# Domestic Abuse Related Death Review

# Executive Summary

# East Herts Community Safety Partnership

## Denise

## Died: November 2023

Chair and Author: Christian Brazier

Date of completion: 15th March 2025

**Tribute from Denise's mother and step-father:**

*You were born with a beautiful flaming auburn punk style hair-do. You were my victory.*

*You were a really happy child, always getting involved in lots of different things and making lots of friends wherever you went. You happily went off to play school and then nursery without even a whimper or looking back at mum.*

*You also loved to do ballet with your childhood friend, and when you were old enough to cross our street you took yourself off every Sunday to Church, opposite our house, for the service and Sunday School, and got involved with the Church parades. Your belief in God never waned.*

*Later you also took up Jiu-Jitsu and worked your way up to green belt, which came in handy for the school bus driver in secondary school, when you kept the kids in check while he got on with the driving LOL!*

*And then you chose your secondary school, you chose a different one to your siblings, where once again you did well and made many friends, and one special friend, with whom you became really close.*

*Whilst at secondary school you learned to play the trumpet and got involved with school productions, such as Blood Brothers, and I remember practicing the songs with you, so much so that I could have been your understudy.*

*You went away ski-ing in the Alps one Christmas, where you were only allowed to phone home on Christmas Day, and the phone call was filled with excitement and telling me all the things you had been doing. I realised at that point that I had been worrying needlessly, as you had the ability to embrace change and embrace life.*

*You wanted to learn to play the piano, and you were privately tutored all through your secondary school years, reaching Grade Seven with distinction.*

*You achieved all this despite Mum and Dad breaking up, and you fighting, for several years, to come and live with Mum, which you finally did.*

*You chose to do A Levels at college, your main subjects being Psychology and Music. It was at this point that you found out that you were dyslexic and dyspraxic, for which college gave you immense support to achieve your goals. Once again you got involved with concerts and college life in general, which included Mum being late for work while she looked for you, and eventually found you drunk as a skunk in a bus stop! During your time at college, you fell in love with your music teacher's son, and spent your summer vacations in France with him and his family.*

*From A levels you went on to achieve your Child Care qualifications successfully. You moved towns and supported your partner whilst he was at university, and got yourself a job playing piano in a posh bar, again making lots and lots of friends.*

*Your main job, working in child care, you found to be a real joy, and got immense satisfaction from it. You were successful, and progressed to be a team leader, and you were devoted to the care of the children.*

*Remembering, with a huge smile, taking you to a hen party, and even though you knew no-one there, you soon became known to everyone there, and really made the group light up with laughter and fun. You did the same when we went to a 50th, where again you knew no-one, and then took it upon yourself to be the face painting artist, and as the party got under way, you had pretty much spoken to and got to know everyone.*

*You loved being around your family, and many times after a heavy night out, you would turn up at your elder brother's house the next day, to be fed and to sleep on his couch, cuddling your nieces and nephew.*

*Once, you insisted on us coming for a night out in our local town centre to meet your friends and to see the places you loved to go. It was, to say the least, an eye-opener, however it was wonderful to see how many friends you had, and you weren't one bit embarrassed to introduce them to Mum and Pops. Unfortunately Mom and Pops could only last to 12 am, and then had to make our way home! It always makes us laugh when we think of that night.*

*This is just a small snapshot of you and your life, and it seems that no matter what you did, you gave your all, remaining popular and successful.*

*You could be an absolute pain in the bum at times, as we all can, but despite that you had such wonderful qualities which out-weighed this - you were funny, witty, passionate, fiery, helpful, astute, intelligent, determined, kind, caring, considerate and very loving.*

*Your sister and two brothers are devastated. They miss you so much and they talk about you and the good times often, and they were all looking forward to growing old and being mischievous and havoc-causing old people together, just like when you were all kids.*

*You gave much more than you took from life. We are trying as best we can to keep our hearts unbroken so we may continue to carry you with us, each day, with love, gratitude and remembrance.*

*You certainly lived up to your name girl!*

*Love from a very proud Mum and stepdad Pops*

## Glossary of Terms

| Acronym | Name |
|---|---|
| ACMHS | Adult Community Mental Health Service |
| ASBAG[1] | Anti-Social Behaviour Action Group |
| ASB | Anti-Social Behaviour |
| DA | Domestic Abuse |
| DASH | Domestic Abuse Stalking and Harassment Risk Assessment |
| DARA | Domestic Abuse Risk Assessment |
| DARDR | Domestic Abuse Related Death Review |
| DHR | Domestic Homicide Review |
| EUPD | Emotional Unstable Personality Disorder |
| HPFT | Hertfordshire Partnership University NHS Foundation Trust (HPFT) provides mental health and social care and specialist learning disabilities services in Hertfordshire, Buckinghamshire, Norfolk and North Essex for over 400,000 people. |
| ICB | Integrated Care Board[2] |
| IDVA | Independent Domestic Violence Advisor |
| ISVA | Independent Sexual Violence Advocate |
| IFST | Intensive Family Support Team |
| MARAC | Multi Agency Risk Assessment Conference |
| MATAC | Multi Agency Tasking and Coordination |
| MAPPA | Multi Agency Public Protection Arrangements |
| SPA | Single Point of Access |
| SOP | Standard Operating Procedures |
| SWKR | Social Worker |
| TOR | Terms of Reference |
| UC | Universal Credit |

[1] *ASBAG (Anti-Social Behaviour Action Group) is a local multi agency forum specific to Hertfordshire. Multi agency forums tasked with tackling ASB exist under different names in other counties.*

[2] Herts and West Essex ICS

# DARDR EXECUTIVE SUMMARY INTO THE VICTIM SUICIDE OF DENISE – NOVEMBER 2023

**Preface**

The author and panel wish to express their deepest condolences to Denise's family and friends. Denise was clearly a loved individual and will be missed by many. The author and panel also wish to express their thanks to those family and friends who contributed to the review and gave insight into Denise's life and personality.

**Introduction**

1.1 Domestic Homicide Reviews (DHRs), or as is being transitioned to, Domestic Abuse Related Death Reviews (DARDR)[3] came into force on the 13th April 2011. They were established on a statutory basis under Section 9 of the Domestic Violence, Crime and Victims Act (2004). The Act states that a DHR should be a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by-

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

(b) A member of the same household as herself; with a view to identifying the lessons to be learnt from the death.

1.2 Within Section 18 of the 2016 Multi Agency Statutory Guidance for the Conduct of DHRs / DARDRs, provision was made for DHRs to be conducted:

*"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."* [4]

1.3 The purpose of a DHR / DARDR is to:

- Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims.

[3] The acronym DARDR will predominantly be used for this review as it better reflects the circumstances.
[4] DHR-Statutory-Guidance-161206.pdf (publishing.service.gov.uk)

- Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result.

- Apply these lessons to service responses including changes to policies and procedures as appropriate; and identify what needs to change in order to reduce the risk of such tragedies happening in the future to prevent domestic homicide and improve service responses for all domestic violence victims and their children through improved intra- and inter-agency working.

1.4 This DHR / DARDR examines the circumstances leading up to the death of Denise who ended her life in November 2023. The decision to undertake the review was made by the local Community Safety Partnership on 15th December 2023 having been notified of her death by the Adult Safeguarding Team in Hertfordshire. The Home Office was duly informed. An Independent Chair was appointed on 6th June 2024, the delay due to a shortage of chairs and volume of reviews locally. The Panel met for the first on 5th August 2024 where relevant IMRs (Individual Management Reviews) were requested. There were further meetings of the panel online on:

| | | |
|---|---|---|
| Panel Meeting 2 | - | Monday 21st October 2024 |
| Panel Meeting 3 | - | Thursday 14th November 2024 |
| Panel Meeting 4 | - | Monday 9th December 2024 |
| Panel Meeting 5 | - | Monday 27th January 2025 |

## 2 Overview and Summary

Persons involved in this DHR / DARDR:

| Name | Relationship | Age at time of V/S death | Name |
|---|---|---|---|
| Denise | Subject of review | 37 | Denise |
| Gary | Ex partner | 37 | Gary |

All names are pseudonyms, with Denise's name chosen by the chair after consultation with her mother.

**Overview:**

Denise (pseudonym) was found deceased in her flat in November 2023. She had ended her life via hanging. She was known to agencies such as the Adult Community Mental Health Service (ACMHS), B3 Living Housing Association[5] and the Police amongst others. Domestic abuse concerning her most recent partner had been highlighted as a

[5] B3Living

concern in the months leading up to her death. Antisocial behaviour[6] emanating from Denise's address from November 2022 onwards is a key feature of this review.

Initial scoping indicated Gary and Denise were known to each other from some time in 2022. This information was primarily from the Adult Mental Health Team who had been supporting Denise on and off since she moved to Hertfordshire. Therefore, the panel decided to explore agency involvement with Denise and Gary (pseudonym) from 3rd June 2021, the date Denise began her tenancy with B3 Living, to the estimated date of death in November 2023. It was noted there might be relevant information prior to those dates, especially from the preceding four years when it appeared Denise left a domestically abusive relationship in West Yorkshire in 2017 to move to Hertfordshire. Therefore, agencies were asked to consider inclusion of anything relevant from 2017 to the date of death.

Information provided by friends, family and panel members indicated Denise was a 37 year old woman – friend, sister and daughter with a diagnosis of Emotionally Unstable Personality Disorder who grew up in the North West area of England. She had been known to Hertfordshire services since 2017 when she moved there to temporarily live with her sister. She had previously been married to a male in West Yorkshire whom she had reportedly experienced domestic and sexual abuse from.

Upon arrival in Hertfordshire, Denise was supported by an ISVA (Independent Sexual Violence Advisor) for her prior traumatic experiences. They referred her into the Single Point of Access (SPA) for further support after the ISVA became concerned about Denise's suicidal ideation and mental health struggles. Subsequently she was seen by the Adult Community Mental Health Service (ACMHS) who assessed her as not being an imminent risk to herself due to her having no active plan to harm herself. She was discharged from this service although she continued to have suicidal thoughts.

A year later Denise was reopened to the ACMHS after taking an overdose. This was at roughly the same time she was due in court as the victim of a domestic assault from her ex-partner in the Essex / London area. This overdose triggered psychological therapeutic support and a life skills support group. After some initial engagement Denise declined further support due to disagreeing with the service's assessment she could function without medication. Several months later she re-engaged saying she felt she could be a risk to herself if she didn't have active support in place. Denise was allocated a care co-ordinator and provided with ongoing support by ACMHS.

In early 2020 she reported an improvement in mood, support from friends and family, good insight into her mental health and was in employment. However, she also voiced feeling increasingly more comfortable with the notion of ending her life. It was noted in a risk assessment she was not at risk from others nor a risk to children which was significant as she was working with children in a nursery at the time. However, the same risk assessment mentioned she had shown aggression towards others in the workplace and continued to be a risk to herself from self-harm, suicide and self-neglect. In

[6] Understanding Antisocial Behavior: A Detailed Guide | Crimestoppers

October and November 2020 Denise came to the attention of police due to concerns she was going to end her life. One of these calls resulted in the police detaining her under Section 136 of the Mental Health Act[7]. This brought her back to the attention of the Adult Community Mental Health Service (ACMHS) who had discharged her due to non-attendance and no communication. In early 2021 there were notes of concern on their internal systems that Denise might be becoming overly reliant on her care co-ordinator and her independence was reducing. She was noted as being prescribed Lithium at that time. The years post 2021 are covered within the agreed scoping period and will be summarised in the next section of this report.

The panel wanted to also explore what was known of Gary and his alleged behaviour both during his relationship with Denise and before. Careful consideration of what to include within the report of his alleged offending history / criminal activity was given by the panel. Due to the potential risk posed to others, the panel made the decision to exclude most detail. This should not dilute the significance of this history nor its relevance to Denise's lived experience. During this review Police disclosed intelligence, allegations and convictions which would have assisted in understanding his pattern of offending, the likelihood of reoccurrence and provided greater insight into Denise's fear. As DHRs / DARDRs set out to achieve, this information would have illuminated the past to make the future safer. By shining a light on perpetration, we can better protect those experiencing abuse. In summary, Gary was known on the police systems for:

- abuse of ex partners and family,
- having multiple links to those known for drug supply (Denise would later reference significant fear of Gary's associates)
- an allegation of behaviour suggestive of cuckooing and
- episodes of drug dealing.

The full extent was never known to Denise nor the multi-agency network at any point during the scoping period.

**Summary of the case**

Following a breakdown in Denise's relationship with her sister in November 2020 she approached the council seeking support for homelessness. She was subsequently assessed as priority need[8] for housing under the homelessness legislation by East Hertfordshire Council due to having "moderate mental health issues for which high doses of medication were prescribed." Denise was initially placed in temporary accommodation in a B&B and then a hostel until she was provided a social tenancy by the B3 Living housing provider in June 2021. She would remain there for the rest of her life. This tenancy was in a block of flats where other people had been housed who were deemed to have "vulnerabilities". Upon exploring this with B3 Living, many of the individuals housed there had mental health needs.

[7] Sections 135 and 136 Mental Health Act - legal information
[8] Priority need - Shelter England

Upon signing up with B3, Denise was open with staff saying she had previously experienced domestic abuse and was receiving support for her mental health. She also told them she did not like going out and had a friend who would help get shopping for her.

Denise's contact with the Adult Mental Health Service continued throughout 2021 although her usual care co-ordinator was off work on long term sick. Denise repeatedly told staff she would wait for her usual mental health support worker to come back from leave as she did not want to repeat herself and her story to various professionals; but this never happened. In her conversations with the ACMHS support worker she said she had found moving house stressful, had been off sick from work and did not intend on returning to her employer (local children's nursery). Within this discussion she said she agreed with her EUPD (Emotional Unstable Personality Disorder) diagnosis but also thought she had Bipolar. She said she felt anxious about a meeting she was going to have with her employer and wanted her medical consultant psychiatrist to prescribe medication to manage this. Further home visits from this team were completed over the next couple of months. Within these visits it was identified Denise could benefit from further support with employment, food vouchers and budgeting aswell as general advice re friendships and boundaries.

In September 2021 she had a face-to-face meeting with the consultant psychologist, the author of her care plan. She reported feelings of hopelessness although no further detail was recorded. At this time, she was taking Zolpidem sleeping tablets to try and keep a routine. The doctor recorded her mental health as stable. The ACMHS appeared to closely monitor Denise at this time and visited her at home after not hearing from her from some time. Subsequently Denise re-engaged with them but she told them she felt let down by services. She was upset the doctor stopped her Lithium due to the uncertainty around her diagnosis. She said she had been falling out with friends and thought her neighbours were talking about her mental health. This and the absence of her usual care co-ordinator were behind her disengaging from services, she said. As a result of Denise stopping her medication (Lithium) and overdosing on Promethazine, which she stated was to aid her sleep, the ACMHS referred to the crisis team[9] and Denise subsequently went to the hospital for a check-up. However, she declined input from the crisis team and was reportedly angry an ambulance had been called for her.

In mid-October 2021 Denise reported to the police being raped by a stranger in a park, clearly a traumatic and harrowing experience. The police investigated but were unable to pursue the allegation further due a lack of evidence. Denise told her ACMHS support worker about this who assessed an increased risk of suicide. They created a safeguarding episode[10] to assess whether Denise required additional support and safeguarding. A social worker and support worker visited Denise on the 18th October 2021 to gain her insights. She said she preferred safeguarding support from the police rather than mental health services. The safeguarding enquiry ceased at her request. The

[9] Crisis Support

[10] A safeguarding episode is an official exploration of whether someone is at risk of harm from themselves or others and require further support or intervention.

assessor recorded that she may benefit from having a Care Act assessment[11] to ascertain whether she required additional support, but no evidence exists of this assessment taking place. Some days later the Police were called due to concerns for Denise's welfare. They attended her flat and she confirmed she intended to hang herself and had been feeling suicidal since the recent sexual assault. Police decided to use Mental Capacity Act powers [12] to detain Denise and prevent her from harming herself after she took tablets infront of officers. They removed her from the property and took her to the hospital. This was clearly a traumatic incident for all concerned as Denise was later restrained by officers within the emergency department. No ambulance had been available to assist. Police withdrew once Denise was in the care of medical professionals.

There was a lack of contact with services in early 2022 with the ACMHS trying unsuccessfully to contact Denise on several occasions. On the rare occasions she had had been seen or spoken to she reported being in a more stable place and taking her medication regularly. However, this situation appeared to change at the next home visit by the ACMHS. When asked why she had prevented access previously she said her mood had been "high". She also reported being sleep deprived which impacted on her concentration. She reported overspending on her credit card by ordering £400.00 worth of food to make a pantry cupboard in case there was a war. Concerningly, she said she had been going out at night and had been asked to leave three pubs. She requested support to complete her universal credit job search journal.

From May – July 2022 it is apparent Densie was frustrated with the support she had been receiving from health services. On one occasion she text them saying:

*"Get fucked [name] that was not the answer I gave you my concerns. Everytime I start psychology the person goes off sick and it never finishes and you could not disagree. Hate when you fuckers do that! None of you ever listen. There is no point in us meeting anymore"*

The consultant psychiatrist wrote to Denise's GP stating a need to review what was happening with the Psychology team. The letter referred to a plan to discharge to primary care with support from MIND and Newleaf college, a recovery and wellbeing college, suggested. The letter contained a brief risk review as follows: *Harm to self = low; Self neglect = low ; Harm to others = low ; Abuse by others = low; Risk to children = low.* It appears the psychiatrist was likely reflecting their evaluation based on an individual appointment without being fully aware of recent concerns for Denise's welfare or considering external context. This assessment did not reflect Denise's recent experiences.

It is believed Denise met Gary around October 2021. At this time Denise had detailed having sleep issues, feeling paranoid, low in mood and hearing a voice telling her to wake up. She mentioned it was coming up to the anniversary of the rape from last year which made her feel anxious and she had been having flashbacks. She said she was

[11] Key Care Act duties for assessment and determination of eligibility - SCIE
[12] Mental capacity | College of Policing

concerned she might start to drink and use risky behaviours again. She said she was taking her medication and didn't want to see the consultant. The support worker encouraged her to link in with Redkite[13], a sexual abuse support service but they had no record of Denise contacting them. It is clear Denise was especially vulnerable at this time.

It became known to the panel during this review Gary was 12 months into an 18-month Community Order with Probation at this point. This was for an assault towards a male stranger in a pub which had involved alcohol. He was assessed by the National Probation Service (NPS) as a medium risk of serious harm to the public (specifically to those with who there may be actual or perceived conflict with), known adults (family members and ex-partner) and children (who may witness his violence). The nature of the risk was physical and verbal aggression and threats of this alongside the associated emotional and psychological harm.

Denise cancelled appointments with her ACMHS support worker on the 24th November 2022 and 30th November 2022 at very short notice. She cancelled another appointment on 5th December 2022 but texted her support worker saying: *'I have fucked it big time'*. She was asked to elaborate but did not respond. She latterly asked for time to herself. It is now known, at the same time, neighbours were starting to report antisocial behaviour to the council, housing association and police. This behaviour consisted of allegations of drug use, door slamming, people coming and going and cigarette butts left outside.

On 19th December 2022 a Senior Social Worker within ACMHS opened another safeguarding episode after a support worker visited Denise who had her suitcases packed. She said she was tired, low in mood, had no money and was leaving but did not know where she was going. She said she had been in an on / off relationship since October and mentioned they had both used drugs. She said they had both been barred from local pubs due to "arguing" and an occasion where she "smashed up a pub". She said *she* had been violent towards this man, who she did not name and had attempted to cut him with a glass. However, within this description Denise also disclosed abuse she had been experiencing. She mentioned "loaning" him £3000 for an unspecified reason but did not expect to have the money returned. She said she would not call the police due to Gary's involvement with "gangs" which would bring trouble to her door. The case record mentioned psychological and verbal in addition to physical abuse. There were no domestic abuse risk assessments completed.

ASB (antisocial behaviour) complaints continued and towards the end of December neighbours said their block now smelt of burning plastic which they believed was due to crack cocaine use. They described Denise's partner as being obnoxious and causing anxiety and stress. They said he was a known cocaine dealer / user and passed his vehicle registration over to police. This was the first opportunity to identify him, from his vehicle details. This did not happen.

[13] Red Kite Support | Empowering Communities Together

The neighbourhood advisor at B3 Living recorded 7 complaints in December of several "loud" males visiting Denise's home, making noise, playing loud music, littering the entrance and one incident of a male exposing themselves to their ring doorbell camera. B3 said they would send an "ASB Warning Letter"[14] to Denise who was highlighted as being the tenant of the address and where the issues were emanating from.

Denise sent a text message to her ACMHS support worker on the 4th January 2023 asking them to leave her alone. The message warned them not call the police as she would *"tell them to fuck off too"*. Denise said she had thoughts of self harm and suicide but had no plan or intent to end her life. During this text conversation Denise text back to say she wouldn't leave her house due to fear. She said she and her partner had had a "big argument" on New Year's Eve. A week later Denise text to say "the situation" was becoming more complicated and she was hoping to leave town soon. Attempts were made to call Denise but they were unsuccessful. The police were contacted a week later after "screaming" was heard emanating from near or from Denise's flat. Police could not ascertain the exact location and no further information was forthcoming.

Reports from residents continued to be received through until early April 2023 with Gary now mentioned by his first name. Reports included door slamming, cannabis smells, general noise and loud music. However, in late April, a prominent reporting resident said he was no longer attending the address and subsequently B3 living closed their ASB case on their system. There had been some liaison between the police, ASB team, B3 living since the reports started 6 months previously with some letter drops to residents to stimulate information but this had not lead to services identifying Gary or any robust action towards him. By this point two ASB warning letters had been sent to Denise. It is of note the ASB reports started in earnest when the relationship between Gary and Denise began and appear to have abated once he was no longer visiting the flat. Pattern recognition is a key learning point of this review.

In June 2023 Denise answered the ACMHS support worker's call. During the conversation she explained she had ended the relationship with Gary due to an escalation of physical violence towards her. She also referenced the involvement of gangs who were involved in drugs. She spoke of her partner's controlling behaviours including inviting his friends to her home. She said he "would not stay away" and that she had been involved in "shit" that she should not have been involved in. It appears she had returned temporarily to the North West of England at this time.

Reports of concern began again in late June 2023. Police were told there had been a "disturbance" from Denise's flat and there had been dangerous driving in the car park with "Denise's boyfriend" mentioned as the driver. When officers arrived, Denise "impolitely told them to leave" and no further allegations were made. In July police received further reports that Gary was drink driving and was using Denise's flat to store drugs so he could deal them in local pubs. This information was collected by the police

[14] An ASB Warning Letter is the first step in highlighting to a tenant they need to address the antisocial behaviour emanating from their address. In this instance the letter was a bespoke letter sent via B3 Living Housing.

for information / intelligence purposes and passed to the internal Safer Neighbourhoods Team. No further actions were taken.

ACMHS spoke to Denise in August after she had reached out to them asking for support. She said her "ex-partner" continued to be controlling towards her. She said he had taken photos of her without consent and sent them to her saying he had "eyes and ears everywhere". Denise said he had been emotionally abusive, hidden her medication, taken her house keys several weeks previously and had damaged her flat and belongings. She also said he had made threats to expose the videos / photos of her. Denise agreed for a referral to an IDVA (Independent Domestic Violence Advisor). Despite attempts, the IDVA was unable to engage Denise which has stimulated some learning for this organisation. The ACMHS had opened a safeguarding enquiry after this disclosure but closed this soon after as they stated Denise did not want any further action to occur. No domestic abuse related risk assessments had occurred but the referral for IDVA support was good practice.

Denise reported her car as stolen in September before she said she had located it several weeks later. ASB reports continued too. In October 2023, police were called by Gary to Denise's address who said she had just hit him three times in the face. In the background, the police call taker could hear Denise saying he had hit her first. After the police had convinced Gary to leave, Denise explained he had hit her in the face after coming home from the pub upset and angry. She said she retaliated and hit him back. Denise declined to fully complete a DARA[15] (Domestic Abuse Risk Assessment) at the scene. This was latterly completed by the attending officer. However, within their conversation she said she was worried about drug debts and other drug dealers, which was stressing her out and causing outbursts. This assessment was ultimately graded as a medium risk concern. There were two crimes recorded by the police one for Denise's allegation and one for Gary's but ultimately neither resulted in an arrest. A supervisor from the specialist domestic abuse unit reviewed the material from this incident and felt there was insufficient evidence for a victimless prosecution (also known as evidence lead prosecution[16]). Denise recounted the same incident to her ACMHS support 2 days later. She said Gary had returned home high on cocaine and intoxicated by alcohol. She said the situation was initially fine until he changed and smacked her in the face. She confirmed she retaliated by punching him which had prompted him to call the police. She said she wanted support to stay away from him and his associates.

This latest incident prompted a *safeguarding adults strategy meeting* in late October 2023 which was attended by the police, B3 housing and the adult mental health team. In a markedly different tone to the last contact with Denise it was recorded that she did *not* want any further support and had declined a referral to an IDVA (Independent Domestic Violence Advisor) and CGL (substance misuse service). ACMHS detailed how support had been offered to Denise to engage with the IDVA service, but she had continued to decline. Further updates were shared but, based on the minutes provided to this review, they lacked detail such as a chronology or a thorough understanding of Gary's background. B3 Housing were recorded as saying if "the situation changed, they

[15] Domestic Abuse Risk Assessment (DARA): Rationale for development, structure and content
[16] Domestic Abuse | The Crown Prosecution Service

could look at additional actions and safeguarding, such as a Community Protection Notice and injunctions but whilst Denise was allowing contact with Gary, this would not be effective." It is unknown what would need to have changed for these legal remedies to be considered and the use of the word "allowing" does not accurately summarise Denise's lived experience.

There were limited interactions with services following this with one more meeting with her ACMHS worked. Not long after this visit, concerns were raised from a neighbour about Denise's window being left open for an extended period of time. At roughly the same time the ACMHS became concerned as they failed to receive any communication from Denise. These concerns lead to police attendance at her address where they found Denise deceased. She had ended her life via hanging.

### 3. Parallel reviews

There was a Police investigation regarding the circumstances of the death on behalf of the coroner. The outcome of this was Denise's death was non-suspicious. The police concluded no criminality.

The coroner's inquest concluded death by suicide.

### 4. Domestic Homicide Review Panel

The following agencies and individuals were on the DHR panel:

| Name | Organisation | Job title |
|---|---|---|
| Christian Brazier | Independent Chair & Author | Independent Chair and Author |
| Julie Pomfrett | East Herts District Council | Safeguarding Lead |
| Kate Johnson | Hertfordshire Partnership University NHS Foundation Trust, HPFT | Professional Lead for Safeguarding Adults |
| Leanne McGrath | National Probation Service | Senior Probation Officer, Domestic Abuse Lead |
| Louise Bayston | Refuge | Senior Operations Manager |
| Tracey Ayling | B3 Living | Housing Manager |
| Catherine Mcarevey | Herts and West Essex ICB | Designated Safeguarding Nurse NHS |
| James Luxon | Hertfordshire Police | DHR Review Team, Herts Police |
| Sarah Dixon | GP Surgery | Senior Partner, GP |

None of the representatives at the panel, nor authors of the IMRs, had any direct involvement with the family and were independent.

## 5. Independence

This report is chaired and authored by Christian Brazier. Christian worked in frontline practice within the Police, Family Intervention and Domestic Abuse sectors for nearly 15 years. In 2016, he specialised in domestic abuse perpetrator interventions working within medium and high risk domestic abuse perpetrator projects as a Skills Enhancer and Deputy Manager. He then worked for the national domestic abuse organisation Respect as a Drive Practice Advisor - high risk domestic abuse intervention, and later a Make A Change practice lead - an early intervention domestic abuse intervention. He has also been a Service Manager for a high risk domestic abuse perpetrator intervention in London aswell as a Treatment Manager for two domestic abuse interventions. He qualified as a journalist in 2013.

The author is independent of all statutory and non-statutory services within Hertfordshire and had never had contact with the family prior to this DHR / DARDR.

## 6. Terms of Reference (ToR) and Scope

During the initial panel meeting the panel decided to explore agency involvement with Denise and Gary (pseudonym) from 3rd June 2021, the date Denise began her tenancy with B3 Living, to the estimated date of death, 23rd November 2023. Contact with family occurred after the terms of reference were agreed by the panel. Following contact with the chair family members were able to view the report and comment on the ToR.

Key Lines of Enquiry were as follows:

These were points identified as being particularly pertinent to explore and each point was further detail within the terms of reference:

- Whether Domestic Abuse, Cuckooing and Antisocial Behaviour were present and how they were assessed and addressed if so.

- Whether information was effectively shared between services.

- How domestic abuse perpetration was addressed.

- Whether domestic abuse was risk assessed collectively and by each agency.

- Whether the risk of suicide was considered within Denise's mental health intervention.

- Whether policies were followed, good practice was evidence and whether this review highlights a need for further training.

- The reports of antisocial behaviour received by all teams. How services collated and addressed this information collectively and considered domestic abuse within assessments and action plans.

- Whether attempts were made to engage Denise in domestic abuse support at all available opportunities.

- Whether services were aware of the extensive risk Denise was facing from Gary and whether there are mechanisms to ensure they can be made aware in future.

**7. Confidentiality and dissemination**

The findings of each review are confidential until such a time as the review has been approved for publication by the Home Office. Denise's mother and step father were provided a draft copy of the review but, aside from this, information was available only to participating professionals and their line managers. Consideration has been given as to the timing of publication and avoidance of sensitive dates.

**8. Methodology**

The agencies listed below submitted an Individual Management Review:

- Hertfordshire Police
- Adult Community Mental Health Service - Hertfordshire Partnership Foundation Trust (HPFT)
- Probation
- GP
- B3 Living Housing
- Antisocial Behaviour Team
- Refuge

The report is an anthology of information and facts gathered from:
- The Individual Management Reviews (IMRs)
- DHR Panel discussions
- Information from friends and family

**Involvement of family, friends, colleagues, neighbours and wider community.**

The chair sought to locate family and friends who were willing to shed light on the situation, give their perspective and provide insight into Denise and her life. Their contributions are below as is a pen portrait of Denise from combined contributions from family and friends.

The chair also reached out three former employers of Denise; two pubs and a children's nursery. None responded to communications.

Denise's mother was offered AAFDA[17] support but declined. Home Office information was provided. Support was also offered to other contributors to the review. Denise's mother and her partner offered this reflection after reading the draft report in February 2025:

*The fact that there are eleven lessons to be learned - caused by numerous serious mistakes by all involved, resulting in eight recommendations, of which two are of national importance, is very significant.*

*It seems all agencies, to a greater or lesser extent, followed procedure, with little or no professional curiosity. Had they 'read between the lines' of the case, this would have enabled them to see beyond the face value of the many events that led up to Denise's death.*

*More should and could have been done to ensure her safety. The use of the phrases 'lack of consent' and 'refused to engage' are in my opinion poor excuses for ignoring what were plainly her requests for help.*

*These failings are very worrying to us, because they have led us to believe that what happened to Denise could happen again - or could already be happening - to somebody else.*

*Had all involved been more diligent, communicated more effectively and shared information, I think it probable she would still be alive today.*

Consideration was given to involving Gary in this review, to aid future learning. Due to the potential risk Gary posed to others and a lack of information / current agency input to effectively risk assess his involvement, it was decided it was in the interest of public safety not to approach him.

**Pen Portrait of Denise.**

Denise grew up in the North West of England and was the second eldest child of four. At the age of 10, Denise's mother Sandra left the family home after experiencing domestic abuse including controlling behaviour from Denise's father over the previous ten years. The separation resulted in Denise remaining with her siblings in the care of her father. She was described as having a role akin to a guardian for her siblings. Child contact with her mother was eventually agreed via the courts, but the children experienced very different views of what had occurred from both parents. It was the view of one family member that Denise needed to lie to have a relationship with both parents with her father allegedly insinuating he would not have a relationship with her if she maintained contact with her mother. Her father was reportedly disparaging about her mother making various allegations such as her being dangerous, mentally unwell, accusing her of affairs and generally demonising her. Denise learned that to have a relationship with her father she needed to tell him what he wanted to hear. Her father reportedly did not

[17] Advocacy After Fatal Domestic Abuse

believe mental health issues were a real concept. It is unknown how influential this attitude was when Denise decided not to tell family about her own diagnosis in 2018.

Denise had ambitions to go into a childcare career. However, it was felt that when she entered relationships, she would put the partner and the relationship ahead of her own career. She was a caring and giving person, often to her own detriment. She was always keen to have a large family and wanted six children. This ambition appeared to impact on the length and sustainability of relationships as, once in them, Denise was reportedly keen to start a family and wanted to begin IVF at an early stage due to her fertility difficulties.

Denise was described as having periods of mental stability followed by periods where she would fall out with family and friends over seemingly innocuous comments or disagreements. Although these opposing ends of a spectrum were experienced by friends and family more frequently as she aged, it was not until she was told she would be unable to have children her unwell times became more accentuated. This impacted on Denise heavily as she had always wanted to be a mother. Denise had very little involvement with her family after 2019 due to multiple fall outs.

**Denise's mother (Sandra)**

Sandra described Denise as kind, fun, loving and generous; when she was well. She was musical, playing the piano and had an interest in sport, joining a rugby club when she moved to Hertfordshire. Denise would often put her own wants and needs to one side to support others. She was loved deeply by many including several longer-term friends and her mum was keen to remember the positive times, of which there were many. However, she also described the impact of Denise's periodic decline in mental health and how she could be cutting and hurtful towards people she cared about. She was described as "self destructive" and would regularly fall out with people and push them away, although Sandra felt she did not do this to her father through fear.

Sandra supported Denise to move down to Hertfordshire in 2017 to be closer to her sister who she had a positive relationship with. Denise and her sister lived together temporarily but this ended when her sister gave birth and Denise needed to relocate. Sandra saw Denise settle in Hertfordshire as she gained accommodation, a job and a mental health diagnosis of Emotional Unstable Personality Disorder (EUPD), something which was a relief to both Denise and Sandra. Despite the relief of having an increased understanding of her mental health, Denise reportedly did not want to tell her family about it. She told her mother, "I know I need to let people know" but swore her mum to secrecy. It was only recently at the coroner's inquest this diagnosis became clear to family.

In 2019 Denise fell out with Sandra for what would be the final time. Sandra said this stemmed from a comment she made about moving forward with her life and stepping back from relationships and a desire to have children. This was something Sandra had

seen Denise struggle with via IVF over many years. This upset Denise who asked her mum to leave. Denise did not respond to olive branches over the following years.

Sandra recalled Denise once saying, “If I can’t have a baby, what’s the point”.

Having read the report Sandra wished to add that Denise probably felt unable to tell her family about what was happening to her. She most likely would have worried about repercussions to them if they got involved and embroiling them in a complex and violent situation.

**Friend of Denise – James**

James met Denise in a Bishops Stortford pub in approximately 2017 after she had not long moved to Hertfordshire. Both he and two others befriended Denise and say they tried to assist her. James said it was clear early on from her demeanour she was vulnerable, needed help and found life challenging. He supported her with housing applications, managing her money and her universal credit application. At one point she stayed on James’ floor after she had to leave her prior accommodation.

When James first met Denise she was on crutches after severely injuring her leg playing rugby. At this time, she was a supervisor at a local pre-school nursery. James described her as caring, creative and the sweetest person when she was mentally well. She would take pride in creating displays for her pre-school children.

He also described her difficulties with mental health and how she could become aggressive as though “a switch had been flicked”. He described one occasion where Denise, 5ft in height, pushed a male, 6ft plus, onto the pool table in a pub and bit him.

After Denise’s employment ended with the nursery, James assisted her in gaining work with a local café for people with learning disabilities. She needed to leave after “exploding” whilst at work one day. James said similar behaviour happened without warning. Denise had issues with this friendship group and alluded to inappropriate sexual advances from each individual separately over time. This created barriers in her friendships and lead to people walking away from her.

James felt he had a good relationship with Denise and could often calm her. He was able to notice when her mood and behaviour were becoming heightened. He described boisterous mannerisms such as increased swearing and agitation, but he could often support her to find balance.

Denise was open about her mental health and was well versed with her diagnosis. In the first two years of knowing Denise he felt both he and his friends helped save Denise’s life from suicide on four occasions. This was often via drug overdoses. Denise was described as fairly secretive about suicide attempts. She once described to James three-year cycles where she would feel “fine, get a job, become settled, get ill and then life would be a mess again”.

Although Denise didn't speak much about life prior to her move to Hertfordshire she said her relationship with her mother was very difficult and didn't get on with her dad although spoke in more positive terms about one of her grandmothers. She never provided James context for this.

**Discussion with childhood friend Fran**

Fran was a childhood friend of Denise, having met her at school aged 11. She described her as happy, bubbly and outgoing. She recalled her love of dancing and singing and said they were always dancing together. If Denise hadn't gone into the childcare profession she thought she would be a dance teacher although she suffered a leg injury which hampered this ambition. Neither Fran nor Denise were "girly girls" and described themselves as 'tomboys' although would still like to do more feminine things such as makeup and hair styling nights in. Despite Denise's outwardly bubbly persona Fran was aware of her difficult homelife. She said she was present once where Denise's dad kicked the door in and "pasted" her mother Sandra. Fran said there was a lot of violence in Denise's home. Aswell as domestic abuse from her father to her mum, one of Denise's younger brothers struggled to manage his behaviour. She did not recall Denise ever having therapy for her experiences but could not be entirely sure. Fran described Denise as "masking" much of the time.

Fran recalled how Denise would fall for people very quickly in a relationship context. She said she would attach herself and change her behaviour to fit into their lives. She gave an example of Denise having no interest in football but then expressing a love for it if her partner at the time did. She described her as "placing herself into their lives" and wanting to spend all of her time with them. She said she craved male attention and would spend a lot of time around men. Fran had conversations with Denise about her relationships when Denise spoke of abusive behaviour she had experienced. She said she was aware of the cycle of abuse, e.g she experienced an abusive behaviour, there would be an apology, and the cycle would begin again. Although "she knew it wasn't right" this pattern had become normal to her.

Fran informed the review that Denise had several abortions in one of her first long term relationships. Fran feels she was manipulated into doing this by her partner at the time. When she later experienced fertility issues, she blamed herself saying it was due to her having these abortions.

Over the years Fran and Denise's contact reduced after a disagreement which occurred after Fran had given birth to her first child. But they remained in contact on and off. Fran recalled, in the lead up to Denise's move to Hertfordshire in 2017, Denise had experienced much sadness around relationships and life not moving in the direction she had hoped. She seemed much happier in the 6 months post move and there was the perception it was working out for her. This appears to fit with Denise's outwardly happy appearance when this may not have been the case inwardly.

The friends had relatively little communication until June 2023 when Denise visited Fran in Lancashire from Hertfordshire. She messaged 2 days before her visit and spent the

day with her. Fran said Denise loved face to face contact with people and didn't overly care for communication via other methods. She told Fran she had made a lot of friends in Hertfordshire but her ex partner was not leaving her alone and was stalking her. She said she had changed her phone number and blocked him but he was not taking the message. He had previously moved in and was refusing to move out. Denise also mentioned having been "sectioned" previously and said that it had probably been the right decision to do so as she had struggled with her mental health at points.

Fran said Denise's suicide came out of the blue which contrasts with other contributors to this review.

**9. Equality and diversity**

Section 4 of the Equality Act 2010 defines protected characteristics as:

- Age
- Disability
- Gender reassignment
- Sex
- Sexual orientation
- Marriage and civil partnership
- Pregnancy and maternity
- Race
- Religion or belief

Those considered relevant to this review are:

**Sex** - In considering the above characteristics the panel felt sex was a significant factor. Domestic abuse and domestic homicide are crimes that disproportionately affect women. Women make up the majority of victims and with the majority of perpetrators being male. For the year ending March 2023, the Crime Survey for England and Wales (CSEW) estimated that 1.4 million women and 751,000 men aged 16 years and over experienced domestic abuse in the last year. This is a prevalence rate of approximately 6 in 100 women and 3 in 100 men. [18]This fact does not diminish the importance of addressing same sex domestic abuse, familial abuse or any other form of domestic abuse but is important to consider and is relevant to this review.
Furthermore, in a review of the 32 published Domestic Homicide Reviews (DHRs) where a victim had taken their own life, 25 of the 32 victims were female. [19]

**Pregnancy and maternity –** As the panel received information from family and friends it became clear Denise was keen to have a family but was unable due to fertility complications. Her mother informed the review she sought IVF treatment and this

[18] Domestic abuse victim characteristics, England and Wale s - Office for National Statistics (ons.gov.uk)
[19] 999368 Law_Domestic Violence MAIN Research Report Final FINAL PRE-PRINT.pdf (aafda.org.uk)

shaped some of her intimate relationships. Although this was not disclosed to agencies, to the knowledge of this review, it is an important and significant point when considering the impact of this on Denise's mental health, risk of suicide and her hopes for the future.

**Disability** - The panel felt it important to consider Denise's mental health within their equality and diversity discussions. She had care provision in place in relation to her diagnosis of EUPD, a condition which was long lasting, had been diagnosed for over 12 months and significantly impacted on her. This had implications when considering local authorities' duties to assess people's care and support needs under the Care Act 2014[20]. The safeguarding duties within this act are relevant for those who:

- Have need for care and support (whether or not the local authority is meeting any of those needs)
- Is experiencing, or at risk of, abuse of neglect.
- As a result of those care and support needs is unable to protect themselves from either the risk of, or the experience of, abuse or neglect.[21]

**Age and Race** – Denise was in her mid / late 30's at the time of her death and was white British. Neither of these factors were deemed to be relevant for the review to explore in additional depth.

## 10. Conclusions

### Conclusions

Anti-social behaviour (ASB) is a somewhat vague term which can encompass a variety of behaviours and causes. Taken from the Crimestoppers website, the following excerpt demonstrates several behaviours which could be domestic abuse:

***What is anti-social behaviour?***

*Acting in a manner that has "caused or was likely to case harassment, alarm or distress to one of more persons not of the same household as the perpetrator." Crime and Disorder Act 1998*

*Anti-social behaviour is a wide range of unacceptable activity and includes things like:*

[20] 43380_23902777_Care Act_Book.indb
[21] Gaining access to an adult suspected to be at risk of neglect or abuse - SCIE

- *Noise (including loud music, banging, DIY at unsocial hours, loud parties, frequent visitors at unsocial hours.)*
- *Shouting, swearing and fighting*
- *Intimidation, harassment and verbal abuse*
- *Driving in an inconsiderate or careless way (for example drivers congregating in an area for racing / car cruising*
- *Dumping rubbish*
- *Animal nuisance, including dog fouling and dog barking*
- *Vandalism, property damage graffiti*
- *Anti-social drinking*
- *Arson*

Therefore, it is essential for services tasked with reducing ASB to have a thorough awareness of domestic abuse (DA) and know how to address it effectively. It is highly likely they will encounter reports of DA within their antisocial behaviour interventions. As the terms of reference highlighted, this extends to cuckooing and other types of abuse. If tenants are being abused or exploited their ability to reach out for support can be significantly hindered. It is important for services to remember: they may be the tenant but that does not mean they are not a victim of abuse or exploitation. Viewing them as the perpetrator of ASB or responsible for the behaviour will likely hinder effective efforts to tackle root causes.

Taken from the Journal of Gender Studies, the following paragraph succinctly summarises this issue: *How vulnerability is generally viewed in ASB policy and practice is important to understanding the experiences of women alleged to be engaged in ASB, as how vulnerability is understood by institutions can impact how services choose to act.*[22]

Under the Antisocial Behaviour, Crime and Policing Act 2014[23] powers are provided to the police, local authorities and other local agencies to respond quickly and effectively to antisocial behaviour. The panel felt the necessary legislation was in place.

One ambiguous term reported by neighbours was “shouting” emanating from Denise’s address and arguing was mentioned several times within the Police Individual Management Review (IMR). Residents who are not versed in agency terminology may phrase abuse in such terms, so it is essential for services to collaborate and analyse them in further depth with a domestic abuse lense.

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[22] Cameron, K. (2024). ‘I feel so trapped’: women’s experiences of antisocial behaviour intervention in social housing. *Journal of Gender Studies*, *34*(1), 96–108. https://doi.org/10.1080/09589236.2024.2315047

[23] Antisocial behaviour: guidance for professionals - GOV.UK

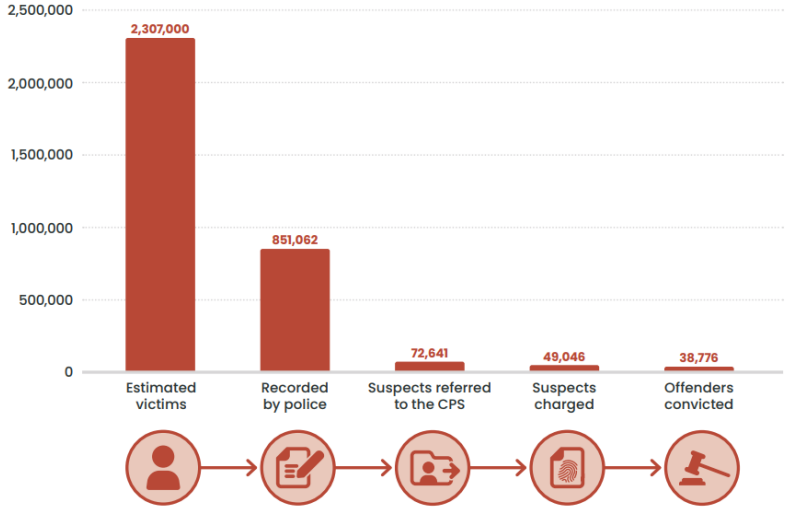
Within the chronology there was a sharp change in resident's reporting patterns relating to Denise's address from November 2022. These initially concerned many "comings and goings", dangerous driving, slamming doors and issues considered nuisance or noise disturbances before quickly evolving into alleged drug dealing and drug usage. This highlights a need for agencies to consider enhanced pattern recognition within their discussions and analysis. For example, what lead to the sharp change in behaviours and reports in November 2022?

Denise disclosed abusive behaviour to the ACMHS on several occasions. They were available to receive this information quickly due to their persistent support and monitoring. The chronology highlights a flexibility from this team evidenced by a use of texting, calling, scheduling future calls despite missed appointments, physically attending Denise's address and alerting the police if they had concerns for her welfare. It is highly likely Denise's experiences would have remained hidden to the partnership had the ACMHS not tried to support her over several years. Therefore there would have been no agency to provide the insight the ACMHS did nor refer for a statutory review.

Neighbours persisted in providing helpful and relevant information to agencies concerning behaviours emanating from Denise's address aswell as a vehicle registration plate linked to Gary. Police held information about Gary's previous domestic abuse related behaviour and a historic concern about him potentially cuckooing an address. B3 Housing, ACMHS and the Police were aware of Denise's previous experiences of abuse in relationships and her vulnerability due to mental health concerns. Therefore, early on in the couple's relationship, concerns were not necessarily hidden from view. The crumbs of concern were evident with pieces of the puzzle held by each agency. Joined up working with a domestic abuse lense could well assist in drawing these concerns together in the future. This would in turn help tackle the ASB more effectively. This thinking or discussion was not evident in any agency interactions from at least November 2022 to July 2023.

Probation have been part of this panel as they were aware of Gary for a significant period of the scoping timeframe. At no point were they aware of Denise. Despite Denise's situation not reaching the ASBAG it does highlight a need for probation to be included and invited in the future. Much of Gary's history which has been analysed as part of this review had not been disclosed to probation prior to this panel. Subsequently probation have reassessed Gary's risk level from medium to high risk. This highlights an issue. It is extremely difficult for probation to effectively safeguard the public without having a thorough understanding of someone's offending history. The nature of domestic abuse means it will always be likely allegations do not reach the point of conviction, thus not appearing on certain police checks. This is evidenced by the Crime

Survey of England and Wales which estimates 2.3 million people experienced DA in the year ending March 2024. Yet Police recorded 851,062 domestic abuse related crimes and there were 49,046 prosecutions. Based on these statistics it is apparent that to effectively analyse ones offending history, convictions alone will not provide a complete picture, as the graphic from the Domestic Abuse Commissioner's Shifting the Scales report highlights:




Denise clearly had mental health struggles as the background information shows. She was at higher risk than most of suicide as she had commented in early 2020 how increasingly comfortable she was with the notion of ending her life. She had previously commented to her mother there was no point in living if she couldn't have children. However, this should not diminish the importance of understanding the impact of the abuse and exploitation she experienced from November 2022 onwards. The threats to expose explicit videos, of repercussions from Gary's associates / his insinuated links to gangs, not letting her go, stalking, manipulation and more will have likely eroded her hope for the future and self worth. More than once she told the ACMHS she needed to leave her home address and she was in a situation she was struggling to get out of.

Domestic abuse played a role in most of Denise's life, from childhood with the experience of her parent's relationship, to multiple partners with allegations of domestic abuse including sexual abuse. These experiences will have shaped her expectations and beliefs of intimate and familial relationships and required in depth therapeutic input with this lense to help her understand it. This was suggested at various times by the ACMHS but it appears Denise declined and / or became heavily reliant on one care co-ordinator which disrupted her motivation and engagement. When they went on long term sick this left Denise feeling as though she did not have any support and she voiced a frustration with having to repeat her story. There is a lesson here for services to understand and utilise someone's organic support network, focus on increasing their independence and involve third sector organisations where

necessary who can broaden their network and reduce their reliance on one particular person. MIND and Newleaf College were suggested but at the point they were considered, Denise clearly had many other complications in her life. It appears Denise's reliance reduced her independence and as the ACMHS IMR stated: *a lot of the interventions provided by ACMHS were tasks that Denise used to do independently. An integral part of social work is to enable individuals by maximising an individual's independence. This requires a preliminary discussion about professional and service boundaries. NICE guidance[24] has a piece on promoting independence through intermediate care. The concept is for the social worker and service user to identify the support that required, a time frame and specific goals. In theory, this way of working builds an equal partnership, improves motivation, focuses on strengths, and builds confidence."*

The possibility of Gary cuckooing Denise was identified as a term of reference to explore at the beginning of this review. The review has outlined behaviours akin to exploitation and coercion of Denise. The panel do not feel the circumstances as they are now known amount to cuckooing. However, when someone is coerced into behaving in a particular way one could argue their ability to "allow" someone into their home is compromised and therefore it is quite possible Denise felt under duress to allow drug dealing from her address. She stated more than once she feared repercussions from the gang Gary was allegedly involved with. In a conversation between the ACMHS and Police it was noted *"Gary has been known to text Denise pictures of herself whilst she was in town saying "I have eyes everywhere"' – This is Denise's main concern; that if she left him, she would never really be free, and she'd never be able to do anything without being monitored by his associates."*

Significant work has taken place in Hertfordshire around cuckooing in recent years with the Safeguarding Adults Partnership Board agreeing for all agencies to use the Oxford City definition of cuckooing:

"*Cuckooing is a practice where people take over a person's home and use the property to facilitate exploitation. It takes the name from Cuckoos who take over the nests of other birds."*

*How one knows whether a home has been taken over is contentious. If one is made to feel they are loved and cared for whilst also feeling intimidated and threatened to comply, they may appear to the outside world as being complicit in the activity relating to their address.*

[24] Promoting independence through intermediate care | Quick guides to social care topics | Social care | NICE Communities | About | NICE

Regardless of whether this was or was not a cuckooing case there is clear learning. Agencies tasked with tackling ASB must be aware of the potential for abuse to be a cause of the ASB if they are to address it effectively. That can only happen with the right services sharing information in a timely fashion whilst considering the possibility the tenant may be experiencing abuse or exploitation.

## 11. Key findings and lessons to be learned

*Please note, where ASBAG (Anti-Social Behaviour Action Group) is mentioned, it is acknowledged this is a local forum specific to Hertfordshire. Multi agency forums tasked with tackling ASB exist under different names in other counties. This learning should be utilised in all forums tasked with addressing ASB.*

### Lesson 1 – ASBAG representation and information sharing

Narrative

To address antisocial behaviour effectively services need to see the whole picture and understand in greater detail the patterns of behaviour and reasons for it. There is an increased risk of exploitation for those with physical / mental health concerns. Recognising vulnerabilities is crucial so more punitive approaches are not the only strategy considered. Denise was known to have experienced domestic and sexual abuse aswell as having a care co-ordinator due to her mental health diagnosis meaning a heightened risk of exploitation.

Lesson to be learned

The Anti Social Behaviour Action Group (or equivalent named multi agency group) must ensure there is a full representation from services who are likely to be involved with their residents. These include but are not limited to GPs, Probation, CGL and the Adult Community Mental Health Team. This does not necessarily mean they must be present at these meetings as capacity has been cited as an issue within this review, but there must be exploration of case lists shared to ensure vital information is not being missed.

### Lesson 2 – ASBAG awareness amongst the partnership

Narrative

To best utilise forums such as ASBAG services must be aware of its existence and its threshold for hearing and accepting cases. Despite the numerous contacts with a variety of services from Nov 2022 – Jan 2023 especially, there was no referral to this forum.

Lesson to be learned

ASBAG should be promoted and thresholds explained within all responsible bodies:

- Councils.

- Police.
- Integrated Care Boards in England and Local Health Boards in Wales.
- Registered providers of social housing who are co-opted into this group.

**Lesson 3 – Pattern recognition and analysis**

Narrative

In November 2022, there was a shift in the type and frequency of reports relating to Denise's address. The details of a new car and person associated with this car were seen and passed to the police by a resident.

Lesson to be learned

To better understand the reasons behind ASB, pattern recognition plays a vital role. Services should explore patterns of behaviour before and after they receive complaints. Underlying causes such as domestic abuse, cuckooing activity and other forms of abuse should be considered therefore increasing the chance of effectively addressing the ASB.

**Lesson 4 – Domestic Abuse risk assessment within the Adult Community Mental Health Service (ACMHS)**

Narrative

Within this DHR / DARDR the ACMHS were told on a number of occasions about domestic abuse from Denise. Throughout their intervention no domestic abuse risk assessments were completed. It is acknowledged much training has occurred within this service to improve their response which could be further enhanced by adapting recording systems to embed consideration of DA risk assessment.

Lesson to be Learned

Adult Mental Health Services could further embed their work around DA awareness and assessing risk by requesting an adaption to their recording systems to include consideration of domestic abuse risk assessments. The HPFT are intending on developing a trust wide DA strategy.

**Lesson 5 – Police research**

Narrative

To "relentlessly pursue perpetrators of domestic abuse", as the national police chief's council (NPCC) has stated as an intention in July 2024[25], all available information must be analysed. There has been no evidence brought to this review that all available information in relation to Gary was gained, analysed or shared as necessary and the NPCC's intention should be reflected in future practice.

[25] NPCC Call to Action

Lesson to be learned

To effectively tackle ASB and safeguard those at risk of exploitation the police must check all available information to build an accurate profile of the alleged perpetrator. This helps inform risk assessments not just for the police but for all agencies and ultimately helps safeguard those at risk.

**Lesson 6 – Tech abuse**

Narrative

Denise disclosed threats from Gary to disclose intimate images (para 3.59) of her which is a criminal offence[26]. This instills fear and is a control tactic. There is no evidence to suggest this was made clear to Denise at the time of her disclosure.

Lesson to be learned

Tech abuse is an evolving type of abuse which services need to stay upto date with. It is important for frontline professionals to have regular input on this subject, for example – briefings and training which include updated information on tech abuse. The Partnership should utilise their learning event to publicise guidance around threats to share photos / images such as Information and support on tech abuse | Refuge Tech Safety. Guidance should reference updates to law and links for further help and support. This guidance should be owned by the relevant subgroup to ensure it remains upto date and reviewed at regular intervals.

**Lesson 7 – ASB Warning Letters**

Narrative

ASB warning letters are often used by housing providers to raise awareness of ASB related concerns. These letters are typically sent to those whose address ASB is believed to be emanating from. This is one of the initial steps taken by many housing providers in an attempt to prevent a reoccurrence of ASB. It is important to ensure the possibility that the recipient(s) of the letter may be being exploited so the tone and wording of the letter should be considered carefully. For individuals such as Denise, knowing they can reach out for specific support who will understand their set of circumstances (e.g coercive control, intimidation, exploitation etc) could prove valuable.

Lesson to be learned

Housing providers and any organisations sending ASB warning letters or similar should ensure their ASB warning letters consider the possibility of the recipient(s) being exploited. They should consider the tone and wording of such letters and include the relevant support services within to enable residents to reach out for support.

[26] Threats to disclose private sexual photographs and films - GOV.UK

**Lesson 8 – ASB Warning Letters – Agency awareness**

Narrative

In Jan 23 Denise informed her ACMHS worker she had received an ASB warning notice. This would have indicated her tenancy was potentially at risk if issues continued. Homelessness can exacerbate mental health concerns and therefore it is within the remit of agencies such as this to link in with Housing, ASB Services, Police should they become aware of such issues.

Lesson to be learned

The receiving of an ASB Warning Letter indicates someone's tenancy may be at risk and there are issues affecting their neighbours which they are deemed responsible for. Should services become aware of such a letter this should lead to them contact their partners within community safety teams to enable them to see the bigger picture and have a person centred approach to problem solving.

**Lesson 9 – Abortion Services**

Narrative

Abortion services – It is suggested from Denise's friend she was coerced into having several abortions and then blamed herself when she later faced fertility problems.

Lesson to be learned

Abortion services can utilise learning from this review to ensure they have signage and opportunities for disclosures available at all points.

**Lesson 10 – Language**

Narrative

At points during the scoping period it was evident services struggled to engage Denise. It is important for service to be mindful of using phrases such as "refusal to engage" as this suggests an individual has complete autonomy over their choices.

Lesson to be learned

All safeguarding leads to ensure training and policies are updated to reflect harmful language in record keeping. For example "refusal to engage" should not be used as some people are unable to engage for a range of reasons including trauma.

**Lesson 11 – Consent for safeguarding referrals**

Narrative

On more than one occasion (para 3.59) a safeguarding episode was closed by the Adult Mental Health Team but closed with a reason for closure cited as Denise not wanting any further actions. It if it felt someone's choice is compromised, for example, they are experiencing coercive control, consent can and should be over-ridden.

Lesson to be learned

Where there is suspected coercive control, consent for safeguarding referrals should be over-ridden. This should be included in policies and training. Professionals responsible for responding to safeguarding referrals should consider proceeding to a formal safeguarding enquiry when there is coercive control but no consent.

**Lesson 12 - Consent to share reports of ASB within the CSP**

Narrative

As reflected in ToR 4.3 p.33, In relation to para 3.39, the CSP have typically asked the individual reporting ASB for their consent to share the details with other agencies. This had been to ensure reporting victims of ASB felt supported and listened to. Upon reflection it was felt this is an unnecessary barrier.

Lesson to be Learned

The CSP feel they should be sharing information in the first instance but withhold personal information of the reporting person until consent is recorded.

**Lesson 13 – Probation and Police information sharing**

Narrative

During this review the information shared about Gary lead to Probation re-evaluating their risk assessment of him. It should not require processes such as this to ensure Probation have the necessary information to risk assess and safeguard effectively. The chair has liaised with the Police and Probation on this issue which is also of national importance. There is an intention to implement an intelligence hub locally to allow Probation staff to have direct access to information. It is also necessary to ensure licence conditions[27] are uploaded to the police system to enable agencies to take swift action incase of breach.

Lesson to be learned

Information sharing to better understand the risk posed by an individual is essential. Probation and the Police are key criminal justice partners tasked with safeguarding the public. Their information sharing protocols, processes and practice must reflect this.

## 12. Panel Recommendations

**NATIONAL**

**Recommendation 1**

[27] Licence Conditions and how the Parole Board use them - GOV.UK

The Home Office's ASB statutory guidance to include sections on cuckooing, domestic abuse and other forms of exploitation to ensure there is consideration of the presence of these issues within ASB intervention.

**Recommendation 2**

Further to National Recommendation 1, the statutory guidance should re-enforce the legislation available to share information between services to assess and reduce risk. It is vital for services tasked with protecting the public to have confidence in sharing all relevant information to illuminate patterns of behaviour to prevent future harm.

**LOCAL**

*Please note, where ASBAG (Anti-Social Behaviour Action Group) is mentioned, it is acknowledged this is a local forum specific to Hertfordshire. Multi agency forums tasked with tackling ASB exist under different names in other counties. This learning should be utilised in all forums tasked with addressing ASB.*

**Recommendation 1**

For the ASBAG to review it's attendee list and ensure there is representation from services likely to encounter their residents, at least when the service is working with an individual named on the forthcoming agenda. Services should commit to reviewing their records and confirming whether someone has been known or is currently known to them. Services must commit to attending any required professionals meeting in respect of their clients to inform future working.

**Recommendation 2**

Services who are likely to encounter those involved in ASB must be aware of ASBAG, what it means, what happens at this forum and how they can contribute. Therefore, the co-ordinator of the ASBAG, in this case East Herts Council, should be promoted locally to enhance local understanding. Partner agencies should promote awareness and understanding of ASBAG within their own organisations and their professional networks.

**Recommendation 3**

To effectively tackle ASB, Police must utilise all available information and check all systems, not just PNC to build an accurate profile of the alleged perpetrator.

**Recommendation 4**

ACMHS to consider inclusion of a prompt on their recording system to further enhance their response to domestic abuse for example: *Has a DA risk assessment been completed? Yes / No. If not, please explain rationale*. This could be introduced alongside further training.

**Recommendation 5**

The ICB to work with Commissioners to ensure abortion services are providing domestic abuse training to staff to include training around coercion and control, risk

management, routine screening for domestic abuse and clear signposting incorporated in to their policies.

**Recommendation 6**

The CSP identified an unnecessary barrier to information sharing (see para 3.39) where they would not share information about ASB without the reporting person's consent. This can add another step in the ladder making it more complicated to share information effectively. The CSP to review their information sharing processes to ensure it is as efficient as possible.

**Recommendation 7**

For Probation and the Police to continue to ensure their information sharing processes, protocols and practice are robust and allow all relevant, available information to be shared. A fundamental consideration is that domestic abuse often does not make it to conviction level which means allegations and 'no further actions' held on the national database and intelligence systems should be assessed for sharing to enable robust risk assessment and safeguarding actions.

**Single Agency Recommendations**

**Hertfordshire Partnership Foundation Trust - (Adult Community Mental Health Service)**

**Learning Theme 1**

Training to support better understanding of the MARAC process, DASH and the roles of MARAC representatives and agency responsibilities.

HPFT Safeguarding Leads to review existing internal Domestic Abuse training, include addressing how other intersecting needs and characteristics that can heighten risk. Review how training is delivered to improve efficacy and impact.

**Action to achieve theme**

HPFT Safeguarding team to review existing Domestic Abuse training packages in light of learning from DHR.

HPFT Safeguarding Team will explore with Trust People & Organisational Development colleagues whether it is feasible to make DA training compulsory

**Learning Theme 2**

ACMHS teams to continue to support all clinical staff to attend suicide risk training and for attendance to be monitored.

**Action to achieve theme**

Learning from review to be shared via Division QRM

**Learning Theme 3**

Training and structured supervision to reinforce the importance of strength -based interventions.

**Action to achieve theme**

HPFT Safeguarding Team to link in with existing workstreams around Strengths Based Practice. Learning from this review to be shared.

**Learning theme 4**

A continuation of regular decision-making audits of safeguarding adults' documents

**Action to achieve theme**

Audit schedule to be finalised for 2025.

**Learning theme 5**

Findings from this review will be shared with the clinical director who leads on suicide prevention. Feedback about the risk assessments may be considered in future training and development processes. This aims to ensure that risk assessments are up to date and easily accessible.

**Action to achieve theme**

Learning from review to be shared with clinical director leading on suicide prevention and Risk assessment CQI

**B3 Living Housing**

**Learning theme 1**

Newly appointed Neighbourhood Manager to review tenancy management processes including ASB and Domestic Abuse.

**Action to achieve theme**

Review in process. Draft policy and process awaiting approval. Subsequent roll out of training to all relevant staff and monitoring

High risk cases to be assessed and managed by Neighbourhood & ASB Manager in first instance.

Support Services to be contacted at the earliest opportunity

**Learning Theme 2**

Domestic Abuse Awareness Training to be arranged

**Action to achieve theme**

Housing Manager to arrange training for all front-line staff at B3 Living

**East Herts District Council - Community Safety (including Anti-social Behaviour and Environmental Health teams)**

**Learning Theme 1**

To strengthen information sharing between EHC Community Safety and Environmental Health (Nuisance) teams for cases due to separate recording systems.

**Action to achieve theme**

Develop a process to notify each team where addresses / persons are known.

**Learning Theme 2**

To remind all partners of the importance of multi-agency working and referring into ASBAG in a timely way.

**Action to achieve theme**

To ensure that agencies within the CSP are aware of the importance in referring cases to ASBAG. To ensure that new Housing Providers to the district receive relevant information.

**Learning Theme 3**

To produce an ASB Policy and Procedure for internal use within the Community Safety Team and cross reference it with existing Environmental Health policies and procedures.

**Action to achieve theme**

To create an ASB Policy and Procedure for East Herts Council Community Safety use.

**Learning Theme 4**

To include support services advice within a 'Subject Letter' issued by Environmental Health in response to evidence of perpetrating nuisance (as defined by Environmental Health legislations) where the case could indicate possible DA at the address.

**Action to achieve theme**

Officers who respond to initial nuisance complaints to utilise pre-agreed wording and signposting advice to include with letters as appropriate

**Learning Theme 5**

To ensure detailed DA training and advice is provided to staff within East Herts Council so that they can be confident in spotting the signs and raising with safeguarding leads.

**Action to achieve theme**

To provide frontline staff with more detailed information on 'spotting the signs' of DA, in addition to the inclusion of DA in mandatory safeguarding training, and encourage professional curiosity.

**Learning Theme 6**

For the CSP to continue to strengthen links with DA support services such as Safer Places

Action to achieve theme

To invite specialist services to provide guest presentations or attend community events. To promote national campaigns such as White Ribbon week.

**Refuge**

**Learning Theme 1**

Refuge to develop good practice guidance on reaching people with multiple disadvantage to access community based services.

**Action to achieve theme**

1. Hold an EDI focus group with services at Refuge to gather current good practice and areas for improvement
2. Write good practice guidance on reaching people with multiple disadvantage
3. Disseminate good practice guidance to services via services information channel and through operational managers meetings and then individual team meetings.

**GP**

**Learning Theme 1**

Improve documentation and recording in relation to domestic abuse risk.

**Action to achieve theme**

To use clinical templates which allow abuse to be flagged on the clinical system alerting future clinicians and reception staff to this risk

**Learning Theme 2**

Training to improve response to domestic abuse, suicide risk and mental health.

**Action to achieve theme**

Ensure all staff clinical and non-clinical have completed relevant safeguarding training

**Learning Theme**

Communication

**Action to achieve theme**

Improvement in communication and updates between organisations