Signed by Geoffrey Sullivan
Title Senior Coroner
Jurisdiction Hertfordshire

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: Chief Constable of Hertfordshire Constabulary, Charlie Hall**
1	**CORONER** I am Geoffrey Sullivan Senior Coroner for **Hertfordshire**
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 06/09/2017 I commenced an investigation into the death of Kelly Marie SUTTON. The investigation concluded at the end of the inquest taking place on 17th & 18th March 2020. The cause of death provided by the pathologist: 1a) Features consistent with hanging After inquest: The medical cause of death: 1a) Hanging The conclusion: Suicide contributed to by domestic abuse. For the five months preceding her death Ms Sutton was in an abusive relationship. Following her death on the 26th August 2017, a police investigation and trial at St Alban's Crown Court resulted in the conviction of Ms Sutton's partner for controlling or coercive behaviour in an intimate relationship and two counts of assault. He received a custodial sentence of 4 years 3 months imprisonment and a criminal behaviour order was imposed. In addition to the part played by her relationship, the inquest examined two issues that related to Hertfordshire Constabulary. The second also relates to the Police Service more widely. The first issue concerned the attendance of police officers at Ms Sutton's home on the 9th July 2017, responding to a disturbance reported by a neighbour and the adequacy of their actions at the time. The second issue, which was highlighted in the Domestic Homicide Review (DHR), related to the availability of non-crime information to the police. In this case, there was no match with records in respect of domestic abuse by Ms Sutton's partner against other victims, despite there being reports to the police from 3 previous partners.

	These reports, being non-crime reports, were not available to officers unless they searched for the victims, as opposed to the perpetrator. This sort of information is clearly of value to inform officers' decision making, when dealing with a report of potential domestic abuse and clearly of value when seeking to safeguard more widely the vulnerable parties in abusive relationships. I heard evidence that Hertfordshire Constabulary recently launched a new case management system 'Athena' which links POLE data (People, Object, Location and Event) which will assist with identifying where perpetrators have more than one victim and reveal a history of such behaviour. Hertfordshire is part of a nine-force consortium with Bedfordshire, Essex, Cambridgeshire, Norfolk, Suffolk, Kent, Warwickshire and the West Midlands. The forces have access to the data of the consortium members. I also heard that there are other similar systems and consortia in other parts of the country. I did not find that either of the issues outlined above regarding Hertfordshire Constabulary caused or contributed to the death of Kelly Sutton. The Athena system is a welcome development for safeguarding the vulnerable but based on the evidence I heard, I am concerned that this sort of information sharing is limited to forces within certain groups and is not a national resource.
4	**CIRCUMSTANCES OF THE DEATH** The circumstances of the death recorded at the inquest: On 23 August 2017 at 08:15hrs Kelly Sutton's partner called 999 requesting an ambulance. He had found Ms Sutton hanging from a door handle in the living room of her home address. Police and paramedics attended and following CPR a return of spontaneous circulation was achieved by paramedics. Kelly Sutton was conveyed to the Lister Hospital where despite treatment her death was confirmed on the 26 August 2017. In the 5 month period leading up to her death, Kelly Sutton was subjected to coercive, controlling and abusive behaviour by her partner, which contributed to her death.
5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows. – [BRIEF SUMMARY OF MATTERS OF CONCERN] (1) That non-crime information valuable to the police in safeguarding potential victims of domestic abuse is not available as a national resource. It is still limited to individual police areas or groups of areas. (2) (3)

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you Charlie Hall, Chief Constable of Hertfordshire, have the power to take such action (in your capacity as Chief Constable, Lead and Chief Officer of Athena and your presence on the National Police Chiefs' Council).
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 19th May 2020. I, the coroner, may extend the period. Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise you must explain why no action is proposed.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons [redacted] Solicitor representing members of the family and, The Welwyn Hatfield Community Safety Partnership, who may find it useful or of interest. I am also under a duty to send the Chief Coroner a copy of your response. The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest. You may make representations to me, the coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	24/03/2020 Signature_____ Geoffrey Sullivan Senior Coroner **Hertfo**rdshire