

Domestic Homicide Review  
(Domestic Abuse Related Death Review)

Denise – 2023

East Herts Community Safety Partnership

Chair and Author: Christian Brazier

Date of completion: 15<sup>th</sup> March 2025

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## Glossary:

Acronym	Name
ACMHS	Adult Community Mental Health Service
ASBAG <sup>1</sup>	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 <sup>2</sup>
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

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<sup>1</sup> 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.

<sup>2</sup> [Herts and West Essex ICS](#)

### **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 Mum 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*

**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.

## **Section One**

### **Summary of Circumstances leading to the review:**

- 1.1.1 Denise (pseudonym) was found deceased in her flat in November 2023. She had ended her life via hanging.
- 1.1.2 She was known to agencies such as the Adult Community Mental Health Service (ACMHS), B3 Living Housing Association<sup>3</sup> and the Police amongst others. Domestic abuse concerning her most recent partner had been highlighted as a concern in the months leading up to her death. Antisocial behaviour<sup>4</sup> emanating from Denise's address from November 2022 onwards is a key feature of this review.
- 1.1.3 In addition to agency involvement, the review will examine the past to identify any relevant background information prior to Denise ending her life, whether support was accessed within the community and whether there were any barriers to accessing support. By taking a holistic approach the review seeks to identify appropriate solutions to make the future safer.
- 1.1.4 The panel decided to explore agency involvement with Denise and her most recent partner Gary (pseudonym) from 3<sup>rd</sup> June 2021, the date Denise began her tenancy with B3 Living, to the estimated date of death 23<sup>rd</sup> 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.
- 1.1.5 The key purpose for undertaking Domestic Homicide Reviews / Domestic Abuse Related Death Reviews is to enable lessons to be learned. In order for these lessons to be learned as widely and thoroughly as possible, professionals need to understand fully what happened in each homicide / victim suicide, and most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future.

### **Reasons for Conducting the Review**

- 1.2.1 The Domestic Homicide Review was commissioned by the East Hertfordshire Community Safety Partnership following a referral from the Adult Community Mental Health Services within the HPFT. It was carried out in accordance with the statutory requirement set out in Section 9 of the Domestic Violence, Crime and Victims Act 2004.
- 1.2.2 The review must, according to the Act, 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:

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<sup>3</sup> [B3Living](#)

<sup>4</sup> [Understanding Antisocial Behavior: A Detailed Guide | Crimestoppers](#)

- a) A person to whom he was related or with whom he was or had been in an intimate personal relationship, or
- b) A member of the same household as himself, held with a view to identifying the lessons to be learnt from the death.

1.2.3 Within Section 18 of the 2016 Multi Agency Statutory Guidance for the Conduct of DHRs, 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.”<sup>5</sup>*

Due to the knowledge Denise had been in a recent abusive relationship prior to her death or at the time of her death, it was deemed appropriate to commence a review in order to learn valuable lessons.

1.2.4 The purpose of the DHR is to:

- Establish what lessons are to be learned from the Domestic Homicide / Victim Suicide regarding the way local professionals and organisations work individually and together to safeguard victims.
- 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 those lessons to service responses including changes to policies and procedures as appropriate
- Prevent domestic abuse related deaths and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working.
- Contribute to a better understanding of the nature of domestic abuse.
- Highlight good practice.

## **Timescales**

1.3.1 Hertfordshire County Council were notified of Denise’s death on the 7<sup>th</sup> December 2023 by the Adult Safeguarding Team in Hertfordshire.

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<sup>5</sup> [DHR-Statutory-Guidance-161206.pdf \(publishing.service.gov.uk\)](#)

1.3.2 On the 15<sup>th</sup> December 2023 the Community Safety Partnership decided the criteria had been met to conduct to a Domestic Homicide Review / Domestic Abuse Related Death Review.

1.3.3 The Home Office were notified of this decision on the 20<sup>th</sup> December 2023.

1.3.4 A chair / author was appointed on the 6<sup>th</sup> June 2024. The delay was due to the volume of local reviews and availability of chairs.

1.3.5 Meetings were held via Microsoft Teams on:

Initial Panel Meeting	-	Monday 5 <sup>th</sup> August 2024
Panel Meeting 2	-	Monday 21 <sup>st</sup> October 2024
Panel Meeting 3	-	Thursday 14 <sup>th</sup> November 2024
Panel Meeting 4	-	Monday 9 <sup>th</sup> December 2024
Panel Meeting 5	-	Monday 27 <sup>th</sup> January 2025

Individual meetings were held with services separately outside of these meetings as required.

### **Confidentiality**

1.4.1 The findings of each review are confidential until such a time as the review has been approved for publication by the Home Office. Information is available only to participating professionals and their line managers.

1.4.2 To protect the identity of the deceased and her family, pseudonyms have been chosen for all parties involved. These were chosen by the chair who consulted with Denise's mother.

### **Terms of Reference (ToR)**

1.5.1 At the initial panel meeting on 5<sup>th</sup> August 2024 panel members were asked to consider which points required in depth exploration and analysis. These are detailed below with a further breakdown provided in Appendix A. It is also used as the basis for the analysis in Section 4. 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.

- 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.

1.5.2 Key lines of enquiry were identified as follows:

- 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.

## **Methodology**

1.6.1 It was agreed for information to be sought from:

- Organisations who had contact with both Denise and Gary.
  - Families, friends, neighbours of Denise
  - Any other specialist services deemed appropriate by the panel
- To review current roles, responsibilities, policies, and practices in relation to victims of domestic abuse (with specific consideration of coercive control, economic abuse and stalking) – to build up a picture of what should have happened
  - To review this against what happened to draw out the strengths and areas for improvement.
  - To review national best practice in respect of protecting adults from domestic abuse.
  - To draw out conclusions about how organisations and partnerships can improve their working in the future to support victims of domestic abuse.

## **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 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 multiple lessons to be learned - caused by numerous serious mistakes by all involved, resulting in numerous 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.

#### 1.7.1 **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 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.

#### 1.7.2 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.

### 1.7.3 **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.

#### 1.7.4 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.

### **Contributors to the Review**

- 1.8.1 Those agencies contributing to the review did so under Section 2 (4) of the statutory guidance for the conduct of DHRs. It is the duty of any person or body participating in the review to have regard for the guidance.
- 1.8.2 All individuals interviewed by the Chair were made aware of the aims of the DHR and referenced the statutory guidance.
- 1.8.3 The following agencies contributed to the review:

<b>Name</b>	<b>Organisation</b>	<b>Job title</b>
Christian Brazier	Independent	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 Operation 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

- 1.9.1 Many of the agencies were contacted separately via e-mail to clarify points or had separate video call meetings to talk through pertinent issues. All IMR (individual

management review) authors and panel members were independent and not directly involved in direct case management.

### **The Author of the Overview Review Report**

- 1.10 This report is chaired and authored by Christian Brazier. He is independent of all statutory and non-statutory services of Hertfordshire County Council and has never had contact with the family prior to this review.

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. Following this he worked for the national domestic abuse organisation Respect as a Drive Practice Advisor - high risk domestic abuse intervention, and later as a Make A Change practice lead - an early intervention domestic abuse intervention. Here he created tools and workshops for friends, family and colleagues who might be concerned about people using harmful behaviour towards their loved ones. He is an associate trainer for the national domestic abuse charity Safelives facilitating their high harm perpetrators and MARAC sessions as well as their Engaging Those Who Use Harm training. Christian attended the Advocacy After Fatal Domestic Abuse Chair's Training in January 2023 and completed the Home Office DHR / DARDR qualification in September 2024. He qualified as a journalist in 2013.

### **Parallel Reviews**

- 1.11.1 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.
- 1.11.2 The coroner's inquest concluded death by suicide.

### **Equality and Diversity**

- 1.12.1 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:

1.12.2 **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. <sup>6</sup>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. <sup>7</sup>

1.12.3 **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 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.

1.12.4 **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<sup>8</sup>. 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 or 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.<sup>9</sup>

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<sup>6</sup> [Domestic abuse victim characteristics, England and Wales - Office for National Statistics \(ons.gov.uk\)](https://ons.gov.uk)

<sup>7</sup> [999368 Law Domestic Violence MAIN Research Report Final FINAL PRE-PRINT.pdf \(aafda.org.uk\)](https://aafda.org.uk)

<sup>8</sup> [43380\\_23902777\\_Care Act Book.indb](#)

<sup>9</sup> [Gaining access to an adult suspected to be at risk of neglect or abuse - SCIE](#)

1.12.5 **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.

1.13.1 **Dissemination List:**

The following will receive copies of the review report:

- Denise’s friends and family.
- Review Panel members
- The Home Office
- The Domestic Abuse Commissioner
- Police and Crime Commissioner

Additionally, Hertfordshire County Council will conduct a DHR / DARDR (domestic abuse related death review) briefing for every case that has been published. This will be sent to panel members to disseminate at their future meetings and learning events. Briefings are finalised once a review has been quality assured and approved for publication by the Home Office.

Key dates to avoid for publication such as Denise’s birthday have been considered during the finalisation of this review.

**Section Two**

**Background Information and Overview**

2.1 Pseudonyms

<b>Name</b>	<b>Relationship</b>	<b>Age at time of V/S death</b>
Denise	Subject of review	37
Gary	Ex partner	37

Denise was a 37 year old woman 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 services 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 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. This brought her back to the attention of the Adult Community Mental Health Support (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.

Denise was known to be in a domestically abusive relationship with Gary from approximately October 2022 onwards. In late 2022 she informed ACMHS they used drugs together, she had been violent towards him, they'd been banned from local pubs and she had loaned him £3000 for an unspecified reason. She said she did not expect to get this money back. She said she would not call police because she knew Gary had connections to a gang which would 'bring trouble to her door' and latterly said she feared for her safety. Over the course of several disclosures she referenced physical and emotional abuse, controlling behaviour, harassment, threats to leak intimate photos of her amongst many other behaviours. The following chronology will address these in further detail.

Gary's alleged behaviour will also be explored within this review. Careful consideration of what to include 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 DHR's set out to achieve, it 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.

### **Section Three - Chronology**

#### **Introduction**

The review panel chose the scoping start date as 3<sup>rd</sup> June 2021, when Denise began her tenancy with B3 Living Housing service. It was unknown when she met Gary prior to the commencement of the review but it was believed to be after this date and likely to have been via the local pubs. Denise worked behind the bar in at least two local pubs. The review has found no evidence of a relationship between Gary and Denise before October 2022. Therefore, between June 2021 and October 2022 information relates to Gary and Denise when it is believed they weren't known to each other.

#### **Chronology**

- 3.1 Information from family and friends suggests Denise had been living with her sister after moving from the North West of England. Following a breakdown in their relationship in November 2020 she approached the council seeking support for homelessness. She was subsequently assessed as priority need<sup>10</sup> 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.” It was noted how a lack of stable accommodation would be detrimental for her mental health. Denise was initially placed in temporary accommodation in a B&B and then a hostel between 4<sup>th</sup> December 2020 and 3<sup>rd</sup> June 2021 at which point she was provided with a social tenancy by the B3 Living housing provider. She stayed here for the remainder 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.
- 3.2 The B3 Living Neighbourhood Advisor who completed the relevant sign-up forms with Denise discussed her recent experiences. She told them she'd previously experienced domestic abuse and moved to Hertfordshire to be closer to support. She was accompanied to this appointment by her friend who she had met while working in a pub. This friend had helped her gain furniture via a charity. She said she had recently been in a mental health unit, was receiving support and was on medication. Her mental health situation was recorded on the B3 Housing system. The friend's details were also recorded as her next of kin contact and advocate.
- 3.3 Around the same time the Care Co-Ordinator with ACMHS at the Hertfordshire Partnership University NHS Foundation Trust (HPFT), who support service users with their mental health needs, visited Denise at her new address. She reported finding moving

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<sup>10</sup> [Priority need - Shelter England](#)

stressful, had been off sick from work and did not intend on returning to her employer. It is believed her employer was a 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 as well as general advice re friendships and boundaries.

- 3.4 On the 16<sup>th</sup> July 2021 the B3 Neighbourhood Advisor made an unplanned visit as they were in the area. Denise said she would not normally open the door unless she was expecting a visitor. She said she rarely went out and a friend supported her with shopping. If she did need to go out, she would wait until later in the evening as it was quieter. She told the B3 housing practitioner a neighbour was trying to befriend her which was unwanted. They reassured her the neighbour was likely being friendly but agreed to speak and latterly requested they give Denise "some space". Other than this Denise said she felt settled in her home and seemed "cheerful and happy".
- 3.5 On 3<sup>rd</sup> September 2021 an ACMHS Support Worker telephoned Denise due to her usual care co-ordinator being on leave. She told the worker she felt generally anxious but did not want to keep repeating herself to various professionals. She said she would wait for her care coordinator to return to update her on her Universal Credit application.
- 3.6 Ten days later Denise 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. She was taking Zolpidem sleeping tablets to try and keep a routine. The doctor recorded her mental health as stable.
- 3.7 On 16<sup>th</sup> September 2021 Denise was called again by an Adult Community Mental Health Service (ACMHS) worker due to the continued leave of her care co-ordinator. She said she didn't have enough support. When asked what additional support she would like she said she wanted to get to know herself better. She had previously been provided activities and information about her condition which she found helpful. A week later Denise requested a food parcel as her allocated support worker usually did this monthly for her due to issues with Universal Credit.
- 3.8 Two days after this call the ACMHS attempted to call Denise but she did not pick up. Staff were worried about her wellbeing so visited her at home but after speaking with her, no concerns were recorded.
- 3.9 Soon after this, following a routine physical health check, a nurse contacted the ACMHS duty line. They said they had known Denise for a long time and felt she seemed more anxious and agitated. The day after, and in response to this, she was contacted by a duty worker. She said her house was a mess and she was busy painting. The call was ended due to Denise "being busy".

- 3.10 On the 7<sup>th</sup> October 2021 mental health services contacted the Police after being unable to contact Denise. They were concerned her suicidal thoughts had been increasing. There was a report from a neighbour of her front door being left open. The police attended to check on her welfare and found her in the property safe and well. She subsequently re-engaged with mental health services and told them she felt let down by services. She was upset by the doctor stopping her Lithium due to the change in diagnosis from bipolar. 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. 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 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.
- 3.11 Contact with Denise remained challenging during this period for the mental health service. Via phone and text contact she blamed them for causing her stress citing an incorrect diagnosis and continued staff absences as core reasons. She said she did not need their help and no longer wanted support to fill in forms.
- 3.12 On the 15<sup>th</sup> October 2021 Denise called the police saying an unnamed male had raped her the night before. She said she had fallen asleep within the grounds of a nearby park / leisure centre and woken up to a male shining a light at her. They had begun talking before the male had taken her trousers down and raped her. The police took swabs but no semen or blood was detected to assist with the investigation. Police said Denise did not wish to engage in the investigation process and so, due to a lack of evidence, the case was closed.
- 3.13 Denise told her mental health support about this. They assessed an increased risk of suicide, abuse from others and self neglect due to her recent experiences. They suggested she stay at a friend's house temporarily and requested for the crisis team to become involved to monitor and assess the situation.
- 3.14 During a follow up call from ACMHS a day later Denise said she felt 'let down' by the psychiatric services and 'forced' into situations by the police. The nurse explained the available support but Denise did not take these up.
- 3.15 Due to this recent information, ACMHS created a safeguarding episode<sup>11</sup> to assess whether Denise required additional support and safeguarding. A social worker and support worker visited Denise on the 18<sup>th</sup> 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 assessor recorded that she may benefit from having a Care Act assessment<sup>12</sup> to ascertain whether she required additional support, but no evidence exists of this assessment taking place.

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<sup>11</sup> 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.

<sup>12</sup> [Key Care Act duties for assessment and determination of eligibility - SCIE](#)

- 3.16 A week later, a friend of Denise’s called the police concerned about her. She had sent a message saying “thanks for everything” and had been distressed about the recent rape. Having not been contactable by phone the friend attended the address and let police know she was ok. A few days after this Police were called again due to concerns Denise intended to hang herself. They forced entry to her address and found her under the influence of an unknown substance and alcohol. 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 <sup>13</sup> to detain Denise and prevent her from harming herself after she took tablets in front 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.
- 3.17 Several calls were made to Denise over the next week or so from the Adult Community Mental Health Service (ACMHS). These were either not picked up or, when Denise was spoken to, she provided limited information. On 4<sup>th</sup> November 2021 she reiterated she could keep herself safe but was struggling. She again said she was not receiving enough support due to staff leaving. She said she had been self-medicating by taking 2-4 extra pills to numb her thoughts. She said the regular phone contact was not helpful but would continue to accept the calls.
- 3.18 During another follow up call a week later Denise said she felt 'shit' and she had self-harmed by cutting her arm two days previously. She told the ACMHS she was not using alcohol or excessive amounts of Promethazine but was not sure whether she was taking her prescribed medication. She said she was not eating properly but declined the offer of a food parcel. She said she was no longer seeing friends and would only go out at night when it was quiet. Due to this conversation a home visit was made the next day. On arrival she was sitting in a “dark cold flat”. She said she was anxious about doing a police video in relation to the rape as she did not want to relive the experience. A rape support charity number was provided to her. They were contacted during the course of the review but found no evidence of contact with Denise.
- 3.19 Separately, on 3<sup>rd</sup> November 2021 Gary began an 18-month Community Order 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 whom 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. At no point during the scoping period were the NPS involved with any agencies who knew Denise and were not aware of her existence until this review.

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<sup>13</sup> [Mental capacity | College of Policing](#)

- 3.20 On 25<sup>th</sup> November 2021 Denise sent a text to the ACMHS saying her neighbours kept knocking on her door “demanding to talk”. She was concerned she might be arrested as they continued to antagonise her even though she has told them she didn’t want to talk.
- 3.21 On 26<sup>th</sup> November 2021 a neighbour reported alcohol related abusive behaviour from Denise’s flat to B3 Housing. Limited information was recorded to enhance the panel’s understanding of this report.
- 3.22 In December 2021 there was little interaction between Denise and the ACMHS. She reportedly missed a consultant psychiatric appointment, but this appears to have been an error with the letter being sent out late and Denise not receiving it in time. She continued to want to speak to her original care co-ordinator who remained on sick leave.
- 3.23 Due to a lack of contact with Denise, a Social Worker from ACMHS visited her unsuccessfully in mid-January 2022. She picked up the phone the day after and continued to ask for her care co-ordinator’s details. She reported improvements in mood and sleep patterns. She also mentioned being upset with a recent GP assessment for recording she drank alcohol. She requested the removal of this entry but this request was denied. A couple of days later a home visit observed the property was 'clean and tidy' and Denise had purchased a medication dossett box which evidenced increased self care. She said she could not recall the events over the last couple of months other than flash backs. The support worker recorded Denise mentioned she had used cocaine and alcohol twice in the previous 2 months, when she had been unwell.
- 3.24 On 14<sup>th</sup> April 2022 Denise was visited at home by the ACMHS. When asked why she had prevented access previously she said her mood had been “high”. She also reported being sleep deprived and this 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.
- 3.25 The ACMHS continued to visit and communicate with Denise and two weeks later she reported feeling tired but also said her sleeping tablets were helping her sleep through the night. She said she had not been taking her medication as prescribed. She described more concerning behaviour such as stealing a takeaway and a man’s wallet from a pub. The support worker observed parcels in the home but Denise said she did not remember what the items were. A counsellor contacted her by text to invite her to an appointment to discuss psychology-based treatments.
- 3.26 On the 17<sup>th</sup> May 2022 Police were called by the ACMHS and asked to welfare check Denise after she had text them saying she was stopping her medication and doctor’s appointments and was contemplating self-harm. She said she was “tired of fighting and not being heard”. Officers attended and spoke with her over the intercom but she would not open the door. She said there was nothing wrong and she had already spoken to the mental health team that afternoon. Officers assessed there were no powers to forcibly enter the home and left with no further actions taken. On reflection police feel this was a

missed opportunity to submit an adult at risk referral which would have raised awareness of concerns for Denise's welfare to the local authority.

3.27 Police were contacted again several days later after a neighbour saw Denise sitting on her window ledge and thought she might jump. Officers attended but after speaking to Denise she said she had no intention of doing so and just wanted to sit there. She eventually returned inside.

3.28 Four days after this, Denise text an ACMHS support worker 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"*

3.29 In a letter from the consultant psychiatrist to the GP dated 10<sup>th</sup> June 2022 it was stated there had been no recent medication changes. The letter confirmed plans for Denise to receive ongoing support from her care coordinator. The consultant mentioned there was 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 the individual appointment without being fully aware or considering the external context. As has been seen within this chronology, this assessment does not reflect Denise's recent experiences.

3.30 On 21<sup>st</sup> June 2022 the ACMHS duty support worker made a telephone call to Denise. The worker recorded Denise was very unhappy to be informed by her GP that she needed to contact Oxford House to discuss her Lithium medication. She said that she was being "pushed from pillar to post" and as a result, she did not know "what the fucking hell" she was supposed to be doing. A couple of weeks later it seems she had reflected as, after not attending her psychology review, she told ACMHS she had changed her mind and now thought therapy with a different therapist might help.

3.31 On 5<sup>th</sup> September 2022 Denise informed the duty worker that she was struggling with her emotions as it was coming up to the anniversary of her trauma. She said she felt paranoid and unable to rationalise anything but, after the conversation with the duty worker said she felt better. A few weeks later she mentioned to the same team she was experiencing sleep problems. She said she would hear a voice telling her to wake up and which had happened periodically over her life. She said she didn't need to see her consultant about this.

3.32 It is approximately around this time the panel and family / friends believe Denise met Gary or began a relationship with him. It is unknown how but based on current information it is possible they were introduced in a local pub.

- 3.33 During an ACMHS home visit on 11<sup>th</sup> October 2022 Denise described feeling 'low', agitated and sleeping excessively. She could not identify a trigger but said she was experiencing flashbacks from the rape last year. She said she was 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<sup>14</sup>, a sexual abuse support service. An ACMHS appointment was made for the 18/10/2022 but Denise cancelled. Another home visit was attempted on the 01/11/2022 but there was no reply.
- 3.34 On 8<sup>th</sup> November 2022 contact was made with Denise who said she felt well but had had a few days where she thought someone was living in her loft. This thought coincided with lack of sleep. She said she had been out with friends a couple of times. She mentioned council tax issues which were creating financial difficulties.
- 3.35 Denise cancelled appointments with her ACMHS support worker on the 24<sup>th</sup> November 2022 and 30<sup>th</sup> November 2022 at very short notice. She cancelled another appointment on 5<sup>th</sup> 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.
- 3.36 Although it remains unknown what Denise was referring to by this comment, there had recently been increased activity emanating from her address which was coming to the attention of other services. On the 8<sup>th</sup> November 2022 police received the first of numerous calls in relation to anti-social behaviour. The caller described lots of "comings and goings" from Denise's address. They also said the occupant of the address, it is not clear who, headbutted an attending officer on one occasion although there is no record of such an incident. The resident also reported a "female regularly going to the car park to meet people in cars" who was identified as Denise. The police contacted the reporting resident, gave advice and sent an e-mail to the housing association requesting they provide CCTV to the block. This was latterly put in place but did not aid evidence gathering.
- 3.37 Approximately 10 days later police received another call from a resident at the block of flats. The police record read: *"Occupant of the address is vulnerable but has had various visitations causing concerns to the entire block of vulnerable adults. Frequent door slamming and coming and going from the address."* Police offered advice around further reporting and said they would ensure local PCSOs (Police Community Support Officers) were aware.
- 3.38 On the 15<sup>th</sup> November 2022 there was a notification received by the council that Denise had cancelled her council tax direct debit.
- 3.39 On 13<sup>th</sup> December 2022 an e-mail was received to Environmental Health (EH) from a neighbour of Denise's. It referenced anti-social behaviour (ASB), drugs, door slamming, people coming and going and cigarette butts left outside. EH officers passed this through to the Community Safety Team (CST) at the local authority as the Environmental Health

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<sup>14</sup> [Red Kite Support | Empowering Communities Together](#)

remit was to deal with noise complaints. The next week the CST attempted to contact the reporting resident to seek their permission to discuss with the housing provider B3 Living. It is unclear if this consent was ever gained. Nonetheless this point has been reflected on within the analysis as it was considered an unnecessary barrier to sharing information to prevent crime and disorder.

- 3.40 On 19<sup>th</sup> December 2022 a Senior Social Worker within ACMHS opened another safeguarding episode to see if further intervention for Denise was required. This was after a support worker had 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 there was drug use. 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. The case record mentioned psychological and verbal in addition to physical abuse.
- 3.41 Within the safeguarding report there was limited exploration of the nature of the abuse Denise had experienced, what was said or potential triggers. There were no domestic abuse risk assessments completed and no deeper consideration of Denise or her partner being a victim or perpetrator of domestic abuse or whether specialist domestic abuse services were required. The ACMHS worker was concerned enough to contact Denise post appointment to see if she wanted to report her partner to the police. However, concerningly, Denise said she would not call the police due to fear of repercussions as he allegedly had links to gangs and police involvement would bring “trouble to her door”.
- 3.42 On the 22<sup>nd</sup> December 2022 police received a further call from residents at the block of flats. They 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. They did not know his name. The Police’s Safer Neighbourhood Team were alerted including local officers. This is the first piece of information received which could have potentially been used to identify Gary.
- 3.43 Around this time B3 Living Housing created an ‘Antisocial Behaviour case’ after they received a report of damage to a dummy CCTV camera. There were also reports of several “loud” males visiting Denise’s home, making noise, playing loud music and littering the entrance. The resident said they had also emailed Hertfordshire Police too. The Neighbourhood Advisor added previous reports from same complainant on the:

5<sup>th</sup> December 2022

6<sup>th</sup> December 2022

8<sup>th</sup> December 2022

9<sup>th</sup> December 2022

12<sup>th</sup> December 2022

13<sup>th</sup> December 2022 – this report related to a male exposing himself to the complainant's ring doorbell camera. This report was discussed with Hertfordshire Police who said they would visit the resident to check on them.

14<sup>th</sup> December 2022

All reports related to visitors attending Denise's address and were of a similar nature. B3 said they would send an "ASB Warning Letter"<sup>15</sup> to Denise who was highlighted as being the tenant of the address and where the issues were emanating from.

- 3.44 On 30<sup>th</sup> December 2022 Denise called the ACMHS regarding an ASB letter she had received. The letter referred to complaints of anti-social behaviour linked to her flat. Evidently, during this conversation her relationship with her partner was discussed as Denise said she felt he would not harm her. She said she was more worried about the drug dealers he worked for.
- 3.45 In early January 2023 Police received more frequent calls from neighbours mainly relating to cannabis use. The Safer Neighbourhoods Team advised residents to keep reporting and contacted the Community Safety Team to see if they had received any further reports.
- 3.46 Denise sent a text message to her ACMHS support worker on the 4<sup>th</sup> 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. Denise told the worker there had been no physical violence. A home visit by this team occurred on the same day but it is unclear if it was before or after this text conversation. Denise told the worker she'd had contact with Gary's brother. She said Gary and his brother had fallen out because of Denise which had lead to him cutting off Gary's drug supply. She felt this could have direct implications for her safety.
- 3.47 On 9<sup>th</sup> January 2023 ACMHS support worker called Denise but could not get through. She text back and said: *"U lot r a joke " "Wish you all would fuck off" "there's never any help you are all cunts" "You can all fuck off"*. A day after this Denise text again asking the support worker if they had called the police. They confirmed they hadn't. After being asked why she had sent the abusive text messages yesterday she replied saying she was fed up and admitted to also calling her GP 'a cunt' the previous day.
- 3.48 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.
- 3.49 Police were called again in mid-January after screaming was heard potentially emanating from Denise's flat. Police could not get any answer from Denise's address, despite

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<sup>15</sup> 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.

multiple attempts. After speaking to neighbours they assessed they could not be certain which premises the noise was coming from nor who had made it and therefore had no further actions they could take.

- 3.50 Between the 3<sup>rd</sup> January 2023 and 6<sup>th</sup> March 2023 there were regular reports to B3 Living of comings and goings with Gary mentioned (his first name) and several visitors. Reports included: door slamming, cannabis smells, general noise and loud music. The B3 Living Neighbourhood Advisor liaised with Hertfordshire Police although the notes, actions and outcomes were limited on the B3 system. There remained no direct contact with Denise from B3 during this time. After hearing from the reporting neighbour that Gary was no longer attending the address and the antisocial behaviour had abated, the case on the B3 system was closed on 26<sup>th</sup> April 2023. During this time a second ASB warning letter had been sent to Denise from B3 Living Housing.
- 3.51 Meanwhile, an ACMHS safeguarding meeting with Denise had occurred on 30<sup>th</sup> January 2023. The purpose of this was to gain Denise's wishes and feelings about the aforementioned safeguarding concerns from December 2022 e.g financial & domestic abuse from her partner. The Social Worker conducting this meeting felt there were no concerns in relation to her mental capacity. There was a discussion about Denise assaulting Gary and "smashing up his car". She described the relationship as being "toxic". Denise did not want to change the locks to prevent him from having access which is evidence of some safety planning from this team. She said she had given her partner money knowing she may not get it back. Within this meeting Denise mentioned she believed Gary was asking his friends to take photos of her which the Social Worker said was a form of control. In response to these concerns the Social Worker offered to set up a safe word and suggested they call the police. Both options were declined by Denise. There were no further actions following this meeting.
- 3.52 On 25<sup>th</sup> February 2023 the police received a call from one of the neighbours. They reported "unusual activity" and thought Denise was involved in prostitution. They said one male usually attended the address but then another person would take over. Another call was received a month later in a similar vein and reported unusual "comings and going" at all times of the early morning. Police received further information about activity at the flat in April 2023.
- 3.53 There were multiple attempts from the ACMHS to contact Denise after the 30<sup>th</sup> January 2023 via text, letter and phone call but no contacts were returned. There is a significant reduction in all contacts with agencies between March and June 2023. Between late April and the whole of May there are no police contacts with regards to Denise and her address although police continued to have concerns about Gary's drug dealing activities.
- 3.54 On 6<sup>th</sup> June 2023 Denise answered the ACMHS support worker's call. During the conversation she explained she 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. Denise said she had temporarily moved

back to the North West, where she had many friends and family connections, due to fear. The support worker noted the importance of considering The Sunflower Project<sup>16</sup> which could support her with her experiences of domestic abuse but there were no further actions in regards to this. There was mention in the notes for Denise to practice mindfulness exercises to gain mental and physical strength.

- 3.55 Another safeguarding document was opened by the ACMHS on the 7<sup>th</sup> June 2023 following the previous conversation with Denise but no actions came from this. It was documented how risk had lowered because Denise had removed herself to the North West although it is believed she had now returned to Hertfordshire. The concerns mentioned in para 3.54 were not mentioned to any other agency. Denise said she had blocked Gary from social media and phone and didn't want to report the incidents to the police. Due to Denise not wanting to take matters further the safeguarding episode was closed.
- 3.56 In late June 2023 two police reports were made within the same day from the block of flats. One stated there had been a "disturbance" from Denise's flat and the other was a report of 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.
- 3.57 A month later 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 for information / intelligence purposes and passed to the internal Safer Neighbourhoods Team. No further actions were taken.
- 3.58 On the 8<sup>th</sup> August 2023 the ACMHS spoke to Denise who 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). The ACMHS had opened a safeguarding enquiry but closed this soon after as they stated Denise did not want any further action to occur.
- 3.59 The referral to Refuge for an IDVA service was made and Refuge attempted to contact Denise via phone on 10<sup>th</sup> August 2023. The abusive behaviour listed in the referral was "controlling behaviour, stalking, emotional abuse, withholding medication, possible threats to share intimate images, and destroying property". Although the call was accepted, Denise did not reply to the practitioner's "hello" and hung up.
- 3.60 A few days later, in the early hours of the morning, the police received an emergency call from a neighbour saying they could hear the couple at Denise's address shouting at each other. They said this was frequent, but they didn't always report and it had been going on

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<sup>16</sup> [Herts Sunflower](#)

for the past 30 minutes. When officers arrived, there was no noise nor were there lights on. Attempts were made to welfare check over the next few days but there was no answer from Denise's address. Within that time, another police report was received in relation to Gary's dangerous and antisocial driving which was described as erratic and happening at "irregular hours".

- 3.61 Refuge attempted to contact Denise three times but without success. On the 15<sup>th</sup> August, having updated the referring agency, the ACMHS informed Refuge Denise *did* want support from them but was wary of speaking to people she didn't know. Following the communication between agencies, Refuge assessed it was safe to leave a message on Denise's mobile phone and duly did so also providing her with the number for the National Domestic Abuse Helpline.
- 3.62 On the 24<sup>th</sup> August 2023 Denise contacted the IDVA directly via text message asking if she could be contacted after 2pm that day. The IDVA stated they were unavailable. After discussing alternatives over text message, they agreed to speak a week later on Friday 1<sup>st</sup> September after 2pm. Denise was called at this time but did not answer. Subsequently the IDVA text Denise asking if she would still like support but also stated they would be closing her to their service due to a lack of successful contact. The file was officially closed on 20<sup>th</sup> September by a manager citing the same reason. There was no evidence of ACMHS being notified of this.
- 3.63 On the 7<sup>th</sup> September 2023 Denise reported to the police the theft of her vehicle overnight. There was no evidence of how the vehicle was taken.
- 3.64 On the 8<sup>th</sup> September 2023 a further call was made to the police by a resident. They said the occupant of Denise's address had been making a lot of noise throughout the night, including turning music up and shouting in the early hours. This had been reported to B3 Living. The incident was not responded to and was referred to the local authority as it was seen as a noise complaint. The Safer Neighbourhood Team were not notified of this incident.
- 3.65 Denise informed the police on 26<sup>th</sup> September 2023 she had found her stolen car at a location close to her home address and had recovered it to her home. She declined an examination of the vehicle by scenes of crime officers. Her reluctance to cooperate with the investigation was not explored.
- 3.66 On the 17<sup>th</sup> October 2023 the 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. When officer's arrived they could hear shouting from inside the address. Denise was clearly distressed as when she spoke to officers she was shouting and swearing. She initially did not want to disclose what had been going on and just wanted Gary to leave her address. 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<sup>17</sup> (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<sup>18</sup>).

- 3.67 Evidently Denise spoke to ACMHS within 48 hours of this incident as she recounted a similar story. 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 told the ACMHS worker her suicidal thoughts were 'coming and going'. Significantly, she told her support worker and senior social worker in attendance she wanted support to break the cycle and stay away from Gary and his associates.
- 3.68 This incident prompted a *safeguarding adults strategy meeting* a week later on 25<sup>th</sup> 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 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 there is a nuance to the word "allowing" which will be discussed further in the analysis.

Having a ring doorbell installed on Denise's front door as a safety measure was discussed. The police felt this would not be accepted by Denise as it would lead to professional's observing who she allowed in her property which she might not want in the context of drug dealing. There were limited actions from this meeting and a consensus from those in attendance that Denise had the capacity to protect herself. The safeguarding episode closed and the outcome 'inconclusive' was recorded.

A MARAC<sup>19</sup> referral was not made with a note stating the ACMHS would speak to the police about this. This will be also be discussed further within the analysis.

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<sup>17</sup> [Domestic Abuse Risk Assessment \(DARA\): Rationale for development, structure and content](#)

<sup>18</sup> [Domestic Abuse | The Crown Prosecution Service](#)

<sup>19</sup> [Learn more about the Marac - SafeLives](#)

- 3.69 On the 1<sup>st</sup> November 2023 a neighbour contacted both the local authority and the police via webchat stating a young child had gone into Denise's flat. This information was passed to B3 housing. As there was no immediate concern for the child's wellbeing, no further action was taken. It is known Gary had a child from another relationship which is worth noting at this juncture.
- 3.70 On 10<sup>th</sup> November 2023 the ACMHS support worker visited Denise and recorded how she laughed several times during the visit. Denise told them she felt 'more with it' and was motivated to sort out her debts which ACMHS said they would support with. Denise was offered the ring doorbell but declined. She said she was already aware of housing's intention to try and improve the security of the communal back door which had been cited as an issue related to the previous 'comings and goings' reports. Denise mentioned her ex was 'driving her mad' recently as he continued to turn up at her property in the hope Denise would allow him in. She mentioned an occasion when he had spent an hour ringing her buzzer and had been driving up and down her street. This was the last time Denise had contact with the ACMHS.
- 3.71 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 involvement who attended the address and found Denise deceased. She had ended her life via hanging.

## **Section Four**

### **Analysis**

The terms of reference agreed by the panel has been used as the basis for this analysis.

Prior to analysing the specific points it is clear from the chronologies provided Denise disclosed domestic abuse at various points to the ACMHS. This is with the benefit of hindsight but for continued learning it is important to note the behaviours disclosed. These included but are not limited to:

- stalking and harassment (“partner driving me mad recently”, not leaving me alone, driving up and down passed the flats, continuously ringing the intercom - Oct 23),
- threats (“eyes everywhere”, fear of links to gangs),
- sexual abuse (explicit photos and threats to disseminate them),
- physical violence (punched),
- potential financial abuse (Denise provided money knowing she wouldn’t get it back to someone she had seemingly just met, council tax debt),
- controlling and coercive behaviour (hid her medication, took her house keys),
- criminal damage (damaged her flat and belongings).

Denise described how Gary would invite his friends over, would not stay away and neighbours reported alleged drug dealing and increased drug use. Denise said on more than one occasion she didn’t want this and packed her bags to leave. This highlights the importance of utilising domestic abuse risk assessments so services can gain a better understanding of all the behaviours someone is experiencing over an extended period of time.

### **Domestic Abuse, Cuckooing and Antisocial Behaviour**

**4.1 Was domestic abuse and cuckooing considered within the reports of antisocial behaviour received by Environmental Health, ASB Team, Police, Housing? If not, should it have been and are there ways to ensure it is considered in future?**

The services listed within this specific ToR (term of reference) were addressing and seeing the issues as ‘antisocial behaviour’ for the majority of the scoping period. Domestic abuse concerns became known to the police for the first time in July / August 2023.

ASB is a broad term encompassing many different behaviours and domestic abuse, cuckooing and other types of exploitation could well be a factor within them. In this instance, the early neighbour reports described potential drug use and drug dealing with multiple comings and goings appearing to emanate from Denise’s flat. A consistent male was seen and was later described as her partner. This was a marked change in pattern in comparison to the lack of reports prior to November 2022. The Adult Community Mental Health Service were the first service to become aware of domestic abuse concerns on 19<sup>th</sup> December 2022 when Denise told them about psychological and financial abuse though limited details were recorded.

The agencies listed within this specific ToR had limited direct dealings with Denise between Nov 2022 (when the ASB reports started in earnest) and October 2023 and were basing their actions on neighbour reports. There was evidence of liaison between Housing, Police and the ASB Team but without any direct contact with Denise other than police speaking to her via the intercom. Cuckooing nor domestic abuse were considered by these teams within their early interventions and there is learning here. The wellbeing of neighbours and impact of ASB on them was rightly being considered, but the causes of ASB could well be related to the exploitation of individuals with vulnerabilities. Domestic abuse and cuckooing fall within this bracket and require agencies to look deeper into the detail. This shall be considered further within the lessons learned section.

East Hertfordshire holds an ASBAG (Anti Social Behaviour Action Group) Forum where repeated and concerning antisocial behaviour can be raised and discussed between multiple agencies. Although this situation was never heard at this forum it has been the focus of discussion within the panel meetings with aspects considered being:

- Eligibility for to be discussed at this forum
- Ensuring consideration of the vulnerability of all residents (including those whose address ASB is stemming from)
- Sharing of all available information
- Attendance by all agencies with valuable information to share.

**4.2 Was Cocoon Watch and any other relevant schemes / initiatives considered within the measures available to address concerns and gain support from neighbours?**

Taken from the college of policing website Cocoon Watch is described in the following terms:

*Where Neighbourhood Watch schemes are impractical or where it is necessary to raise awareness about a specific crime trend, householders can be encouraged to develop a local cocoon watch. This is where neighbours watch out for one another.*

*When combined with tailored target hardening, this tactic can be effective in preventing crime and repeat victimisation. Consider burglary alert cards in the cocoon watch area.*

Within the information received by this review, cocoon watch nor neighbourhood watch schemes are mentioned. This does not mean there weren't attempts made to maintain and enhance reporting from neighbours. There is good practice in evidence with a variety of reporting methods utilized and encouraged such as web chats, QR codes, letter drops, and a resident meeting organized. Despite issues recurring and the likelihood of reporting fatigue, neighbours continued to report which could suggest the variety of reporting methods available assisted in maintaining a level of reporting. One neighbour was contacted by the chair but did not respond to an e-mail attempt.

Neighbours continued to report concerns with this information passed between the aforementioned teams. There are some actions stemming from these such as letter drops to residents and B3 sending Denise two ASB warning letters. But there is no targeting of the apparent instigator of the concerning behaviour, Gary, following the neighbour reports. Para 4.3 provides more context for this.

#### **4.3 Whether family, friends and neighbours were aware of any abusive or concerning behaviour between the perpetrator and victim (or other persons). Were there any barriers they may have experienced in reporting concerns?**

The review found that two neighbours in particular consistently reported issues to the police, B3 Living Housing and the ASB Team. B3 Living have acknowledged that one resident's complaints may not have been taken as seriously as they should have as they had previously complained consistently about another resident for similar issues. This goes against Principle 1 from a set of principles developed by the Anti Social Behaviour Strategic Board in 2022 - *Victims should be encouraged to report antisocial behaviour and expect to be taken seriously.*<sup>20</sup> As B3 Living have acknowledged, these premises house people assessed as having some level of vulnerability. Unfortunately, vulnerable people are more likely to be exploited and therefore the likelihood of concerns being reported is higher. The neighbour used phrases such as shouting. This is as much as agencies should expect neighbours to report. It is not for them to differentiate between a couple raising their voices at each other and domestic abuse. Often neighbours will feel frustrated at their own quality of life being impacted by consistent issues and the review has found that Denise herself could be aggressive. To expect empathy and understanding from neighbours as well as continued reporting is perhaps unrealistic.

This question asked the panel to consider what barriers were experienced by neighbours and in this case it seems a barrier was a belief by housing that the neighbour reported frequently and unnecessarily. It is with the benefit of hindsight it can be seen there was

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<sup>20</sup> [Anti-social behaviour principles - GOV.UK](#)

truth to the concerns and it is a lesson to explore and focus on all available evidence rather than perception of the complainant.

The ASB Case Review (formerly the Community Trigger) <sup>21</sup> was also discussed during this review. This is a method where residents can request an in depth investigation into what is being done to address their ASB reports. It will remain unknown as to why this was not requested but thorough investigation of reports should not be reliant on neighbours requesting this action. Often they will be unaware of such initiatives. The panel have discussed mechanisms for bringing cases such as this to ASBAG prior to any community trigger being activated.

In relation to para 3.39, the CSP would typically ask the reporting person for their consent when sharing details of the report with another agency. They state this is for several reasons:

- There have been cases where there is a distrust of a certain agency and the reporting person does not want them to have their contact details.
- The person may have concerns for repercussions and therefore not want to be identified.

They state they have had this step in their processes to ensure reporting victims of ASB feel supported and listened to.

However, on reflection the CSP feel this may be an unnecessary barrier. They feel they should be sharing information in the first instance but withhold personal information of the reporting person until consent is recorded.

#### **4.4 Were opportunities to support V/S to apply for legal orders (e.g non-molestation orders, occupation orders) recognised and utilised?**

Within the police incident in October 2023 Denise was informed about the NCDV<sup>22</sup> (National Centre for Domestic Violence) who could support her to gain a legal order such as a non-molestation order<sup>23</sup>. Police and the ACMHS were the only ones to have direct contact with Denise. There would have been a variety of orders available to assist this situation such as banning Gary from the block of flats. It may be that taking the onus away from the victim to gain this order would reduce the worry of repercussions from the perpetrator or associates. In Denise's case this will remain unclear and it is noted again how fearful she was of Gary and gang links.

#### **4.5 Whether counter allegations were appropriately considered within the context of the abusive relationship.**

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<sup>21</sup> [Anti-social behaviour case review - GOV.UK](#)

<sup>22</sup> [Domestic Violence & Abuse · Emergency Injunction Service](#)

<sup>23</sup> [Get an injunction if you've been the victim of domestic abuse: Who can apply: non-molestation order - GOV.UK](#)

The police have considered the key incident in October 2023 where counter allegations were made to them. They believe these were investigated and considered appropriately. No arrests were made for either party.

ACMHS have reflected how there was no consideration of Gary when Denise initially disclosed being violent towards him. Information was limited at this time but he may well have been vulnerable himself and in need of safeguarding.

- 4.6 **Additional point of note** – The Police IMR (Individual Management Review) analysis highlighted Denise was known to have been a victim of domestic abuse in West Yorkshire in 2017, and the Metropolitan police area in 2018 (by different perpetrators) but little detail was known by Hertfordshire Constabulary. They reflected how having this information clearly on file would have been of value and warning flags<sup>24</sup> should be utilised in similar cases in future. They highlighted how best practice is for addresses of victims of domestic abuse to be flagged on their command and control system through approved practice and protocols. They highlighted how flags can be raised by other partnerships.

### **Information Sharing**

- 4.8 **Were all appropriate services connected and liaising with each other to try and reduce the risk of domestic abuse? If not, are there ways to improve responses in similar circumstances to include all relevant practitioners.**

The antisocial behaviour statutory guidance<sup>25</sup> states: *The response to anti-social behaviour may require collaborative working between different agencies to determine the most appropriate solution. Where a report or complaint is made to one agency, that lead agency should consider the potential role of others in providing a solution if they are not themselves able to take action. This will help to ensure that reports of anti-social behaviour are not inadvertently lost between the different reporting arrangements of different agencies. It may also help to provide a mechanism for considering the potential for engaging the wider community in finding solutions to specific local anti-social behaviour issues.*

It goes on to state that if an ASB Case Review<sup>26</sup> is triggered, relevant bodies should explore *the “drivers and causes of the behaviour”* to identify a solution. Although there was no formal ASB Case Review in this instance this point still has relevance.

There were two spheres of work operating throughout the majority of the scoping period: the antisocial behaviour sphere (police, housing, antisocial) and the mental health sphere. The ACMHS had valuable information which would have given much insight into the context and reasons for the antisocial behaviour. This in turn could have shaped the ASB response and seen Denise through the lense of someone being exploited rather than someone perpetrating antisocial behaviour. Connecting services who have this insight into the person is vital if services are to fully understand the nature of the behaviour and

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<sup>24</sup> Warning markers can be added to the STORM command and control system which immediately alerts call takers and attending officers of relevant history in respect of an address/location/telephone number/victim.

<sup>25</sup> [Anti-social behaviour powers: statutory guidance for frontline professionals \(accessible\) - GOV.UK](#)

<sup>26</sup> Point 1.1 [Anti-social behaviour powers: statutory guidance for frontline professionals \(accessible\) - GOV.UK](#)

address it effectively. It was not until a month before Denise died that relevant services liaised with each other specifically to discuss her situation at a strategy meeting.

**4.9 A review of any Multi-Agency Risk Assessment Conference (MARAC) involvement and, where there wasn't any, whether there could have been.**

No MARAC referral occurred throughout the scoping period. ACMHS set themselves an action to liaise with the police around whether one was necessary in October 2023. It has been reaffirmed via panel discussions how agencies must have the confidence to refer into MARAC if they feel the criteria has been met. Regardless of what the police thought, the option was open to the ACMHS to refer in and not reliant on police opinion.

**4.10 If MARAC referrals were made and declined, what were the reasons and are they in line with current recognised national best practice?**

As mentioned, no MARAC referrals were made, nor declined within the scoping period.

**4.11 A review of any multi agency meetings in relation to this couple and whether they addressed domestic abuse effectively. If not, are there any improvements which can be made to improve future practice.**

The only multi agency meeting to occur in relation to Denise and Gary occurred in the safeguarding meeting on 25<sup>th</sup> October 2023. If the minutes are an accurate summary of the discussion held then the police gave incomplete information about Gary's previous history (see para 4.12) in contrast to information disclosed to this review. There was mention by the police that Denise would not want a ring doorbell as: *"it will be unlikely that she will consider this as it would allow other professionals to see who is coming and going from the flat."* The insinuation perhaps is that Denise was working together with Gary rather than Gary imposing himself on her, which Denise's disclosures to ACMHS indicated was a more likely scenario.

The thread throughout this review is a lack of information about Gary which began in December 2022 when his information could have been available via the car registration provided to the police from neighbours. The background now known about Gary would have helped build a profile of the risk he posed to Denise. This would have helped direct agencies to actions which would have placed the onus on Gary to stop his abuse. As the police are the holders of this information. It is recommended they make attempts to identify the potential perpetrator and, once they become aware of their identify, research available information via *all* of their systems to build an accurate picture of risk.

**4.12 Was a Claire's Law disclosure considered for Denise? If not, could it have been. Would this disclosure have included his previous cuckooing activity?**

The Hertfordshire Police review commented *"A Clare's Law request was open to Denise, although there is no indication that consideration was given to disclosing information to Denise. The police have common law powers to disclose information, broadly where*

*there is a pressing need to protect people. In this context, these powers form the basis of disclosures under the DVDS, meaning in practice information can be shared about a person's known history of violence or abuse, normally relating to previous convictions or charges, to members of the public where there is a pressing need for disclosure of the information in order to prevent further crime."*

As has been established, within the safeguarding meeting on 25<sup>th</sup> October 2023, the police were present and disclosed the following with regards to Gary's offending:

*"With regards to the Police National Computer, Gary is known to the Police and found guilty of battery, damage to property and has NFA for a number of other issues. Denise has no record on the PNC"*

This information is limited, omits many significant events now known to the panel and provides agencies minimal insight into Gary's pattern of offending. This lack of information hinders agency's ability to assess risk and adequately understand the dynamic. Additionally, for a time within the scoping period, Gary was known to NPS for an unrelated offence. Knowing his most recent conviction would have given an indicator as to whether NPS were likely involved which again, would have opened up other ways of reducing his ability to offend (e.g license conditions).

### **Addressing Perpetration**

As a preface to this section the author wishes to highlight the following statement from the National Police Chiefs Council (NPCC) which was released in July 2024. It is noted this is after Denise died but it's important for police forces to consider as a direction going forward:

*"We have worked hard to improve the public's trust and confidence in policing and have brought our response in line with the 4Ps model used in counter terrorism to reflect how seriously policing takes VAWG. We continue to work at pace to make our response to VAWG more consistent, by; **relentlessly pursuing high harm and repeat perpetrators**; by preparing to more effectively respond by improving our workforce capability and culture; by protecting victims; and by delivering on our statutory commitments to prevent VAWG happening in the first place."*<sup>27</sup>

The "relentless pursuit" of domestic abuse perpetrators is an area of growing focus to those attempting to tackle domestic abuse more effectively. It requires *all* agencies to consider this statement within their practice, not just the police as services can ask pertinent question such as "who is the alleged perpetrator?", "what do we know about them?", "what can be done to reduce the risk they pose to current and future partners?". Gary needed to be identified in the first instance which he was not until much later in the scoping period. As per paragraph 4.11, identification could have been possible if the necessary checks had been carried out on the information provided by neighbours. It is

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<sup>27</sup> [National Policing Statement 2024](#)

recommended that any police officer addressing antisocial behaviour conducts checks based on all available information, for example, running number plates through their system to identify the registered keepers. This enables them to in turn run those individuals through their systems including intelligences databases to help build a picture of risk and identify patterns of behaviour.

**4.13 Were there services available locally for those using harmful behaviour and if so, were these known about and were there opportunities to inform and direct him to these (e.g probation). Were practitioners confident in knowing how to ask these questions?**

Gary's offence for which he was with probation was not a domestic abuse offence. For the entirety of his probation order, probation had no knowledge Gary was using abusive behaviour within a relationship or was in a relationship with a vulnerable person. Therefore, this terms relevance diminished as further information was gained.

**4.14 What measures were taken to disrupt Gary's abuse of Denise e.g banning him from the block of flats, DVPO (Domestic Violence Protection Order) etc**

This analysis considers what measures were taken to disrupt Gary's *general* offending which would in turn have impacted his ability to abuse Denise.

Police received information about drug dealing which lead to several stops of Gary's car but no drugs were found other than a minimal amount on a passenger. Police state the threshold had not been met to commence a drug search of Denise's flat throughout the course of the scoping period.

Gary was identifiable as of December 2022 when a neighbour passed details of a car which was driving antisocially and linked to drug activity at the flat. Gary was the registered keeper of this car. However, this check does not seem to have been made.

At the same time concerning activity was increasing at Denise's flat, Gary was with the National Probation Service (NPS) for an unrelated offence. He had been sentenced to an 18-month Community Order for which he was subject to Probation Service Supervision from November 2021 until mid 2023 with a brief period prior to this when NPS would have compiled the pre-sentence report<sup>28</sup>. The courts and NPS often have restrictions they can impose on someone if they are concerned about their risk to members of the public, in this case Denise and other residents at the block of flats. This is dependent on the type of order they are on and whether they have knowledge of the risk posed to others. In this case, probation did not have knowledge of the risk Gary posed to Denise.

It appears Denise was viewed through the lens of being a perpetrator of anti social behaviour as it was her tenancy noise disturbances were emanating from. Given this was

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<sup>28</sup> A pre-sentence report (PSR) is an expert assessment of the nature and causes of an offender's behaviour, the risk they pose and to whom, as well as an independent recommendation of the sentencing option(s) available to the court.

her tenancy there were options open to the multi agency network such as banning Gary from the block of flats as was mentioned in the strategy meeting in October 2023. This is 10 months on from the first reports. B3 housing stated in this meeting that “should the situation change” they could consider this but it is unclear what they felt needed to change and they had no direct contact with Denise from November 2022 to the date of her death other than sending her two ASB warning letters.

#### **4.15 Were opportunities taken to address all of Gary’s offending towards Denise including harassment, stalking and coercive control (not an exhaustive list).**

Denise was reluctant to officially report concerns to the police due to fear of reprisals from Gary and his associates. It appears she experienced extensive control as evidenced by Gary’s alleged assertion he had eyes everywhere, his threats to disclose intimate photos of her as well as numerous other intimidating and abusive behaviours.

At the point of their last contact Denise disclosed to the ACMHS what could be considered stalking and / or harassment. However, there were no further actions taken. Gary remained invisible to services throughout the scoping period despite not being a tenant at the block of flats and being on probation. Stalking of victims of domestic abuse has been flagged as a high risk behaviour linked to numerous domestic homicide reviews and Denise’s story should be used to highlight the importance of being alert to these behaviours and taking appropriate safeguarding actions.

Coercive control is not mentioned throughout the scoping period within agency chronologies. When considered together, Gary’s reported behaviours are clearly coercive control and his alleged connection to gangs, as Denise alluded to, left her feeling fearful and without options. Whether Gary was also intimidated by these associates or was using them to control Denise will remain unknown but the impact on Denise was significant and traumatic. Services can not rely on victims of domestic abuse to name this. It is for agencies to recognise and understand it so they can safeguard appropriately.

The lack of domestic abuse risk assessment hindered an ability to collate all alleged behaviour. It is noted the ACMHS have focussed on improving responses to DA significantly since 2022. They state they now have a DA resource kit which includes information for staff on resources, DASH (domestic abuse stalking harassment risk indicator checklist), Clare’s law disclosure, safety planning and more. They have a risk assessment and safety planning webinar which an IDVA facilitates as well as a ‘routine enquiry’ webinar. There has previously been an over-reliance on referral to IDVA services for the DASH to be completed but staff are now encouraged to complete it themselves. There is acknowledgment the opportunity to risk assess and suggest basic safety planning can be missed if services are reliant on IDVAs alone to do this work.

#### **4.16 Was Gary known to MAPPA<sup>29</sup> and if not, would he have been eligible?**

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<sup>29</sup> [Multi-agency public protection arrangements \(MAPPA\) | College of Policing](#)

Gary was not known to MAPPA (multi-agency public protection arrangements) which are multi agency meetings designed to protect the public, including victims of crime, from serious harm by sexual or violent and other dangerous offenders. MAPPA requires criminal justice agencies and other bodies to work together in partnership with these offenders. He did not meet the criteria to be heard at this forum

**4.17 MATAC<sup>30</sup> is a recent introduction to Hertfordshire. Would Gary have been eligible to be heard at this forum? If not, would it be of benefit for people in similar circumstances to be eligible?**

Under the MATAC criteria, as Gary was under probation he would not have been eligible for this forum.

Risk Assessment

**4.18 Whether Gary's domestic abuse related history was considered when assessing risk.**

By virtue of the fact this case was not deemed appropriate for MARAC it could be argued Gary's domestic abuse history was not sufficiently considered as he was never deemed at high risk of causing Denise serious harm. The police state the OIC (Officer in Charge) was aware Gary had a DA history with others outside of his relationship with Denise. They recorded an awareness of an ongoing, unreported domestic abuse history between Denise and Gary including potential financial abuse as reported to the ACMHS. The crime report from October 2023 was reviewed by a Supervisor from the Specialist DA Unit who asked the OIC to elaborate on this history prior to the investigation being closed.

As the panel now knows, Gary had offended against family to such a degree he had received a restraining order preventing him from contacting a family member. Much of this related to harassment and demands for money. He had offended against at least one ex partner with one allegation containing extreme threats of violence. This is relevant when considering Denise's fear of Gary's alleged associates and Gary's apparent willingness to threaten and intimidate via his links to alleged gangs and other criminality. Additionally, there was a previous report linking Gary to an allegation of behaviour suggestive of cuckooing from 2019. Had this information been considered, parallels may well have been drawn with Gary's alleged behaviour towards Denise and the likelihood of it continuing. It is concluded that Gary's history was not sufficiently considered when assessing risk.

**4.19 Were DA risk assessments completed with appropriate referrals made from these?**

In December 2022, when the ACMHS first became aware of domestic abuse there was no risk assessment completed. Within this initial disclosure, physical, psychological and

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<sup>30</sup> [Multi-agency tasking and coordination \(MATAC\) to reduce domestic abuse offending | College of Policing](#)

potentially financial abuse were disclosed as was an acknowledgment from Denise she had used physical aggression towards her new partner. There were other warning signs too such as the very short time the couple had been together. In line with the Care Act 2014, safeguarding practice within ACMHS encourages practitioners to consider three elements which include:

- the risk of abuse,
- care and support needs and
- whether the care and support needs limit the individual's ability to self-protect.

During the safeguarding investigation stage, Denise told the support worker she gave her partner money for a car and she was aware that it was likely that she would not get the money back. There were no concerns from ACMHS at the time about Denise's capacity in relation to her finances and so it was deemed she made an "unwise decision" which placed her in debt. There was no explanation or context recorded around Denise's allegations towards Gary nor what he said to Denise. The recorded narrative referred to Denise's admission of harming Gary. The ACMHS recorded how "*there was no evidence of professional curiosity to establish whether the partner was a victim of DA, or whether he required any perpetrator specialist services that agencies such as the Sunflower Project provide. Additionally, there was no exploration into whether the partner had care and support needs, requirements for safeguarding and/or a carer's assessment (Care Act 2014). The risk section of the safeguarding document contained sentences that were incomplete and was finalized despite this.*" The ACMHS have reflected this suggests more thorough screening is required to ensure robust recording.

Safeguarding episodes were repeatedly closed by the ACMHS due to a lack of consent from Denise and an assessment she had capacity. However, where concerns are significant enough consent is not required. As stated in the ACMHS IMR (Individual Management Review) : *consent should not be the only consideration when domestic abuse is concerned and the grounds to override consent could have been to protect Denise's vital interests, particularly as the risks appeared to be increasing.* It does not appear the impact of coercion and control on decision making was considered at any juncture. The ACMHS IMR continued: *The Care Act 2014 (section 42) lays out the local authority's duty to make enquiries if an adult may be at risk of abuse or neglect. It does not mention consent. Nonetheless, it is best practice to ask the individual if they wish to partake in the enquiry process. The Hertfordshire Safeguarding Adult Board policy provides guidance about consent and, in line with Making Safeguarding Personal, it is preferable that the individual agrees to partake with the safeguarding process.*

This point was discussed as a panel and whether the issue of consent could become a barrier to sharing information which can safeguard individuals who are experiencing harm such as Denise. The ACMHS reflected how practice has changed more recently with an emphasis on the individual consenting to be involved rather than consenting to the safeguarding process going ahead.

The only DA risk assessment completed was by police in October 2023. This was a DARA (Domestic Abuse Risk Assessment)<sup>31</sup> and was graded at medium risk although was not completed with Denise directly as per the following update from the officer involved:

*“Denise was not engaging with officers on scene, was extremely difficult to understand exactly what has been going on - appears this has been ongoing for some time and Denise has been engaging with her support worker. She asked me to make contact with [her support worker] to discuss on going safeguarding - which I have done. DARA was not completed due to her welfare concerns, however due to comments she made to me regarding her fear of the suspects associates and previous DA reports, I deem medium risk to be the most suitable.”*

Therefore, no domestic abuse risk assessment was ever completed with Denise directly. As this officer assessed it as medium risk, no referral to MARAC was completed. The overall circumstances were also reviewed by the specialist DA unit prior to the investigation being finalised.

### Mental Health

#### **4.20 Was risk of suicide considered within the support Denise received?**

Risk of suicide certainly was considered at various junctures by the adult mental health team. However, in June 2022 (para 3.29) an ACMHS consultant assessed Denise’s risk of harm to herself as low which appeared to be at odds with other information available to this review. It is important for anybody reviewing risk to review their up to date records and other information available to them rather than basing their assessment solely on their most recent interaction with the service user.

#### **4.21 Was the domestic abuse Denise disclosed considered within mental health support plans / suicide intervention plans?**

As mentioned, there were no domestic abuse risk assessments completed by the mental health team for the entirety of their involvement. Therefore the risk of suicide and how this can be increased by being within a domestically abusive relationship or within the context of feeling fearful of Gary’s associates, does not appear to have been considered in depth within ongoing plans. Domestic abuse is acknowledged with discussions about IDVA referrals recording of domestic abuse matters, but this does not appear to extend to suicide prevention plans. The ACMHS IMR noted: *HPFT ACMHS teams employ a range of qualified staff including Nurses and Social Workers, however they also employ unqualified support workers alongside these professionals. In this case, the support workers did not always gather the correct information and there appeared to be a lack of professional curiosity, potentially exacerbated by fear of Denise disengaging.*

Denise was quoted as saying she was leaving to go back to the North West more than once, and was recorded as saying she had “fucked” her situation and gotten into “shit she shouldn’t have got involved with”. She referenced Gary having “eyes everywhere”, threats to disclose intimate photos of her, she received ASB warning letters in relation to her tenancy, she felt fearful of Gary’s associates. Information provided to this review

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<sup>31</sup> [Domestic Abuse Risk Assessment \(DARA\): Rationale for development, structure and content](#)

indicates Denise was experiencing a situation she felt she had limited control over which can influence a feeling of hopelessness. This in turn can indicate an increased risk of suicide as an individual feels their choices are narrowing. Whilst risk of suicide always appears to be on the radar of the ACMHS, the increased risk linked to DA and potential gang intimidation did not trigger a suicide intervention plan which considered these risks. It is not recorded that Denise's support networks were explored in any great depth.

### **Training Needs / Polices / Practice Review**

#### **4.22 An evaluation of any training or awareness raising requirements that are necessary to ensure a greater knowledge and understanding of domestic abuse processes and/or services with specific consideration of coercive control, stalking and harassment behaviours.**

All agencies considered this point within their IMR and reflections can be seen within the action plans in this review.

#### **4.23 Whether the work undertaken by the services in this case is consistent with its own: professional standards, compliant with its own protocols, guidelines, policies and procedures.**

For brevity, the majority of work was consistent and in line with standards, protocols, policies and procedures but enhancements have been identified. These have been reflected in the recommendations section. Detailed below are the ACMHS and Refuge reflections:

*From the ACMHS IMR - Cuckooing: At the time HPFT had no specific policy for cuckooing however HSAB are developing specific training in this area and there are plans within HPFT for a CQI (Continuous Quality Improvement) project to develop a cuckooing resource pack. The current safeguarding adult policy (version 10) mentions that cuckooing may also meet the definition of modern-day slavery where the cuckooed person is also being exploited.*

*Safeguarding Processes: The legislation around Safeguarding individuals can be complex to navigate. It requires professional curiosity and communication skills to ask the right questions at the right time. A practitioner needs to strike a balance between the duty to protect and respecting individual freedoms as outlined in the (Care Act 2014 s42; Human Rights article 3 and 5 and the MCA unwise decision principle).*

*These safeguarding investigations may not have appeared to be complex initially however, there were elements of complexity as there were more than one type of abuse to consider and potentially, more than one abuser/victim.*

*The safeguarding documents were generally opened in a timely manner and in accordance with the HSAB and HPFT safeguarding policies and Care Act Legislation. The Mental Capacity Act was also applied appropriately.*

Refuge felt casework management procedures were followed. Policy states initial contacts should be made within 24 hours of receiving a referral or the next working day,

and three attempts to contact the service user should be made within the first five working days with the following two attempts made over the course of the next week. This happened as did their communication with the referring agency to advise them of their unsuccessful attempts. This proved helpful as Denise then responded requesting contact after 2pm that day. Unfortunately, once the IDVA was in direct text contact with Denise no appointment could be agreed upon until the following Friday after 2pm. Refuge state this is not an advisable approach, as reaching a victim of domestic abuse and offering support is best received by survivors as close to initial referral or incident as possible. This is often referred to as the golden window of opportunity. Refuge's referral and admission policy has strict guidelines about the timing of contacting survivors following referrals for this reason. It may be advisable for practitioners to consider alternatives such as asking a colleague to call the service user at their preferred time if they are unavailable.

As a result of their reflection Refuge have identified learning from this review. It is felt there may be a lack of guidance on different approaches that staff should take in making initial contact, especially with those who may have mental health and / or substance misuse concerns. At the time of the contact attempts with Denise, the IDVA held a case load significantly over the recommended amount. It is acknowledged the staffing levels of this service are different at time of writing. In the context of a very busy service with a high volume of referrals people who may have barriers to accessing the service via a phone call are potentially not being given the opportunity to receive timely support and advice.

#### **4.24 Do the lessons arising from this review appear in other reviews held by this Community Safety Partnership?**

The following review was cited as having similarities in terms of health involvement and the need to share information. Other than this fundamental point, due to some significant differences the extrapolation of any learning was not apparent.

[‘Celeste’ 2021 Executive summary for the DHR Panel \(PDF 285KB\)](#)

#### **4.25 Any other information that becomes relevant during the conduct of the review.**

Although slightly out of the remit of this review, it has been highlighted how probation were unaware of the extent of Gary's offending history at the commencement of the first panel meeting. This means, when they were allocated Gary, they did not know as much as the panel now knows of the risk he posed. Due to the disclosure within this review process, they have been able to re-assess Gary's risk level and enhance their understanding of the risk he poses to others. This will aid their safeguarding interventions. This highlights a wider issue as to the limitation of police disclosures to probation which hinders their ability to safeguard effectively. Potentially there is a national issue with the content of probation PNC (Police National Computer) prints and a local issue around the suitability of current information sharing agreements. This is an issue which has been flagged in previous domestic homicide reviews.

## **Section Five**

### **Conclusions**

- 5.1 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 cause harassment, alarm or distress to one or 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:*

- *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

- 5.2 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.
- 5.3 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.*<sup>32</sup>
- 5.4 Under the Antisocial Behaviour, Crime and Policing Act 2014<sup>33</sup> 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.
- 5.5 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.
- 5.6 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?
- 5.7 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

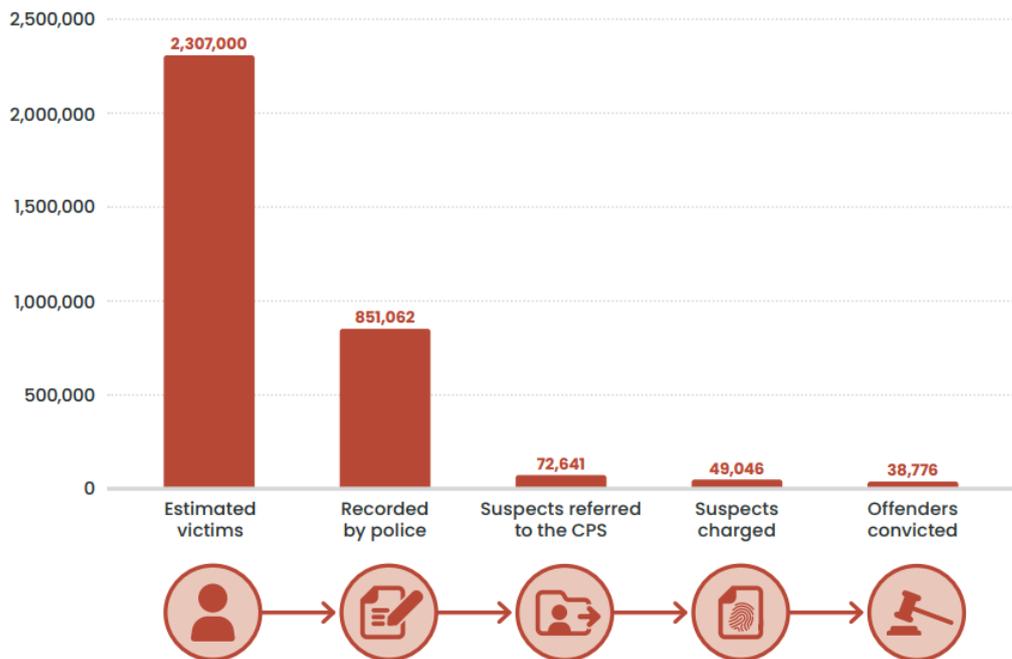
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<sup>32</sup> Cameron, K. (2024). ‘I feel so trapped’: women’s experiences of antisocial behaviour intervention in social housing. *Journal of Gender Studies*, 34(1), 96–108. <https://doi.org/10.1080/09589236.2024.2315047>

<sup>33</sup> [Antisocial behaviour: guidance for professionals - GOV.UK](#)

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.

- 5.8 Neighbours persisted in providing helpful and relevant information to agencies concerning behaviours emanating from Denise's address as well 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.
- 5.9 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:



5.10 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.

5.11 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<sup>34</sup> 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.*"

5.12 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."*

5.13 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.

5.14 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 tackle 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.

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<sup>34</sup> [Promoting independence through intermediate care | Quick guides to social care topics | Social care | NICE Communities | About | NICE](#)

## **Section Six - 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 as well 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 Mental Health Service**

### Narrative

Within this DHR 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<sup>35</sup>, 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.

## 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<sup>36</sup>. 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.

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<sup>35</sup> [Call to action as VAWG epidemic deepens](#)

<sup>36</sup> [Threats to disclose private sexual photographs and films - GOV.UK](#)

### 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.

### **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 to consider proceeding to 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<sup>37</sup> 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.

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<sup>37</sup> [Licence Conditions and how the Parole Board use them - GOV.UK](#)

## **Section Seven - Recommendations**

### **NATIONAL**

#### **Recommendation 1**

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.

**Domestic Homicide Reviews in Hertfordshire: SMART Recommendation and Action Plan Template for the case of Denise**

Recommendation (SMART goal)	Scope of recommendation (i.e. local or regional)	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target Date	Date of completion and Outcome
<p><b>Recommendation 1</b></p> <p>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.</p>	<p>Local</p>	<p>The ASBAG terms of reference and membership to be reviewed and updated by the Community Safety Manager at East Herts Council.</p> <p>Briefings to be delivered to ASBAG members on the revised ToR and the expectations for each agency.</p> <p>Any new agency identified to have a one to one meeting with EHDC Community Safety Team so they are aware of the meetings.</p>	<p>ASBAG - East Herts Council – <i>as the administrator of ASBAG</i></p>	<p>The ASBAG Terms of Reference have been reviewed and shared with agencies in January 2026.</p> <p>Briefings have delivered as and when appropriate. This has been via Teams, in person or emails.</p>	<p>December 2025</p>	<p>The completion date for circulating a revised Terms of Reference was January 2026.</p>

<p><b>Recommendation 2</b></p> <p>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, ASBAG should be promoted locally to enhance local understanding.</p> <p>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.</p>	Local	Briefings to be delivered to ASBAG members on the revised ToR and the expectations for each agency.	ASBAG - East Herts Council – <i>as the administrator of ASBAG</i>	<p>Briefings have delivered as and when appropriate. This has been via Teams, in person or emails.</p> <p>Meetings took place with services who were not attending ASBAG meetings and did not have officer capacity to do so. Arrangements have been made to help facilitate effective information sharing.</p>	On-going - Quarterly	On-going - Quarterly
<p><b>Recommendation 3</b></p> <p>To effectively tackle ASB, Police must utilise all available information and</p>	Local	To Review ASB guidance ensure fitness for purpose.	Herts Police	A new and comprehensive ASB SOP now exists - last reviewed October		Completed.

check all systems, not just PNC to build an accurate profile of the alleged perpetrator.				2025 and includes clear guidance on the Oversight, management and supervision of ASB NPT/CSU Supervisors have responsibility for oversight and management of local ASB. This includes review of all systems and information reports to effectively scan for problems and ASB themes.		
<p><b>Recommendation 4</b></p> <p>ACMHS to consider inclusion of a prompt on their recording system to further enhance their response to domestic abuse for example: <i>Has a DA risk assessment been completed? Yes / No. If not, please explain rationale.</i> This could be introduced alongside further training.</p>	Local	<p>HPFT Safeguarding team to be represented at wider Trust Risk assessment CQI work to ensure DA risks are incorporated into Risk assessment pathways and practice.</p> <p>HPFT Safeguarding team to include 'Routine Enquiry' and 'DA Risk assessment' training within annual training programme</p>	Hertfordshire Partnership NHS Foundation Trust	<p>Safeguarding representation at Risk assessment CQI and Risk assessment Summit.</p> <p>Recording of DA assessment to be considered alongside wider Risk assessment frameworks</p>	<p>Q.4 2024/25</p> <p>Q.1 2025/26</p>	<p>Completed. Domestic Abuse prompt incorporated into risk assessment documentation and guidance.</p> <p>Completed Prompt embedded in Risk assessment to ensure this area is considered. DA Checklist issued as actions to</p>

				Webinars scheduled within 2025/26 programme	Q.4 2024/25	complete when DA disclosed.  Completed Jan 25 Routine Enquiry and DA Risk assessment training remain embedded within HPFT Training programme.
<p><b>Recommendation 5</b></p> <p>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 into their policies.</p>	Local	<p>ICB commissioning of Abortion Services includes Standard Contract SC32 Safeguarding Children &amp; Adults includes 32.3.9 the Domestic Abuse Act 2021 and associated Guidance.</p> <p>ICB hold Quarterly contract monitoring meetings with Providers. Contract includes training on domestic abuse that will be monitored for compliance of content on coercive and controlling behaviour content.</p> <p>The ICB Safeguarding Team review policies at the start of contracts, and review dates.</p>	Hertfordshire and West Essex Integrated Care Board			Ongoing.
<p><b>Recommendation 6</b></p>	Local	This recommendation can be achieved through the revised ToR for	East Herts Community Safety Partnership	The Terms of Reference for ASBAG have been updated.	December 2025	The completion date for circulating a revised Terms of

<p>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.</p>		<p>the Anti-social Behaviour Action Group (ASBAG).</p>		<p>Section 8 refers to information sharing and the legal basis where information can be shared:</p> <ul style="list-style-type: none"> <li>• Crime and Disorder Act 1998 (Section 115)</li> <li>• Data Protection Act 2018 and UK GDPR</li> <li>• Local information sharing agreements</li> <li>• Safeguarding statutory frameworks</li> </ul>		<p>Reference was January 2026.</p>
<p><b>Recommendation 7:</b></p> <p>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</p>	<p>Local</p>	<p>Herts Police and Probation are currently developing and information sharing hub where probation staff will be embedded in the Herts Police Intelligence Bureau, with direct access to Police systems.</p>	<p>Herts Police and Probation</p>	<p>Ongoing development work owned by our Central Intelligence Bureau.</p>	<p>Ongoing – next update February 2026.</p>	<p>Ongoing – next update February 2026.</p>

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.						
<b>National recommendations</b>						
<b>Recommendation 1</b> 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.	National					
<b>Recommendation 2</b> Further to National Recommendation 1, the statutory guidance should re-enforce the legislation available to share information between	National					

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.						
<b>Single agency recommendations</b>						
<b>Hertfordshire Partnership NHS Foundation Trust (HPFT)</b>						
<p>Training to support better understanding of the MARAC process, DASH and the roles of MARAC representatives and agency responsibilities.</p> <p>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</p>	Local	<p>HPFT Safeguarding team to review existing Domestic Abuse training packages in light of learning from DHR.</p> <p>HPFT Safeguarding Team will explore with Trust People &amp; Organisational Development colleagues whether it is feasible to make DA training compulsory.</p>	HPFT	<p>Existing webinar package reviewed internally.</p> <p>Review of DA training provision as part of Safeguarding training programme plan for 2025-26.</p> <p>HPFT Safeguarding team consultation with People and</p>	<p>End Q.3 2024</p> <p>February 2025</p> <p>Q.3 2024</p>	<p>Completed. All DA training reviewed.</p> <p>Completed. Programme reviewed annually.</p> <p>Completed. DA Training to be incorporated as mandatory component of Level 3 SG Adults</p>

to improve efficacy and impact.				Organisational Development.		and Children training.
ACMHS teams to continue to support all clinical staff to attend suicide risk training and for attendance to be monitored.	Local	Learning from review to be shared via Division QRM	HPFT	Learning shared via QRM	November 2024	Completed.
Training and structured supervision to reinforce the importance of strength-based interventions.	Local	HPFT Safeguarding Team to link in with existing workstreams around Strengths Based Practice. Learning from this review to be shared.	HPFT	HPFT Professional Lead for Safeguarding Adults to consult with HPFT Professional Lead for Social Care.  Learning from review shared.	November 2024  Q.3 2024	Completed.  Completed.
A continuation of regular decision-making audits of safeguarding adults' documents.	Local	Audit schedule to be finalised for 2025.	HPFT	Audit schedule finalised.  Audits carried out	November 2024  Monthly, ongoing.	Completed.  Completed. Monthly dip audits carried out as Business as usual.
Findings from this review will be shared with the clinical director who leads	Local	Learning from review to be shared with clinical director leading on	HPFT	HPFT Safeguarding team represented within Risk	September 2024	Completed. DA now included within risk assessment form.

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.		suicide prevention and Risk assessment CQI.		assessment CQI group.  Learning from review shared.	Q.3 2024	Completed. DA and Suicide included within relevant training packages including Suicide Prevention pathway training
<b>B3 Living</b>						
Newly appointed Neighbourhood Manager to review tenancy management processes including ASB and Domestic Abuse.	Local	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.	B3 Living	Robust policy and processes for staff to be able to investigate ASB and support Victims of domestic abuse.  Training arranged to ensure consistency and embed process with team.	December 2024	Update March 2025: ASB policy reviewed, updated and implemented formally as of January 2025.  Training rolled out to Housing Neighbourhood Team in October & November 2024 including new process for prioritising ASB cases, interviewing skills, case Investigation skills, supporting &

						<p>safeguarding victims of ASB including domestic abuse.</p> <p>Neighbourhood &amp; ASB Manager assesses domestic abuse and other priority cases and actioning in first instance.</p>
Domestic Abuse Awareness Training to be arranged.	Local	Housing Manager to arrange training for all front-line staff at B3 Living.	B3 Living	Skills to support and advise victims of domestic abuse, make referrals to support agencies and safeguard victims.	December 2024	<p>Update: March 2025</p> <p>Safer Places tea/coffee afternoon arranged for 28/2/25. Presentation given relating to services. Attended by several frontline staff. Further session arranged for 25/3/25 with B3 staff at housing team meeting.</p>
<b>East Herts District Council - Community Safety (Anti-social Behaviour) and Environmental Health</b>						

To strengthen information sharing between EHC Community Safety and Environmental Health (Nuisance) for cases due to separate recording systems.	Local	Develop a process to notify teams where addresses / persons are known.	East Herts Council – Community safety & Environmental Health	Review of existing process and how to overcome the use of different case management systems without duplicating work.	December 2024	July 2024  Officers from Community safety have been given access to 'Uniform' and can place 'Alerts' on addresses to notify officers that they are aware of the address and also check for any records Env Health hold if a new complaint is received.
To remind all partners of the importance of multi-agency working and referring into ASBAG in a timely way.	Local	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.	East Herts Council – <i>as the administrator of ASBAG</i>	Revised Terms of Reference includes details of case referral process and criteria.	Ongoing- quarterly	Ongoing- quarterly
To produce an ASB Policy and Procedure for internal use within the Community Safety Team and cross reference it with existing	Local	To create an ASB Policy and Procedure for East Herts Council Community Safety use.	East Herts Council – Community Safety Manager	Meetings have taken place with Environmental health to align local processes to support collaborative working	March 2025	March 2025

Environmental Health policies and procedures.				and sharing of information.		
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 legislation) where the case could indicate possible DA at the address.	Local	Officers who respond to initial noise complaints to utilise pre-agreed wording and signposting advice to include with letters as appropriate	East Herts Council – Environmental Health	Additional information has been added to the 'Subject' letter to include information about support available and a recognition that residents can experience challenges that can result in increased noise. The information provided is not specific to DA so as to not place any victim at further risk.	March 2025	January 2026
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.	Local	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.	East Herts Council	One session was delivered in February 2024 however additional sessions to be delivered.  In 2025 Housing Options attended DA training at Future Living (a local DA charity)	March 2025	Ongoing.

				As part of the global 16 days of activism (Nov – Dec) to end Violence Against Women and Girls (VAWG) a session was delivered at EHDC Offices on DA. This was delivered by a survivor of DA who had lived experience. This was also live streamed on YouTube.		
For the CSP to continue to strengthen links with DA support services such as Safer Places	Local	To invite specialist services to provide guest presentations or attend community events. To promote national campaigns such as White Ribbon week.	East Herts Community Safety Partnership	<p>East Herts and Broxbourne now have an established DA Forum. This has representatives from both district and borough councils and local DA charities and agencies.</p> <p>A number of events took place during the 16 days of activism. This included an awareness walk, information stand in a shopping centre and a co-ordinated social</p>	December 2025	Ongoing

				media campaign. The social media posts had over 35000 views over the 16 days.		
<b>Refuge – IDVA service</b>						
Refuge to develop good practice guidance on reaching people with multiple disadvantages, to access community-based services.	Regional	<p>1, Hold an EDI focus group with services at Refuge to gather current good practice and areas for improvement.</p> <p>2, Write good practice guidance on reaching people with multiple disadvantage</p> <p>3, Disseminate good practice guidance to services via services information channel and through operational managers meetings and then individual team meetings.</p>	Refuge		<p>Dec 24</p> <p>Jan 25</p> <p>Feb 25</p>	<p>1. Completed April 2025 – focus group held with service and deputy managers.</p> <p>2. Completed December 2025- guidance was written and reviewed by service managers and EDI chairs.</p> <p>3. Completed February 2026 – guidance has been disseminated and will be discussed at service managers</p>

						meeting on 11/02/26
<b>GP</b>						
Documentation	Local	To use clinical templates which allow abuse to be flagged on the clinical system alerting future clinicians and reception staff to this risk.	Primary Care	Discussed at surgery SI meeting and review meeting.	Nov 2024	Completed at review meeting Nov 2024
Training	Local	Ensure all staff clinical and non-clinical have completed relevant safeguarding training.	Primary care	Regular monitoring of compliance with training aiming for 100% compliance.	Jan 2025	Regular monitoring in practice by HR Team - ongoing
Communication	Local	Improvement in communication and updates between organisations.	Primary Care	Quarterly PCN mental health MDTs	Jan 2025	Ongoing
<b>Hertfordshire Police</b>						
Where anti-social behaviour plans are adopted, it would be prudent for the plan holder to consult with the PVP safeguarding team to determine whether there is a correlation between the anti-social behaviour and domestic abuse in respect of the occupiers	Local	To Review ASB guidance ensure fitness for purpose, ensuring that that consultation takes place with relevant safeguarding teams when conducting ASB assessment and planning.	Police	SOP Update Required. Action owned by Service Delivery Policing Team/PPC and under review by SCROL team to establish appropriate wording and guidance.	April 2026	

and those frequenting the address/location to ensure that the safeguarding intelligence perspective is fully informed, and relevant safeguarding considerations are made as part of the partnership response.						
Officers should consider other opportunities to safeguard victims of domestic abuse where possible considering whether a domestic violence protection notice is appropriate and whether Clare's Law disclosure is applicable.	Local	To review policy, procedure, training and process to ensure fitness for purpose, and to ensure that risk around DA perpetrators is properly assessed and acted upon in order to utilise Clare's law where appropriate.	Police	Significant increase in use of DA disclosure laws across the organisation, since this recommendation was first introduced. Use of Claire's Law and DVPN update in terms of most recent review processes and SOP to be provided by DAISU DCI.	April 2026	
Best practice is that addresses of victims of domestic abuse are flagged on the STORM command and control system through approved practice and protocols.	Local	To review Domestic Abuse SOP and protocols, ensuring fitness for purpose, and that consideration is given to flagging Domestic Abuse Victims on Command and Control Systems where appropriate.	Police	Enquiry in hand with the Public Contact Centre (Force Control Room) to confirm that this takes place as standard and is reflected in the wider DA SOP.	April 2026	

Note, flags can be raised by other partnerships.						
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## **Appendix A**

### **Terms of Reference**

The following are the specific terms of reference chosen by the panel to explore at their initial panel meeting.

#### **Domestic Abuse, Cuckooing and Antisocial Behaviour**

- Was domestic abuse and cuckooing considered within the reports of antisocial behaviour received by Environmental Health, ASB Team, Police, Housing and any other relevant organisations. If not, should it have been and are there ways to ensure it is considered in future?
- Was [Cocoon Watch](#) and any other relevant schemes / initiatives considered within the measures available to address concerns and gain support from neighbours.
- Whether family, friends and neighbours were aware of any abusive or concerning behaviour between the perpetrator and victim (or other persons). Were there any barriers they may have experienced in reporting concerns?
- Were opportunities to support Denise to apply for legal orders (e.g non-molestation orders, occupation orders) recognised and utilised?
- Whether counter allegations were appropriately considered within the context of the abusive relationship.

#### **Information Sharing**

- Were all appropriate services connected and liaising with each other to try and reduce the risk of domestic abuse? If not, are there ways to improve responses in similar circumstances to include all relevant practitioners.
- A review of any Multi-Agency Risk Assessment Conference (MARAC) involvement and, where there wasn't any, whether there could have been.
- If MARAC referrals were made and declined, what were the reasons and are they in line with current recognised national best practice?
- A review of any multi agency meetings in relation to this couple and whether they addressed domestic abuse effectively. If not, are there any improvements which can be made to improve future practice.
- Was a Claire's Law disclosure considered for Denise? If not, could it have been. Would this disclosure have included his previous cuckooing activity?

#### **Addressing Perpetration**

- Were there services available locally for those using harmful behaviour and if so, were these known about and were there opportunities to inform and direct Gary to these (e.g probation). Were practitioners confident in knowing how to ask these questions?
- What measures were taken to disrupt Gary's abuse of Denise e.g banning him from the block of flats, DVPO etc

- Were opportunities taken to address all of Gary's offending towards Denise including harassment, stalking and coercive control (not an exhaustive list).
- Was he known to MAPPA and if not would he have been eligible?
- MATAC is a recent introduction to Hertfordshire. Would Gary have been eligible to heard at this forum? If not, would it be of benefit for people in similar circumstances to be eligible?

#### Risk Assessment

- Whether Gary's domestic abuse related history was considered when assessing risk.
- Were DA risk assessments completed with appropriate referrals made from these?

#### Mental Health

- Was risk of suicide considered within the support Denise received?
- Was the domestic abuse Gary disclosed considered within mental health support plans / suicide intervention plans?

#### Training Needs / Polices / Practice Review

- An evaluation of any training or awareness raising requirements that are necessary to ensure a greater knowledge and understanding of domestic abuse processes and/or services with specific consideration of coercive control, stalking and harassment behaviours.
- Whether the work undertaken by the services in this case is consistent with its own: professional standards, compliant with its own protocols, guidelines, policies and procedures.
- Do the lessons arising from this review appear in other reviews held by this Community Safety Partnership?
- Any other information that becomes relevant during the review.

