not appear to be explored. Instead, the session focused on "*problem solving*". There was no liaison between GP Practice and IAPT (Improving Access to Psychological Therapies) – nevertheless, at the time of Eve's interaction with the service, she had not disclosed any concerns about her relationship with Jake to the GP Practice.

It was apparent that during Covid19 Eve struggled to fully engage with IAPT (Improving Access to Psychological Therapies) and found it difficult to discuss the issues affecting her. As a result, she did not receive the most appropriate mental health support. A reflective study [9] highlighted the importance of learning from previous health crises to improve IAPT's long-term response.

Key insights included:

- The need for flexible service models that can quickly adapt to remote working
- Prioritising mental health access and outcomes for vulnerable populations

[8] Eve was not receiving cognitive behavioural therapy (CBT) counselling, she was accessing Guided Self-Help with IAPT. The sessions were 30 minutes in length.

[9] Beyond the COVID-19 pandemic: 'Learning the hard way' – adapting long-term IAPT service provision using lessons from past outbreaks | the Cognitive Behaviour Therapist | Cambridge Core – accessed online 15 August 2025

- Better integration with other health services to address long-term mental health impacts
- Improved sharing of information across health providers to improve greater professional judgement of the root causes of mental health concerns.

RECOMMENDATION

iii. The Enfield Community Safety Partnership to formally write to the Integrated Care Board (ICB), as the commissioner of talking therapies, and oversight of GP practices, requesting that they consider the learning and practice recommendations arising from this Domestic Homicide Review (DHR) and ensure these are appropriately shared with, and implemented.

Changes implemented in Barnet Enfield and Haringey Mental Health Trust (including IAPT) since August 2022 when the Domestic Abuse and Sexual Safety Co-ordinator post was formed:

- The co-ordinator acts as a single point of contact to provide consultation around domestic abuse and sexual violence – including any presenting risk, support with routine enquiry, safety planning, relevant safeguarding referrals and supporting engagement/safety
- A weekly drop-in surgery has been set up where all staff can bring cases where there are concerns of domestic abuse, sexual abuse and harmful practices.
- Domestic Abuse Training has been delivered to all IAPT teams
- There has been a review of the assessment
- The Domestic Abuse Policy has been updated in line with the Domestic Abuse Act (2021)
- A Domestic Abuse Directory has been developed and is available to all staff detailing local, pan-London and national specialist services including by-and-for services
- Staff intranet has been updated with resources to support staff responding to disclosures
- Best practice flowchart based on the A.V.A.A model has been produced
- Domestic Abuse and Harmful Practices is a mandatory 3.5-hour training session that staff are required to achieve L3 safeguarding compliance
- Frequent webinars are organised and delivered across the trust on specific areas related to Domestic Abuse, Harmful Practices and Sexual Abuse that staff are able to access.

## 6.3. Eve's private counsellor

Eve approached a private counsellor in June 2020 at the same time as she was having sessions with IAPT (Improving Access to Psychological Therapies). She had weekly sessions with her private counsellor between 16 June 2020 until the time of her death in October 2020.

The Chair of this review spoke to Eve's counsellor. Her counsellor described that Eve's presenting issue was her low mood (depression) and her relationship with Jake. She had found the Covid19 lockdown difficult as her cleaning business had collapsed. Her counsellor described Eve as "*sparky and lively*" woman, who appeared younger than her years and did not come across as depressed.

Eve told her that initially she and Jake had been really happy, but an event had happened to make her re-evaluate their relationship. Eve described to her counsellor an occasion when she picked Jake up from the airport following a golfing holiday. He had verbally attacked her on the way back to her place swearing at her and being extremely critical of her. Eve was furious that she was being treated like that when she had gone out of her way to pick him up. Part of her wanted to walk away from him, but she still had feelings for him. She had told her parents and brother about Jake's behaviour and they were all upset and wanted him out of her property. They said he could no longer live there and Jake left. Ultimately, because she hated being on her own, she decided to continue seeing Jake and wanted help from the counsellor with her subsequent low mood.

Although during their sessions Eve talked about feeling "*worthless*", her lack of confidence about driving, not wanting to go on holiday with Jake and her difficulty returning to work – she was quite confused about her relationship. From their sessions it was clear that Jake was controlling, and Eve did not like the way he treated her or his own children. The counsellor felt that because of the coercive control that Eve experienced, she was never quite sure if she was correct in her interpretation of Jake's behaviour because he would always say that she had got it wrong. Nevertheless, there were aspects that raised concerns such as she did not trust him and was suspicious of him. He did odd things like take his wallet to the bathroom (even in the middle of the night) – this led Eve to think that he might be seeing someone else. She thought that he was "*after*" her money (from her previous divorce settlement) as Jake was keen that they buy a house (and not live at her parents' rental property). Eve's counsellor was not sure whether Eve truly recognised that her relationship with Jake was abusive. Nevertheless, Eve's counsellor encouraged her to seek help from her GP to exclude other reasons for her low mood e.g. perimenopause. In early October 2020, Eve told her counsellor that a duty GP had reduced her antidepressants without seeing her face-to-face. The counsellor was concerned and asked for Eve's permission to contact her GP Practice.

The counsellor phoned the GP Practice on a Monday in early October 2020 to ask for the GP's email. The counsellor emailed her concerns to the GP Practice that day. On the Tuesday/Wednesday she telephoned the GP Practice again to ensure they had received her email and was told that it had not arrived. The counsellor discovered that she had been given an incorrect email address. She therefore resent her email whilst remaining on the telephone until it had been received and printed out by the receptionist.

### 6.3.1. Analysis of counsellor involvement

When interviewed for this review, the counsellor felt that there was no more that she could have done. She had chased her email and made her concerns known. She had been told a

doctor would contact her in the next couple of days (before Friday) to discuss her concerns. She did not chase up her email yet again that week, as she thought the GP would read her email and take the appropriate action. Furthermore, the counsellor had not contemplated that Eve might take her own life – which she did that weekend.

## 6.4. Metropolitan Police Service

Initially the Metropolitan Police Service was not asked to provide an independent management review for this domestic homicide review, as there had been no relevant contact i.e. no police call outs regarding domestic abuse. Nevertheless, it was clear from information provided by the police that Eve's father informed them (on the day of her death) that her relationship with Jake was abusive – "*Eve had been diagnosed with depression 3-4 months ago at the start of the COVID19 lockdown and had recently broken up with her boyfriend Jake, who had been abusive towards her in their relationship*". The abusive nature of their relationship was reiterated by her brother verbally to officers on the day she died and also in a report he made to the police on 29 October 2020. He stated that prior to her suicide Eve had been a victim of coercive and controlling behaviour by her ex-boyfriend, Jake. Her brother reported that Eve had disclosed to her family that throughout her relationship with Jake he had been verbally abusive, called her names and displayed bullying behaviour towards her. He said that there had been several times when she wanted to stop the relationship and did so, but after a while they would get back together again. He reported that Eve and Jake would argue and Jake would belittle her and control her. He referred to the suicide note found on Eve's IPad which he felt showed that it was the relationship that drove her to take her own life (see page 13 for full transcript). Her brother also reported that Jake had made threats to Eve that he would harm him (her brother) and their father, and that this was another way he attempted to control Eve.

Following a meeting between the Chair, the family and their advocate (February 2025), it became clear that the family still had a number of questions that they wished answered concerning the investigation into Eve's death. Specifically, could Eve's partner's abusive behaviour be causally linked to her taking her own life and did the police investigation seek to find this link? In order to understand the breadth and depth of the police investigation, the family asked a series of questions that are set out below:

i. **What is the current Metropolitan Police Service policy on investigating suicides when there is a history of domestic abuse. It should outline any changes that have been implemented since Eve's death in 2020.**

The Metropolitan Police Service provided its policy on investigating suicides (see appendix one and two for the relevant extracts).

ii. **When was the case allocated to the North Area Borough Command Unit for investigation (including rank, experience and training of allocated officer)**

The case was allocated to a detective constable on 10 November 2020. At the time of allocation, the officer was working in the North Area Borough Command Unit Public Protection Team. The Metropolitan Police Service Specialist Crime Review Group was unable to provide information about the individual officer's experience and training. Nevertheless,

they were able to provide some information about the service-wide domestic abuse training that had taken place.

### Metropolitan Police Service Domestic Abuse Training

Between July 2021 to September 2021, the Metropolitan Police Service ran 313 First Responder sessions and nine Champion sessions on Domestic Abuse Matters for 6,796 officers across the service. Domestic Abuse Matters is a full day training. The Community Safety Unit course is 5 days.

During October and November 2024, the Metropolitan Police Service trained around 700 'Rape and Serious Sexual Offences' officers using 'Domestic Abuse Matters'. This is a cultural change programme aimed at improving the way police respond to domestic abuse cases. It was developed by SafeLives in partnership with the College of Policing (see for example, https://www.college.police.uk/article/domestic-abuse-matters-change-programme ).

First line leaders receive input concerning domestic abuse and violence against women and girls in their continuous professional development.

**iii. What is the timeline for seizing items such as mobile phones for interrogation? What was the rationale for not seizing Jake's phone? As his phone was not seized, how did the investigating officer triangulate the information about their abusive relationship?**

There was nothing within the Metropolitan Police Service guidance on timelines for seizing items such as mobile phones – nor was there any guidance on how to investigate a causal link between domestic abuse and a victim taking their own life.

"*Intelligence checks are vital to an investigation into apparent suicide. Officers must consider what led the person to take their life. There must be consideration given to any third-party involvement such as a history of domestic abuse or bullying (either online or physically).*

*The minimum standard required is PND and PNC on both the deceased and informant. You must conduct IIP* [integrated information platform] *checks on the deceased, informant and venue with at least a 5-year parameter.*"

There was no rationale recorded as to why the decision was made not to seize Jake's phone. The Metropolitan Police Service recognised that there was "*much focus on Eve's phone and tablet*" – yet, Eve and her daughter had deleted the photographs, text messages and WhatsApp messages between her and Jake a month before her death. When questioned, the Metropolitan Police Service was "*uncertain as to why the officer would need to triangulate the (deleted) information*" from Eve's phone with the information that was still available on Jake's phone.

**iv. In light of the fact that Eve's father disclosed on the day of her death that Eve's relationship with Jake was abusive, what immediate action was taken to identify/preserve evidence? Did the investigation fully consider the role of domestic abuse in her death – or was the focus on "*no suspicious circumstances*"?**

The Metropolitan Police Service stated that the comments by Eve's father and brother were recorded on the incident details but were not directly considered as a causal factor in her death until the later domestic abuse allegations made by her brother on 29 October 2020. The follow up investigation was "*more comprehensive*" but did not mention any strategy around scene and evidence preservation.

**v. What was the rationale for disregarding Eve's original suicide note which clearly identified Jake as the reason she ended her life?**

The Metropolitan Police Service stated that there was no rationale recorded for disregarding Eve's original suicide note (page 13 for the full transcript). The original note clearly stated that Jake was the reason she took her own life.

vi. **Were offences other than coercive controlling behaviour considered? For example, harassment – according to her family whilst she was in Sussex, she received 255 calls and 6 voice mails to her phone from Jake. She only responded 33 times.**

The investigation recorded on 29 October 2020 was classified as controlling behaviour. There was no evidence that any other offences were considered.

**vii. When were the GP, Counsellor and family members interviewed?**

In March 2021, Eve's brother raised his concern with the police around the GP, counsellor and family members not being interviewed. This was later actioned by the case supervisor. In March 2021, three of Eve's friends were contacted and all gave an outline of their relationship with Eve and their knowledge of her relationship with Jake. A further five friends also provided signed statements by November 2021. The police records state that the initial contact with the GP was made in October 2021 (a year after Eve's death) – although there was no record of an interview taking place. The family stated that Jake was also interviewed under caution, although this took place over a year after Eve's death. According to police records, he denied all allegations of coercive and controlling behaviour.

### 6.4.1. Analysis of the Metropolitan Police Service involvement

On the day of Eve's death, her father told the police officer at the scene that she was a victim of domestic abuse. This information appears to have been disregarded and remained unexamined until the commencement of this review. At this point, the police asked that we halt the review so they could interview family, friends and Eve's counsellor. The delay in investigating Eve's death meant that neither her phone nor Jake's phone were interrogated immediately – allowing potential evidence to be removed or deleted. The delay also meant that the domestic homicide review process was delayed for several years.

Eve's family challenged the police and the Crown Prosecution Service's failure to charge Jake using the "Victims' right to review scheme".[10] The Metropolitan Police Service and the

[10] The Victims' Right to Review (VRR) Scheme gives victims the right to ask for a review of a police decision not to charge a suspect. VRR applies to cases where a suspect has been identified and interviewed under caution. This happens either after they have been arrested or because they have volunteered to be interviewed. For

Crown Prosecution Service determined that there was insufficient evidence to charge Jake with coercive controlling behaviour (no other charges were considered). The domestic homicide review panel concluded that a more appropriate method of understanding the depth and breadth of the investigation might be for the family to approach the Independent Office for Police Complaints (IOPC). This should elicit more valuable information such as:

- The training, experience and expertise of the investigating officer
- The quality and timeliness of the investigating officer's supervision
- Whether the case was reviewed by a senior officer
- Whether senior officers had input into the key lines of enquiry

A thorough review of the case should establish why Jake's phone was not seized, why there was a delay in interviewing him and other witnesses. It would also be able to establish whether the focus of the investigation remained on whether Eve had taken her own life rather than on any potential causal link between her death and the abuse she suffered.

Clearly the Metropolitan Police Service's current policies on domestic abuse and suicide should be amended to include coercive and controlling behaviour (and other associated offences) – with greater emphasis on how to investigate cases when victims take their own life following domestic abuse.

RECOMMENDATION

iv. The Metropolitan Police Service should review its current policies to provide clear guidance on the investigation of cases involving suicide where there is a known or suspected history of domestic abuse.

# 7. EMERGING THEMES/LESSONS LEARNT

## 7.1. Suicide linked to domestic abuse

The link between domestic abuse and suicide is not a new or recent concept. In 2011, Southall Black Sisters released their report "Safe and Sane".[11] It focussed on the relationship between domestic violence, mental health and suicide/self-harm among Black and minoritised women (particularly those of South Asian origin). The research found that a significant number of women had contemplated or attempted suicide after experiencing domestic abuse. More recent research has identified similar patterns. For example, Aitken and Munro's 2018 report[12] revealed that almost a quarter (24%) of Refuge's clients felt suicidal at one time or another and 18% had made plans to end their life.

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further information see https://www.met.police.uk/advice/advice-and-information/victim-support/victims-right-review-scheme/ - accessed online 18 August 2025

[11] Siddiqui, H. and Patel, M. (2010) Safe and Sane: A Model of Intervention on Domestic Violence and Mental Health, Suicide and Self-Harm Amongst Black and Minority Ethnic Women, Middlesex: Southall Black Sisters.

[12] Aitken, Ruth and Munro, Vanessa (2018) Domestic abuse and suicide: exploring the links with refuge's client Base and work force. London: Refuge – accessed online http://wrap.warwick.ac.uk/103609 4 August 2025

Jane Monckton-Smith's work on the eight stages to suicide reflects Eve's experience and her reaction to the situation in which she found herself.




Indeed, the fourth annual report (2025) from the national Domestic Homicide Project[13] concluded (for the second year running) that more people in the United Kingdom are dying by suicide following domestic abuse than are being killed by a current or former partner. The report identified 98 suspected suicides linked to abusive relationships which was more than the number of intimate partner homicides over the same period. This is unsurprising as there is now increased awareness about the relationship between domestic abuse and

[13] See Domestic Homicide Project - VKPP Work – accessed online 4 August 2025

suicide – so reports of such deaths are becoming more frequent. As result of the increased awareness of the link between abusive relationships and suicide, SafeLives has called for an "*effective, coordinated response between health, domestic abuse, and mental health services – so that survivors are met with support, not silos*". [14]

## 7.2. Lifelong trauma and cumulative risk

The reasons why some women stay in or return to abusive relationships are complex and deeply personal. Professionals who are not trained in trauma-informed practice may struggle to understand this behaviour, often viewing it as a choice rather than the result of long-term trauma, emotional harm, and learned patterns. Several key factors help explain repeated victimisation:

- Childhood and attachment trauma

Experiences of trauma or neglect in childhood — especially where love and safety were inconsistent — can impact a person's ability to form healthy relationships as an adult. If someone grows up around abuse, they may believe it is normal or deserved.[15] This belief can make it harder to recognise abusive behaviour later in life.

- Erosion of self-worth

Every abusive relationship chips away at a woman's self-esteem. Over time, she may lose the ability to imagine life outside of abuse. This can create a sense of hopelessness and disempowerment.

- Learned helplessness

This is when someone feels that no matter what they do, they cannot change their situation.[16] They learn that they have no sense of agency towards their own life (no control, no options, no choices). In abuse, this feeling is reinforced by the perpetrator's control and manipulation, making it difficult to leave or resist future abusive partners.

- Gaslighting

Gaslighting is a form of emotional abuse in which the perpetrator manipulates the victim into doubting their own perception of reality. Over time, this can erode the victim's ability to trust their own judgment (as in Eve's case), making it difficult to recognise the abuse for what it is. For women experiencing gaslighting, especially in the context of domestic abuse, this often leads to confusion, self-blame, and fear.

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[14] For further information, see When the system doesn't see the signs: the link between domestic abuse and suicide - SafeLives – accessed online 5 August 2025

[15] See for example https://pubmed.ncbi.nlm.nih.gov/37832203/ or https://www.sciencedirect.com/science/article/pii/S0022395623004454#sec4 and https://eprints.whiterose.ac.uk/205712/1/Repeat%20victimisation%20paper.pdf – accessed online 17 August 2025

[16] https://digitalcommons.unl.edu/cgi/viewcontent.cgi?article=1216&context=ncpacapstone#:~:text=Learned%20helplessness%20is%20something%20that,to%20remain%20in%20abusive%20relationships and UROP Poster 2 (1).pdf – accessed online 17 August 2025

When combined with symptoms of post-traumatic stress disorder (e.g. fragmented memory, difficulty recalling events clearly, or inconsistent narratives), victims may struggle to provide a clear and consistent narrative. If professionals express doubt or struggle to believe the woman, it exacerbates the gaslighting perpetrated by the abuser i.e. "*No one will believe you*," or "*You're crazy*", thus deepening the woman's sense of isolation and helplessness.

- Impaired danger response

Living with trauma can change the way someone reacts to danger. The brain may become desensitised to warning signs, meaning that red flags in a new relationship are overlooked or misinterpreted [17]

- Neurological impact of trauma

Trauma physically alters the brain, affecting how people process information, emotions, and relationships. These brain changes can influence behaviour patterns, making it harder to break away from unhealthy cycles. [18] Eve's case highlights how easy it is for signs of cumulative or escalating risk to go unnoticed. Although she had previously experienced low moods due to events like miscarriage, post-natal depression, and divorce, these were time-limited and reactive to her life circumstances. She had no history of long-term depression. After rekindling her relationship with Jake, Eve's mood significantly declined. Her family believes this was directly linked to his abusive behaviour. Over a short space of time, she also lost her job, faced housing instability, became increasingly isolated due to Covid19, and recognised she was in an unhealthy relationship — all major risk factors for suicide.

Unfortunately, professionals did not fully recognise how these events combined to put Eve at increased risk. Risk is not fixed — it can escalate quickly when someone is facing life challenges such as loss of employment, housing instability, relationship breakdowns, and social isolation. These cumulative pressures, are even more serious for people who have experienced trauma or abuse in the past. In Eve's case, they should have been seen as warning signs.

Professionals need to be aware of how someone's situation is changing. This means having frequent contact, regular re-assessment, and being genuinely curious about what the person is going through. Rising risk does not always look dramatic – it might show up as someone becoming more withdrawn, feeling hopeless, or returning to an abusive relationship. Without an understanding of the trajectory of risk, including contextual and historical factors, critical signs can be overlooked — as tragically seen in Eve's case.

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[17] van der Kolk, B. A. (2014). The Body Keeps the Score: Brain, Mind, and Body in the Healing of Trauma. Viking

[18] See for example *https://www.unco.edu/assault-survivors-advocacy-program/learn_more/neurobiology_of_trauma.aspx*, *https://www.qla.ac.uk/news/archiveofnews/2023/october/headline_1017084_en.html#:~:text=The%20study%20found%20that%20women,including%20cardiovascular%20and%20cerebrovascular%20disease*, *https://my.clevelandclinic.org/health/diseases/23018-white-matter-disease* and *https://pmc.ncbi.nlm.nih.gov/articles/PMC9931748/* - accessed online 17 August 2025

Enfield's domestic abuse strategy (2025 – 2030) acknowledges that domestic abuse is not only a safeguarding and criminal justice issue but also a significant public health concern. The strategy prioritises a trauma-informed approach that recognises the intersectionality of domestic abuse (particularly coercive control), mental ill health and suicide. One of the key goals is early identification — supporting frontline practitioners across services to understand and spot the nuanced signs of coercive control, repeated victimisation, and escalating psychological distress. The strategy recognises that survivors of abuse are at increased risk of poor mental health outcomes, including suicidal ideation, and it underscores the need for integrated pathways between domestic abuse, mental health, and safeguarding teams.

In light of the fact that domestic abuse presents challenges to safeguarding and criminal justice systems as well as public health, the London Borough of Enfield has recently updated its Joint Health and Wellbeing Strategy (2025 – 2030).[19] The Public Health department was the lead agency in this process and this domestic homicide review was instrumental in informing the strategy. Therefore, the mental health and wellbeing components of the strategy reflect the importance of lifelong trauma and the cumulative risk this causes. In a parallel process the Suicide Prevention Strategy of the Council is being updated. The multi-agency action plans of the strategy have already been amended under the recommendation of the Council's suicide prevention lead officer to include a specific section relating to domestic abuse as a source of increased risk. An additional commitment was included to ensure that in future all relevant domestic homicide reviews and domestic abuse related death reviews will be supported by an appropriate Public Health Officer.

RECOMMENDATION

v. The Department of Health and Social Care should instruct all local authorities to ensure that their suicide prevention strategies explicitly recognise domestic abuse, in all its forms, as a significant risk factor for suicidal ideation and suicide. Strategies should include clear actions to address this risk and ensure that learning from domestic homicide reviews and domestic abuse related death reviews informs suicide prevention planning and delivery.

## 7.3. Prosecuting perpetrators for manslaughter (and other offences) when domestic abuse leads to suicide

Despite growing awareness of the link between domestic abuse and suicide, there is still a significant gap between the number of suicides related to domestic abuse and the number of successful convictions for related offences such as manslaughter, coercive or controlling behaviour, assault, or harassment.

[19] See https://www.enfield.gov.uk/__data/assets/pdf_file/0027/48591/e46dfde9e57b0634bf030fb63166006b39a76534.pdf - accessed online 7 September 2025

In a guest blog for the Centre for Women's Justice by Dame Vera Baird, she stated "*Successful prosecutions for manslaughter are essential. Women abused into such despair that they take their own life, do so by compulsion, not by choice*".[20] In the blog, she also pointed out that there have only been three attempts by the Crown Prosecution Service to prosecute a domestic abuser after their victim has taken their own life.

Nevertheless, Crown Prosecution Service guidance states that "*Murder or manslaughter may be the appropriate charge where suicide follows an unlawful act or acts by the suspect. This most obviously applies (but is not restricted to) a domestic abuse context; for instance, where a suspect has subjected the victim to controlling and coercive behaviour or ongoing violence. Early advice and engagement between police and prosecutor is essential where the police are considering such an investigation. This should cover coordination with the coroner, and identifying and obtaining all relevant information to understand the relationship history between suspect and the victim and what led the victim's state of mind in order to establish causation. Such material would include medical records and any digital material between the parties, in addition to third party accounts.*"[21]

Inevitably, prosecuting domestic abuse perpetrators when their conduct leads to suicide presents complex legal and evidential challenges. A crucial part to any prosecution is a thorough police investigation. Although challenging, prosecutions for gross negligence manslaughter, controlling or coercive behaviour, and other serious offences may be appropriate where the abuse is shown to have materially contributed to the victim's death. In order to do this, the Vulnerability Knowledge and Practice Programme (VKPP) has set out guidance (s.8.3.1) in respect of investigating suspected suicides.[22] The guidance includes advice about checking any known history of domestic abuse, applying a curious, investigative mindset, challenging the apparent explanation for death (e.g., suicide) and exploring possible domestic abuse links, particularly where coercive controlling behaviour is involved.

Dame Vera Baird's statement that women who die by suicide due to domestic abuse do so "*by compulsion, not by choice*" is a powerful reminder that coercive control can amount to psychological entrapment, where the abuser's actions effectively become a lethal force.

If the criminal justice system continues to overlook this, it risks failing victims twice—once in life, and again in death.

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[20] https://www.centreforwomensjustice.org.uk/new-blog-1/2025/2/18/saving-women#:~:text=The%20CPS%20says%20it%20intends,by%20compulsion%2C%20not%20by%20choice.

[21] https://www.cps.gov.uk/legal-guidance/homicide-murder-manslaughter-infanticide-and-causing-or-allowing-death-or-serious#:~:text=Murder%20or%20manslaughter%20may%20be,coercive%20behaviour%20or%20ongoing%20violence – accessed online 7 August 2025

[22] https://www.vkpp.org.uk/assets/Year-4-Report_publication-with-footnote.pdf - accessed online 8 August 2025

## 7.4. The impact of Covid19

Research studies[23] since Covid19 have shown that lockdown restrictions kept victims in abusive relationships for longer and domestic abusers used the lockdown to intensify or conceal their violence, coercion and control. An exploration of survivors' views[24] identified a number of themes that may have impacted on Eve. For example (amongst others):

i. Lockdown meant being confined to a place where abuse was escalating

ii. Barriers to accessing support, including 'cancelled' services and missed opportunities to intervene during interactions in lockdown with frontline workers

iii. Increased feelings of fear, isolation, and loss of control, particularly during the early stages of the pandemic from the combination of abuse and pandemic-related changes to daily life.

Victims of domestic abuse also reported being less able to cope with their abuse during the pandemic.[25] It was evident from reviewing Eve's records that the lockdown during Covid19 had a detrimental effect on her many aspects of her life including her mental health. She found it hard to socialise, as she was not keen on using a computer. Not only was she unable to work as a cleaner but her accommodation became unstable because she could not stay at friends' houses. Covid19 also prevented her from going out to socialise – something that had helped her when she felt 'low' in the past. The restrictions also meant that she only had access to her GP Practice via the telephone – and she had difficulty accessing mental health services such as IAPT (Improving Access to Psychological Therapies) and struggled to benefit from her sessions via the telephone.

Eve first approached the GP in Enfield in April 2020. All her interactions with the GP between April 2020 and her death in October 2020 were by telephone or video call. She had eight telephone appointments and one video call. Although Eve engaged with a private counsellor, again, all these sessions were online. The exploration of survivors' views[26] also highlighted the importance of combined public awareness campaigns and community intervention points for victims to safely seek help during social distancing restrictions – which would have potentially been helpful for Eve.

It is however important to reflect the views of Eve's family in relation to the Covid lockdown period and the long term impact domestic abuse which she had suffered.

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[23] For further information see How the COVID-19 lockdowns affected the domestic abuse crisis – UKRI – accessed online 5 August 2025

[24] For further information see How did UK social distancing restrictions affect the lives of women experiencing intimate partner violence during the COVID-19 pandemic? A qualitative exploration of survivor views | BMC Public Health | Full Text – accessed online 5 August 2025

[25] Domestic abuse during the coronavirus (COVID-19) pandemic, England and Wales - Office for National Statistics – accessed online 5 August 2025

[26] For further information see How did UK social distancing restrictions affect the lives of women experiencing intimate partner violence during the COVID-19 pandemic? A qualitative exploration of survivor views | BMC Public Health | Full Text – accessed online 5 August 2025

Eve's family wish to point out that whilst it is clear Covid-19 restrictions and access to face-to-face healthcare impacted her, Eve had navigated the worst of the 'Covid period'. She had started driving again, had gained new clients and returned to self-employed work, started to improve in terms of enjoying time seeing her children and speaking with friends. Her family stated:

*"The fact is, Eve was improving in many ways, but damaged and still under the harmful influence of her partner."*

It is the view of the family that Eve was not a victim of Covid restrictions and isolation, but that Covid measures concealed the impact of her experiences of domestic abuse and the long-term impact this had on her.

## 7.5. The domestic abuse disclosure scheme (Clare's Law)

The domestic abuse disclosure scheme was introduced in England and Wales in March 2014. The aim of the scheme is to provide members of the public with a formal mechanism to make enquiries about an individual with whom they are in a relationship (or is in a relationship with someone they know), and there is a concern that the individual may be a domestic abuse perpetrator.

Eve's family clearly had concerns about Jake's controlling and abusive behaviour from the start. Had the family been aware of Clare's Law, they could have made enquiries to the police about his offending history as a perpetrator of domestic abuse. Although an enquiry to the police may not have revealed a significant history, it may have helped Eve and her family to better understand his pattern of behaviour. Understanding this behaviour may have given her an opportunity to make an informed choice about whether she wanted to continue her relationship with him.

Furthermore, in cases where someone has taken their own life because of domestic abuse and no criminal proceedings have taken place; it is still important for the police and panel members to consider whether the alleged 'abuser' has started a new relationship or could pose a risk of harm to future partners. In these cases, a disclosure under Clare's Law could still be made by the police. The Metropolitan Police Service updates the Police National Database (PND)[27] to include information about any individuals who have been the subject of a domestic homicide review or domestic abuse related death review. This information would then be revealed under the domestic abuse disclosure scheme.

[27] The Police National Database (PND) is a national information management system that allows police forces to share and access operational intelligence and other local policing data electronically to prevent and detect crime. It serves as a national intelligence-sharing system where individual forces contribute copies of locally held records, such as those related to crime, custody, and child protection, enabling a unified national view and overcoming geographical barriers.

RECOMMENDATION

vi. The Community Safety Partnership in Enfield should consider launching an awareness raising campaign aimed at the public and professionals around the Domestic Violence Disclosure Scheme, commonly referred to as Clare's Law.

vii. The Office of the Domestic Abuse Commissioner should instruct all police forces in England and Wales to update the Police National Database (PND) to include information about any individuals who have been the subject of a domestic homicide review or domestic abuse related death review. This should include their full names and alias's, date of birth and last known address.

## 8. CONCLUSION

Eve's case highlights the need for a more integrated, trauma-informed, and responsive system to address domestic abuse and its devastating consequences. Her experience highlights how the intersection of coercive control, mental health deterioration, and systemic gaps in support can lead to tragic outcomes — outcomes that are preventable with the right structures in place. It is increasingly clear that domestic abuse must not only be recognised as a criminal justice and safeguarding issue, but also as a serious public health concern, with suicide being one of its most under-acknowledged outcomes. The growing body of evidence, alongside the findings from the Domestic Homicide Project and other national research, shows that suicide linked to domestic abuse is not rare — it is just under-identified and under-investigated.

## 9. RECOMMENDATIONS

i. IRIS[28] should undertake a review to ensure the GP Practice is up to date with training on domestic abuse. This review should include whether:
   - Domestic abuse alerts are routinely and appropriately placed on patient notes
   - Multi-agency communication and referrals are routinely used
   - Victims of domestic abuse are prioritised for face-to-face appointments.

ii. Enfield Community Safety Partnership should formally write to the Deputy Mayor for Crime and Policing at the Mayor's Office for Policing and Crime (MOPAC) to raise concerns about the increasing financial pressures on local partners to sustain core domestic abuse services, including IRIS and Independent Domestic Abuse Advisor (IDVA) provision. The letter should request that the Deputy Mayor undertakes a review and realignment of the current funding formulas to ensure they reflect the

[28] IRIS is a specialist domestic violence and abuse (DVA) training, support and referral programme for General Practices – for further information see https://irisi.org/about-the-iris-programme accessed online 18 August 2025

growing demand and adequately support the Government's ambition to halve violence against women and girls by 2030.

iii. The Enfield Community Safety Partnership to formally write to the Integrated Care Board (ICB), as the commissioner of talking therapies, requesting that they consider the learning and practice recommendations arising from this Domestic Homicide Review (DHR) and ensure these are appropriately shared with, and implemented by, talking therapies providers.

iv. The Metropolitan Police Service should review its current policies to provide clear guidance on the investigation of cases involving suicide where there is a known or suspected history of domestic abuse.

v. The Department of Health and Social Care should instruct all local authorities to ensure that their suicide prevention strategies should explicitly recognise domestic abuse, in all its forms, as a significant risk factor for suicidal ideation and suicide. Strategies should include clear actions to address this risk and ensure that learning from domestic homicide reviews and domestic abuse related death reviews informs suicide prevention planning and delivery.

vi. The Community Safety Partnership in Enfield should consider launching an awareness raising campaign aimed at the public and professionals around the Domestic Violence Disclosure Scheme, commonly referred to as Clare's Law.

vii. The Office of the Domestic Abuse Commissioner should instruct all police forces in England and Wales to update the Police National Database (PND) to include information about any individuals who have been the subject of a domestic homicide review or domestic abuse related death review. This should include their full names and alias's, date of birth and last known address.

## 10. Appendix One – Metropolitan Police Service: Policy for Apparent Suicide

Where the deceased is a child (under 18), please refer to the 'SUDI and Child Death' section above.

Suicide is the term used by the coroner where the facts have determined that the death was as the result of self-killing. Self-killing is the term applied to those deaths where evidence suggests that the deceased has taken their own life. Officers should avoid using the word suicide with family and or next of kin [NoK] as this may be difficult for them to accept. Police should also avoid using the word suicide when talking to the media, unless these are the findings of a coroner's court. The cause of death is something for the medical profession and ultimately the coroner to determine. Police should therefore refer to the death as unexpected until the case is fully investigated. This does not prevent officers from providing facts surrounding the death to the family and or next of kin, particularly if asked, and clearly and honestly answering questions they may have.

In cases of apparent suicide, it is imperative to ensure that all family members/NoK and close friends of the deceased are safe and well.

In cases where it appears that the subject has taken their own life, a supervisor must attend and must ensure that the scene has been adequately forensically examined and that a Forensic Practitioner/Crime Scene Examiner has been requested to photograph the body position and the scene. Photography is mandatory in all these incidents.

For incidents of hanging, if it is believed that there may be still be signs of life, the body must be released from the rope or other item used. An ambulance or other medical professional should be requested and all efforts must be made to keep the individual alive. If death is obvious, the rope should be left in situ. The type of knot used in the ligature, its position on the neck, together with the point from which the individual is suspended, are all key areas from a forensic and evidential point of view.

Photograph and seize any ligatures and send with the deceased to the mortuary. Cut the ligature clear of the knots and mark each cut end to show which has been joined to which. Do not loosen nooses, or loosen or untie knots (except to save life).

Thoroughly search the scene and the clothing of the deceased for a suicide note (note of intent). Any note should be treated as an exhibit and preserved for fingerprints and / or other forensic examination, and for comparison of handwriting. Seize a sample of the deceased's handwriting if available. Officers should consider asking family and or NoK to validate whether they recognise the handwriting, style and content as being that of the deceased, and a statement should be taken to record their opinion either way. If there is a note of intent, the original note must be exhibited. The note may be suitable for analysis against a control sample, fingerprints, DNA or indentation so it is essential you contact Forensic Services to establish the best method of packaging the exhibit. Once any forensic examination has been completed, this exhibit should be made available to the Coroner's

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Office with an accompanying MG11. The MG11 should note whether it is believed to be the handwriting of the deceased and why this is thought to be the case.

Any items deemed relevant to any potential investigation or to assist HM Coroner in their inquest must be seized and considered for further forensic examination and/or analysis. Examples of relevant property may be, mobile telephones, computers, USB / SD flash drives / cards, drugs and drugs paraphernalia. Seizing computers and electronic devices may be relevant as there could be information relevant to the person's death contained on the devices. Preserve for fingerprints and / or digital forensic examination. The rationale for sending or not sending items seized for further enquiries must be recorded within the CONNECT Death Investigation.

Intelligence checks are vital to an investigation into apparent suicide. Officers must consider what led the person to take their life. There must be consideration given to any third-party involvement such as a history of Domestic Abuse or Bullying (either online or physically).

The minimum standard required is PND and PNC on both the deceased and informant. You must conduct IIP checks on the deceased, informant and venue with at least a 5-year parameter.

You must assess the investigation and consider whether further checks are required to further your investigation. i.e. other persons present. Intelligence checks must be completed while you are at the scene. The Operations Room will assist with PNC and IIP checks.

If you do not have access to PND you may request MO2 assistance through your Operations Room.

Between the hours of 0700 and 2200 your MO2 Local Intelligence Team (LIT) will be available to assist with PND checks. Outside of these hours MO2 24/7 will assist.

Once assigned to the CAD the initial investigating officer will be sent a SharePoint form to populate with a summary of the intelligence checks. This must be returned via the provided link. The CAD will not be closed until this is complete.

The results of intelligence checks need to be summarised within the CONNECT death investigation.

If the death is suspected to have been caused by a firearm, do not attempt to touch either the body or weapon unless necessary to preserve life or limb.

If you feel this may be a critical incident please refer to the critical incidents policy.

# 11. Appendix Two – Metropolitan Police Service: Suicide 'Gold Dust' Sheet

METROPOLITAN POLICE

**Apparent/Suspected Suicide Gold dust Sheet**

All incidents of the death of an adult that Police Officers attend are to be treated as suspicious until the police investigation has established that is it not. Your priorities are Preserve and Protect Life, Preserve the Scene and Evidence, Identify the Deceased, Identify and Arrest Offenders (If relevant), Identify Family / Next of Kin / Witnesses. Further information can be found within the Death investigation policy

Suicide is the term used by the Coroner where the facts have determined that the death was as the result of self-killing. Self-killing is applied to deaths where evidence suggests that the deceased has taken their own life. Officers should avoid using the word suicide with family/Next of Kin (NoK) as this may be difficult for them to accept. The cause of death is something for the medical profession and ultimately the Coroner to determine. You should therefore refer to the death as **unexpected** until the case is fully investigated. This does not prevent officers from providing facts surrounding the death to the family and or NoK, particularly if asked, and clearly and honestly answering questions they may have.

A substantive supervisor MUST attend the scene and review the initial investigation and assess whether the death is considered suspicious or not. If the supervisor cannot be certain the death is not suspicious, a substantive Detective (DC or DS) MUST attend the scene. If they are unable to determine there is no third party involvement then they MUST brief a DI.

The scene MUST be forensically examined and you must request a Forensic Practitioner/Crime Scene Examiner to photograph the body position and the scene. Photography is mandatory in all these incidents. Any items deemed relevant to any potential investigation or to assist HM Coroner in their inquest must be seized and considered for further forensic examination. Photograph and seize any ligatures and send with the deceased to the mortuary.

Consider relevant exhibits: Drugs and drugs paraphernalia, Mobile telephones, computers, USB / SD flash drives / cards. Seizing computers and electronic devices may be relevant as there could be information relevant to the person's death contained on the devices. Preserve all exhibits for fingerprints and / or digital forensic examination and record rationale for sending/not sending for further enquiries. If unsure what to do, the Homicide Assessment Team (HAT) and Operational Forensic Manager are available 24/7.

Hanging: For incidents of hanging, if there are any signs of life, the body must be released from the ligature. An ambulance or other medical professional should be requested and all efforts must be made to keep the individual alive.
If death is obvious, the ligature should be left in situ. The ligature used, or type of knot, its position on the neck, together with the point from which the individual is suspended, are all key areas from a forensic and evidential point of view. Seek advice from a supervisor or Forensic practitioner/OFM. Do not undo ligatures or loosen / untie knots (except to save life).

Conduct intelligence checks for the deceased, the venue and for any persons present or relevant whilst at the scene and prior to deciding if the death is suspicious or not. The minimum search is PNC and at least 5 years checks on IIP and PND. Identify whether there is any history of domestic abuse and precis the results on the crime investigation report. Consider welfare checks for family/NoK identified.

Sodium Nitrate is a rapidly emerging method for suicide and officers need to be aware of its potential use when attending any unexpected death. Sodium Nitrate appears as a white crystalline solid, it can be used as an ingredient in fertilizers, pyrotechnics or more commonly as a food preservative. It is highly soluble in water, producing a clear or white solution. Sodium Nitrite appears as a yellowish white crystalline solid, it can also be used as a food preservative. It is highly soluble in water, producing a clear or yellowish solution.

As with all apparent/suspected suicides, inform Met CC immediately if you suspect a person may have used gas or chemical exposure to harm themselves. **Consider your own and others personal safety.**

Things to consider:

- Is there any packaging nearby that will identify the chemical involved? This would include 'anti-nausea' drugs or packaging.
- Are there any glasses or drinking vessels which may still contain evidence of toxic solution?
- Consider seizing computers and electronic devices. There may be evidence of recent purchase of Sodium Nitrite or evidence of web research into Sodium Nitrite / Suicide Forums?

Suicide Notes:

- Thoroughly search the scene and the deceased's clothing for a suicide note (**note of intent**).
- Any note should be treated as an exhibit and preserved for fingerprints and / or other forensic examination, and for comparison of handwriting.
- Seize a sample of the deceased's handwriting if available. Officers should consider asking family and or NoK to validate whether they recognise the handwriting, style and content as being that of the deceased, and a statement should be taken to record their opinion either way.
- Once any forensic examination has been completed, this exhibit should be made available to the Coroner's Office with an accompanying MG11. The MG11 should note whether it is believed to be the handwriting of the deceased and why this is thought to be the case.

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