Welwyn Hatfield

Community Safety Partnership

Domestic Homicide Review

Executive Summary

Marie * (August 2017)

Marie was a very much-loved mother, daughter, sister, and friend.
Her mother describes her as "caring, funny, affectionate, bubbly and kind. She didn't have a bad bone in her body."
One of her children said: "She cared for me, and she was my mum .... she would message 'How you doing?' I miss that."
Her friends have paid tribute to an "angel" who "was always there for a cuppa and a chat whenever you needed one."
A friend spoke of her "My dear friend, I will love and miss you forever. Rest in paradise until we meet again."
A neighbour described how "She always used to joke about taking our garden fence down …. we always helped each other out when needed, with a cuppa, chat or hug."
Friends described how Marie was mischievous, funny, and always 'made you laugh' was loyal, caring and was 'always there for you, whatever…'
"Marie a light as bright as yours can never be extinguished. You will shine forever."

Mary Mason
June 2021

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THE REVIEW PROCESS

This summary outlines the process undertaken by Welwyn Hatfield Community Safety Partnership domestic homicide review panel in reviewing the homicide of Marie who was a resident in the area.

The following pseudonyms have been used in this review for the victim and perpetrator (and other parties as appropriate) to protect their identities and those of their family members:

Marie, the victim was 30 years old when she died by suicide in 2017. She was taken into hospital in August 2017 and died 3 days later. She was white British and had three children.

The three children are:

- Leo aged 14 when Marie died.
- Ella aged 11 when Marie died.
- Chloe aged 3 when Marie died.

The fathers of the children are:

- Jake father of Leo
- Andy father of Ella
- Tom father of Chloe

Marie's mother is Lisa.

Ella's paternal grandmother is referred to as Debra and her step grandfather as Grandfather.

Criminal Proceedings were completed in March 2018. Christopher was found guilty of controlling or coercive behaviour in an intimate relationship under the Serious Crime Act 2015, assault by beating and assault occasioning actual bodily harm. He was sentenced to 4 years and 3 months imprisonment which included three months of a suspended sentence for cocaine possession in 2017.
The Judge also imposed a Criminal Behaviour Order, lasting 10 years, requiring Christopher to inform police of any sexual relationship he has in future lasting more than 14 days, and to notify police within 21 days of the start of the relationship.

The Coroner's original verdict was quashed on appeal by family members and the Coroner is waiting for this report in order to re-open the inquest.

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

Welwyn Hatfield Community Safety Partnership (CSP) commissioned a first Review in 2017 which reported on 20 November 2018. The delay being due to the criminal trial of Christopher. The CSP reviewed the circumstances against the criteria set out in the Multi Agency Statutory Guidance for the conduct of Domestic Homicide Reviews (2013) and recommended to the Chair of the CSP that a Domestic Homicide Review should be undertaken. The Chair ratified the decision to commission a Domestic Homicide Review and the Home Office was notified on 31 August 2017.

An independent chair/author was commissioned to manage the process and compile the overview report.

The CSP decided to reconvene the domestic homicide review on 10 March 2020 and notified the Home Office of this decision on 19 March 2020. There was a delay in appointing a Chair until October 2020 because the Home Office advised that work on the domestic homicide reviews should be suspended during the pandemic.

The Panel first met in October 2020 to agree the Aims and Key Lines of Enquiry, the timetable, and any further panel members. Individual Management Reports (IMRs) were also agreed at that meeting. The timetable for the Review was changed to 30 April 2003, the DOB of Leo, to 26 August 2017, the date of death of Marie. This was to include earlier history absent from the first review which reported from 1 May 2014.

A full IMR was not requested from all agencies as most had already written a first IMR, all agencies were however asked to review their IMR and add further information to reflect the changed dates of the DHR. In light of the changes the Chair met with all panel members individually to discuss their reviews in light of the changed Aims and Key Lines of Enquiry.

The total number of agencies contacted which confirmed contact with the victim and/or perpetrator and children involved and asked to secure their files was seven.

CONTRIBUTORS TO THE REVIEW

IMRs, including a chronology were requested and received from:

All IMR authors confirmed their independence in that they had not had any direct or line management involvement in this case or knew the victim, perpetrator, or their families.

Hertfordshire Constabulary
Hertfordshire Community NHS Trust
Hertfordshire Children's Services
East and North Hertfordshire NHS Trust

Reports were requested and received from:

Clarion Housing
Victim Support
Refuge

In addition, for further information, the Chair spoke with:

Advocacy After Fatal Domestic Abuse
Bhatt Murphy Solicitors
Dr Vanessa Munro, Professor of Law, University of Warwick
Hertfordshire CC Strategic Partnership Team (domestic abuse leads)
Hertfordshire Domestic Abuse Helpline
Ludwick Nursery School
Safer Places
Trauma Recovery CIC (Herts)

REVIEW PANEL MEMBERS

The panel met four times. All members were independent of the case i.e., they had no direct management responsibility for any of the professionals involved in the case. The review panel comprised:

Name	Designation and Attendance
Mary Mason	Independent Chair
Louise Bayston	Senior Operations Manager, IDVA service, Refuge (domestic abuse specialist)
Anna Borella	Detective Chief Inspector, Hertfordshire Constabulary (substituted for DCI Walsingham at one meeting)
Vicky Boxer	Senior Social Worker, Spectrum CGL (Drug & Alcohol Specialist)
Sian Chambers	Head of Community and Housing Strategy, Welwyn Hatfield Borough Council (CSP rep)
Tracey Cooper	Associate Director or Adult Safeguarding, East & North Herts CCG and Herts Valleys CCG.
Sarah Corrigan	Children's Safeguarding Lead, East & North Herts NHS Trust (ENHT)
Louise Coulson	Senior Operations Manager, IDVA Service, Refuge (domestic abuse specialist). Superseded by Louise Bayston
Danielle Davis	Senior Development Manager, Domestic Abuse, HCC. Local Authority Statutory Member.
Katie Dawtry	Development Manager Domestic Abuse, HCC. Previously Local Authority Statutory Member. Superseded by Danielle Davis
Brenda Evans	Therapeutic Lead & Hertfordshire Manager, For Baby's Sake Trust (ACE specialist)
Stephenie Evis	Named Nurse for Adult Safeguarding, East & North Herts CCG and Herts Valleys CCG (substituted for Tracey Cooper at one meeting)
Enda Gallagher	Adult Safeguarding Lead Nurse, ENHT
Alison Hopkins	Senior Probation Officer, National Probation Service
Janet Jones	Head of Assessments, Children's Services, HCC
Sheila Middleditch	Safeguarding Children Nurse Manager, Hertfordshire Community NHS Trust (HCT)
Rachel Millar	Senior Business Development & Communications Manager, Safer Places (domestic abuse specialist)
Susan Pleasants	Victim Care Team Manager, National Probation Service. Superseded by Alison Hopkins.
Grace Robertson	Clarion Housing (formerly Affinity Sutton Housing)
Sue Thompson	Named Nurse Safeguarding Children & Rapid Response Lead Unexpected Child Deaths, HCT (for Sheila Middleditch)
Graeme Walsingham	Detective Chief Inspector, Herts Constabulary
Sarah Wells	Head of Operations (East), Clarion Housing (formerly Affinity Sutton Housing)

AUTHOR OF THE OVERVIEW REPORT

The chair and author of this review is Mary Mason. Mary is an independent freelance consultant and has never been employed by or had any connection with the Hertfordshire agencies involved in this DHR.

Mary was formerly Chief Executive of Solace Women's Aid (2003-2019), a leading Violence against Women and Girls (VAWG) charity in London. Mary is a qualified solicitor (non-practising) with experience in both criminal and family law.

She has more than 30 years' experience in the women's, voluntary and legal sectors in supporting women and children affected by abuse. She has experience in strategic leadership and development; research about domestic abuse; planning and monitoring & evaluation of VAWG programmes. Mary has successfully adopted innovative solutions to ensure effective interventions which achieve results, increasing the quality of life of women and children.

TERMS OF REFERENCE FOR THE REVIEW

The review was conducted in accordance with the Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (2016) under s.9(3) Domestic Violence, Crime and Victims Act (2004). Welwyn Hatfield Community Safety Partnership commissioned a first Review in 2017 which reported on 20 November 2018.

Welwyn Hatfield Community Safety Partnership agreed to reconvene the DHR on 10 March 2020. There was a delay in appointing a Chair until October 2020 because the Home Office advised that work on the DHRs should be suspended during the pandemic.

The timeframe for the Review was changed to April 2003 to August 2017, when Marie died. This was to include earlier history absent from the first review which reported from 1 May 2014.

Aims and Key Lines of enquiry

The aim of this review is to:

i. Establish what lessons can be learned from Marie's death about the way in which professionals and organisations work individually and collectively to safeguard victims.
ii. Identify how and within what timescales those lessons are to be acted on, and what is expected to change as a result.
iii. Prevent domestic homicides and related suicide by improving the way services respond to all victims of Domestic Abuse and their children, through improved understanding and intra and inter agency working.
iv. Apply those lessons to service responses including changing policies and procedures as appropriate.
v. The timeline of this review to be from April 2003 to August 2017, when Marie died.

Key lines of enquiry:

i. Police attendances at Marie's home from April 2003 to August 2017, in particular but not solely on 17 July 2017.

ii. Police knowledge of the history of domestic abuse by Christopher, in previous relationships.

iii. Whether agency reports addressed both the 'generic issues' set out in the Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (2016) and the following specific issues identified in this particular case:

a) The history of domestic abuse experienced by Marie.
b) Marie's history of trauma and alcohol use.
c) Marie's fear of having her children removed from her care.
d) Whether Marie was offered support in approaching domestic abuse agencies for help and if not, why not?
e) What support was offered to Marie's children around their experiences of domestic abuse?
f) What knowledge do agencies now have in general and historically about Marie's three children, about the impact of trauma on a child.
g) What knowledge or information agencies had that indicated that Marie and her children might be at risk of abuse, harm, or domestic abuse and how the agency responded to this information?
h) If any agency had information that indicated that Marie and her children might be at risk of abuse, harm, or domestic abuse and if so, whether this information was shared and if so, with which agencies or professionals?
i) If any agency had knowledge of Marie and her children which influenced professionals' decision making in any way. Whether bias impacted in any way on support and professional decision making. Whether this was related to direct and/or unconscious bias because of Marie's needs, her use of alcohol and her position as a single mother.
j) Whether agencies were then and are now limited by lack of capacity or resources and whether at the time this had an impact on the agency's ability to provide support to Marie and her children.
k) Whether agencies were limited by lack of capacity or resources and whether this had an impact on the agency's ability to provide support to or to prevent Christopher, from repeatedly perpetrating domestic abuse.
l) Whether lack of capacity or resources had then and have now an impact on any agency's ability to work effectively with other agencies.
m) Whether staff in all agencies are trained and supported in their practice around all areas of domestic abuse including coercive control.
n) Whether agencies are confident in asking questions about domestic abuse, particularly when the alleged perpetrator is at the meeting and including when the meeting is on-line.
o) Whether agencies are confident in how to respond to domestic abuse and know how to refer cases to other agencies.

iv. What changes have taken place in agencies since 2017 to address the needs of survivors of domestic abuse and prevent Domestic Homicides, including suicide? What further changes are required?

SUMMARY CHRONOLOGY

Marie was 30 years old when she took her own life in August 2017 in response to the coercively controlling behaviour of Christopher, a serial domestic abuse perpetrator. Marie had been in a relationship with Christopher for 5 months, during which time she had experienced multiple forms of abuse: physical, psychological, sexual, and financial. Marie had 3 children, two of whom (Leo and Chloe) were living with her and Christopher at the time she died. They were staying with relatives when Marie took her life.

Marie had experienced much trauma in her life. Christopher was her 4th significant intimate partner relationship; all 3 previous partners had come to the attention of the police for domestic abuse. Christopher was found guilty of controlling or coercive behaviour towards Marie, as well as assault by beating and assault occasioning actual bodily harm, in March 2018. He was sentenced to 4 years and 3 months imprisonment. The Judge also imposed a Criminal Behaviour Order, lasting 10 years.

Assessments carried out by Hertfordshire Children's Services and reports from the schools and health visitors showed a loving relationship between Marie, Leo and Chloe and emotional warmth in the home. There were also many concerns raised with Children's Services and the Police about Marie's being inebriated while caring for her children. The children were affected by the domestic abuse which they had witnessed and Marie's use of alcohol, most likely related to the domestic abuse trauma she had experienced.

Marie's daughter, Ella (aged 8) told her grandmother in 2014, that Marie had physically attacked her while she was under the influence of alcohol. A Fact-Finding Hearing found that on the balance of probabilities this was true. This resulted in a Consent Order in a private family law hearing in 2015, that Ella live with her grandmother and step grandfather. Following this, Marie kept in touch with Ella by text and sent Birthday and Christmas cards but was unable to see her regularly due to distance.

Police attended Marie's home 12 times between 2004 and 2017, for domestic abuse incidents, involving 4 different perpetrators. One medium risk assessment and two standard risk assessments were completed, no risk assessments were carried out at other attendances. Five different referrals were made by the police to Children's Services, but no referrals were made into specialist domestic abuse support services or MARAC.

Christopher was a multiple perpetrator of domestic abuse. There were 7 reports of domestic abuse to the police about him by three different women in a 12-month period in 2014-2015, none of which resulted in him being charged. He had a history of other minor criminal offences and was arrested in June 2016 and convicted in January 2017, for possession of a firearm (a stun gun) and possession with intent to supply a class A drug (cocaine). He received a suspended sentence. Probation prepared a Pre-Sentence Court Report (PSR) but had no record of domestic abuse and no supervision order was put in place. Victim Support received two referrals for Christopher, both were recorded for information only.

Marie and Christopher visited A&E in June 2017, following what was later revealed as a non-accidental injury to her head which required gluing. They presented together and explained the injury as

occurring when they were 'fooling about'. This was accepted and no enquiries were made about domestic abuse.

Significantly the Police attended a call out on 9 July 2017, just over a month before Marie died. One of the Officers present was trained as a DVERO (domestic violence emergency response officer). We now know that the attendance was a result of a call by a neighbour who had been alerted by Leo, Marie's oldest child and that Leo had witnessed Christopher attack his mother and attempt to strangle her.

The officers spoke separately to Marie and Christopher who told them that the altercation had been verbal. They carried out a DASH risk assessment which resulted in 6 positive ticks including that Marie was very frightened of Christopher, was depressed and that Christopher was very angry and had been arrested before. The Officers were aware of Marie and Christopher's history but did not use their Professional Judgement to make a referral to MARAC. The police did not inform Marie about Christopher's history. They could have used Clare's Law to pass her information about his abuse of women he was in an intimate relationship with.

The Police knew there were children living in the house but did not make enquiries to check on their safety and did not carry out a door-to-door enquiry to find out who had made the call. If they had done so they would have found Leo at the neighbours and been able to speak to both the neighbours and Leo about what had happened with the likely result that a MARAC referral would have been made.

A domestic abuse Child Referral form was sent to Children's Services and passed to the Family First Team but as the DASH risk assessment was standard risk it was not treated with urgency and by the time Marie took her own life, six weeks later, there had been no follow up action. A domestic abuse referral was also made to the Health Visitor team who, based on the standard risk assessment did not take follow up action. It appears that neither team reviewed Marie's whole history.

The outcome and impact of this Police call-out is concerning and contributed to a failure to protect Marie and her children.

There are several issues identified in this report. The panel have particularly highlighted the learning in relation to domestic abuse and repeat victims by multiple perpetrators. By not reviewing the whole of Marie's record when there was an incident, agencies did not see the pattern of abuse and although Marie's history was acknowledged in Children's Services assessments, the traumatic impact of domestic abuse was not investigated and professional curiosity around Marie's drinking not used to understand what might be happening to this family.

Agencies have all been open and transparent about the improvements needed and reflected on the learning with many improvements identified and in place. There are improvements needed in recognising and assessing the impact of abuse on individuals, including children, and the trauma they have experienced as well as professional enquiry and clear inter agency communication.

There was a lack of understanding of coercive control particularly by the police officers who attended on 9 July 2017. A lack of referrals to specialist domestic abuse services, and a tendency to look at

individual incidents and not explore factors such as the history of domestic abuse by all parties and the victim's reasons for her behaviour.

Assessments by Children's Services were detailed and thorough but showed a lack of professional curiosity. They do not appear to have asked themselves key questions about why Marie was using alcohol? Why did she not return calls or keep appointments and how her history of domestic abuse had impacted on her?

Key learning has led to recommendations at a national and local level.

KEY ISSUES ARISING FROM THE REVIEW

A number of themes have emerged from this review:

a) Recognising that Domestic Abuse is most likely, in its severest forms to be perpetrated by men against women
b) Suicide associated with Domestic Abuse
c) Importance of seeing the life story of the individual victim/survivor and not individual incidents
d) The link between multiple abuse, trauma, and alcohol use
e) Support for Marie
f) Risk Assessments were carried out which assessed risk but did not fully consider Marie's support needs and did not assess her partner/the father
g) How information is recorded and shared between agencies (including specialist domestic abuse agencies) and how this is reviewed
h) Children as victims of domestic abuse and impact of trauma

CONCLUSIONS

There are several issues identified in this report and conclusions drawn. Agencies have worked to identify and learn from the issues which were highlighted by the previous report writer and changes have been put in place since the last report in 2019.

The panel have particularly highlighted the learning in relation to domestic abuse and repeat victims by multiple perpetrators. By not reviewing the whole of Marie record when there is an incident, agencies did not see the pattern of abuse and although Marie history was acknowledged in Children's Services assessments, the traumatic impact of domestic abuse was not investigated and professional curiosity around Marie drinking not used to understand what might be happening for her and by relationship, to her children.

The impact on the children, who were living in the house with him, was profound. They disliked him intensely and were scared for their mother as well as being worried about being separated from her.

Agencies have all been open and transparent about the improvements needed and reflected on the learning with many improvements identified and in place. There are improvements needed in recognising and assessing the impact of abuse on individuals, including children, and the trauma they have experienced as well as ensuring good and clear inter agency communication.

There was a lack of referrals to specialist domestic abuse services, perhaps because the DASH risk assessment was being used too literally as a determinant of risk, rather than being used as a general indicator with other factors like history of domestic abuse, level of fear and the perpetrators history, guiding the investigation. However, we would expect the police to refer survivors into support in all incidents, having regard to research on the frequency and length of domestic abuse before survivors generally report to the police.

The outcome and impact of the police visit on 9 July 2017 is concerning. The Police have acknowledged several aspects of this which should not have happened and improvements to systems have been put in place. The failings include not investigating fully, particularly as the original call out informed them that 2 children were present with one possibly autistic child who was therefore very vulnerable. This failure meant that the case was not escalated to DAISU, and the domestic abuse Child Referral form registered the risk as standard.

This in turn had an impact on Children's Services, who did not fully access Marie's history, but noted that there was no Children's Services history in the past 12 months. The case was referred to Families First Team, but no actions had been completed prior to Marie death, six weeks later. If they had read her previous assessments, they would have seen that she was a multiple victim of domestic abuse, there were issues about alcohol use and that the Marie and the children had both raised fears about the children being removed, following Ella leaving the family home. This may have alerted them to the increased risk to Marie.

The Health Visiting team similarly used the standard risk assessment to close their investigation after two failed attempts to contact Marie and did not escalate to a home visit.

Assessments by Children's Services were detailed and thorough but showed a lack of professional curiosity. They do not appear to have asked themselves key questions about why Marie was using alcohol? Why wasn't she returning calls or keeping appointments and how her history of domestic abuse had impacted on her? They noted that there was an impact on the family of Ella moving to live with her grandparents but not how the family could be supported through this loss.

This was the first national case of a conviction of coercive control after the death of a victim, since the introduction of the offence under the s76 Serious Crime Act in 2015 and the police were commended for their investigation following Marie's death.

LESSONS TO BE LEARNT

Lessons from the previous review in this case have been put in place by all agencies. There have in addition been key changes which have led to significant learning across services.

Learning has been identified in this report in 8 key areas:

1. Information sharing between agencies, the need for the whole person/family to be visible.
2. To look at the history of abuse by the perpetrator and the impacts of abuse on the victim(s) over the life history.
3. To understand the support someone in Marie's position needs, recognising the different elements of domestic abuse she was experiencing including physical, emotional, controlling, or coercive behaviour and economic abuse and avoid victim blaming which prevents the professional from seeing the whole history of abuse.
4. The need for trauma informed services and assertive outreach for those with multiple disadvantages with a pathway of support in place for repeat victims of multiple perpetrators.
5. Suicide and Domestic Abuse – recognising its frequency, the impact of coercive control, symptoms to recognise and

6. To include learning about attempted / non-fatal strangulation as an indicator of the escalation of domestic abuse.
7. The use of risk assessments as tools to identify but not determine risk. The use of professional curiosity – why was Marie drinking? What was the impact on her of losing Ella and why was she so resistant to referring herself and children into support?
8. The traumatic impact of domestic abuse on victims/survivors and children and the need for agencies to recognise this and support to be in place for children as victims and not bystanders.

RECOMMENDATIONS FROM THE REVIEW

National

The Quality Assurance Panel are asked to write to the Home Office requesting the following recommendations and for agreement that the Home Office response is shared with Hertfordshire County Council:

a) An allocated lead at the Home Office is responsible for establishing a national fund to enable a package of therapeutic and advocacy support to be put in place for child survivors of Domestic Homicide and suicide linked to Domestic Abuse. The Home Office to report back to Hertfordshire CC on this recommendation and its' implementation.
b) That the Home Office issue guidance that repeat victims of multiple perpetrators are treated as a special category of domestic abuse victim/survivor with automatic escalation to MARAC; that the DASH risk assessment is amended to reflect this change with guidance and training in place.
c) National Tier 1 training to include the importance of developing the professional curiosity skills of students, using domestic abuse case studies and national guidance to assist in improving this skill. This recommendation is linked to issues arising following the lack of professional curiosity used which impacted on decision making and professional judgement in this case.

Hertfordshire County

a) All Agencies involved with this review to report that they are now sharing information on a consistent basis with pathways and checks in place to ensure the right information is being shared. Agencies to confirm they are sharing historic as well as current information about domestic abuse.
b) Hertfordshire Domestic Abuse Partnership to roll out an agreed community awareness and training programme over the next 12 months with the aim of increasing awareness amongst all communities of Domestic Abuse and the role organisations, family and friends can play in tackling and reporting domestic abuse.
c) Hertfordshire Domestic Abuse Partnership publish, publicise, and maintain updated lists of organisations who can offer help and support to victims and survivors, ensuring these are available to communities across the County.
d) Police, Health Services and Children's Services increase their awareness of the role of the different third sector and specialist organisations in Hertfordshire, including therapeutic trauma services and ensure they refer their clients/patients/service users appropriately into these services.

e) Statutory and Voluntary sector agencies involved with this Review confirm that they include a trauma Informed approach to their work with victims and survivors and train and support their staff in this approach.
f) Hertfordshire Domestic Abuse Partnership develop a policy which recognises the particular vulnerability of repeat victims of multiple perpetrators and ensures they are treated as a special category with referral into MARAC and specialist outreach support to ensure they can engage with services.
g) Children and Adult Services include in their Safeguarding training an awareness of the link between domestic abuse, substance use, mental ill health and trauma and the services available for those impacted including counselling and therapeutic support.
h) Children's Services, CGL and the IDVA teams work together to develop a joint understanding of alcohol dependency and Domestic Abuse which is reflected in policy, training, and support pathways.
i) Hertfordshire Domestic Abuse Partnership ensures all agencies are aware of their changed responsibility under the domestic abuse Bill once enacted which is expected to recognise children as victims of domestic abuse.
j) Hertfordshire Domestic Abuse Partnership considers establishing Community based support for domestic abuse perpetrators. That a report, outlining successes elsewhere and the cost of a programme, is presented to the Community Safety Partnership
k) Agencies involved in this Review, check their policies, communications, training, and records to ensure they avoid victim blaming which prevents the professional from seeing the whole history of abuse.
l) Hertfordshire Domestic Abuse Partnership facilitates training which includes learning about
    a. domestic abuse and suicide
    b. attempted / non-fatal strangulation as an indicator of the escalation of domestic abuse with risk of homicide and suicide.
m) Hertfordshire Domestic Abuse Partnership reviews services across the County with a view to ensuring therapeutic support is available to all survivors of domestic abuse, including children.

SINGLE AGENCY REPORTS AND RECOMMENDATIONS

Hertfordshire Constabulary

a) Schools are currently notified of domestic abuse incidents. This has not yet been extended to under 5's, this recommendation to be implemented alongside safeguarding reorganisation plans.
b) Recommend that Officers discontinue the use of 'Domestics' and 'Domestic Disputes' and use the term 'Domestic Abuse'.
c) Children are seen by Officers in domestic abuse call outs and where appropriate spoken to individually and separately from the perpetrator.
d) Information shared with Children's Services and within MASH to include any domestic abuse and other violence, including abuse involving previous partners of both perpetrator and victim.
e) Information is passed to all victims of domestic abuse about domestic abuse support services and victims are encouraged to contact services for support.
f) Special consideration to be given to escalate repeat victims of multiple perpetrators to MARAC.

g) Training to include the danger of attempted / non-fatal strangulation as an indicator of escalation of abuse.
h) The Police provide Probation with domestic abuse history alongside other information for Court. Police and Probation to discuss and implement this recommendation.

Hertfordshire Children's Services

a) To share the reflections gained in this IMR with the workforce (by way of a learning bulletin) and in particular the impact of repeat victimisation from multiple partners.
b) To consider additional ways of supporting victims/survivors including young parents who are experiencing substance use and domestic abuse to ensure they can access support.
c) Hertfordshire Children Services contacts the carers of the three children in this case and establishes whether they have access to the therapeutic resources needed to support the three children. If this is not the case that they establish a fund to enable the children to access the support, they need.

East and North Hertfordshire NHS Trust

a) The need for a Trust-wide holistic and robust domestic abuse policy which examines the signs of domestic abuse, barriers to disclosure and gives clear guidance on safe and effective domestic abuse enquiry (including specific guidance on 'asking the question' & question framing).
b) Areas within the Trust, such as Adult ED, Maternity, Community Paediatrics, Gynaecology, Plastics and Orthopaedics to have an enhanced provision of domestic abuse training which supports the development and understanding of the purpose of routine domestic abuse enquiry within those areas and equips staff with knowledge and experience in the recognition, response, and risk assessment of domestic abuse. This training will also focus on case scenarios regarding how to create an environment to support safe enquiry.
c) Further review of the Specialist Health Visitor assessment tool; to incorporate domestic abuse routine enquiry as a standard for each initial assessment, to gather family functioning/dynamics and identification of men in children's lives.
d) The review supports the recommendation of community services employed by East & North Hertfordshire NHS Trust to have read access to community records (System one) to enhance communication and information sharing with universal services.
e) Information sharing between specialist Health Visitor service and community services – a review of current information sharing practices in place should take place.
f) Development of domestic abuse care bundles: domestic abuse care bundles are a bundle of information/documentation which will support a clinician where there is a suspicion of disclosure of domestic abuse. This will include the domestic abuse Pathway, clinical photography prompts, body maps & literature for safety planning and onward referrals to IDVA & Safeguarding Services.
g) Trust wide annual domestic abuse audit to be commenced, examining efficacy of domestic abuse enquiry, recognition, and responses to domestic abuse. This will be the foundation for future training and service improvements.
h) Development of domestic abuse champions within each department within the trust, who will receive additional local training on domestic abuse, risk assessment and safety planning, to

help develop knowledge from the 'ground up'. The role of the domestic abuse champion will be to support the frontline staff on domestic abuse identification, domestic abuse enquiry and to ensure the victim & their children get the right and appropriate support in a timely manner.

i) Domestic Abuse awareness raising throughout the organisation (e.g. screensavers, active participation in awareness days & regular internal communications) alongside the above recommendations will provide a further reinforcement.

Hertfordshire Community NHS Trust (HCT)

a) HCT policy review to be finalised and to ensure there is adequate response to domestic abuse victims who have been subject to abuse from different partners.
b) HCT Domestic Abuse training to be updated to ensure that greater awareness is raised regarding coercive control and victim suicide.

Probation Service

a) The Police provide Probation with domestic abuse history alongside other information for Court. Police and Probation to discuss and implement this recommendation.
b) As a matter of good practice all offenders at Court interview stage are asked about their relationship status, previous relationships, and the quality of those relationships.