Three Rivers Community Safety Partnership

Domestic Homicide Review

Overview report into the death of Fiona

December 2021

Independent Chair and Author of Report: Luke Kendall

Date: December 2024

Pen portrait

Fiona was 53 years old. Fiona reported at different times she had left school at 13 years old and that she had attended Hertfordshire University. Fiona had two adult children and grandchildren. In 1997, Fiona was struggling to care for her two young children, and one went to live with her sister, and the other with her father. Fiona also had two sisters and a niece. Fiona lost her mother to COVID in January 2020; however, it is understood she was survived by her father, who had social care needs because of vascular dementia and physical health problems.

Fiona had sporadic contact with her family and some interactions appeared to result in difficulties. Fiona had diagnoses of F20.0 Paranoid Schizophrenia and Personality Disorder, however she only received a diagnosis for the former in the year leading up to her death. She did not agree with the diagnosis of Schizophrenia and attributed her distress as a result of George's abuse.

At the time of Fiona's death, she was living within the confines of substance dependency and an abusive partner. Fiona was subject to physical and sexual assaults, emotional abuse and financial abuse during this relationship with George. Fiona also suffered with bouts of mental and physical ill health and suicidal ideation. At the time of her death, she was mourning the loss of her mother and feeling isolated.

Dedication

The DHR Chair expresses their deepest sympathies to the family and loved ones of Fiona, and thanks them for their contribution and support of this process.

1. Preface

1.1 Introduction

1.1.1 Domestic Homicide Reviews became statutory under Section 9 of the Domestic Violence, Crime and Victims Act 2004 and came into force on 13 April 2011. The Act requires a review of the circumstances in which the death of a person aged sixteen or over has, or appears to have, resulted from violence, abuse or neglect by a person to whom they were either related, in an intimate personal relationship with or living with in the same household.

1.1.2 The purpose of a DHR is to:

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

b) 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.

c) apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate.

d) prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity.

e) contribute to a better understanding of the nature of domestic violence and abuse;

and f) highlight good practice.

1.1.3 This DHR report examines agency responses and support given to Fiona[1], a resident of Hertfordshire, prior to her death at home. Fiona was found dead at her home in late December 2021. Fiona died by suicide. East of England Ambulance Service (EEAS) attended, as did Hertfordshire Police Service (HPS), but tragically, Fiona was pronounced dead at the scene.

1.1.4 This DHR will consider agencies contact/involvement with Fiona and/or George[2] (Fiona's partner) from the beginning of 2013 to the date of the suicide.

1.1.5 In addition to agency involvement, the DHR will examine the past to identify any relevant background or pattern of abuse before the suicide, whether

[1] Pseudonym
[2] Pseudonym

support was accessed and whether there were any barriers to accessing support. In taking a holistic approach, the review seeks to identify appropriate solutions to make the future safer.

1.1.6 The key purpose of undertaking a DHR is to facilitate learning from homicides where a person died as a result of domestic abuse. The Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews 2016[3] (known hereafter as 'the statutory guidance') says: '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'. For lessons to be learned, professionals need to have an insight into what happened in each domestic abuse related death, and of utmost importance, a clear understanding of what needs to be put into place to reduce the risk of such tragic loss of life occurring in the future.

1.1.7 This DHR does not replace the criminal or coroner's courts. It does not take the form of a disciplinary process either.

1.2 Timescales

1.2.1 In accordance with the Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews, the local Community Safety Partnership (CSP), Three Rivers (TRCSP), commissioned this DHR. Having received notification from Refuge (IDVA service), Hertfordshire specialist domestic abuse service, in March 2022, a decision was made to conduct a DHR in consultation with the CSP partners in March 2022.

1.2.2 Luke Kendall, Independent DHR Chair and Author (hereafter 'the chair') was commissioned for this DHR in July 2023. The completed report was supplied to Three Rivers CSP prior to 27th August, which is the date when the author met with member of the CSP to give an overview of key findings. On 11th June 2024 the DHR report was reviewed at a Hertfordshire DHR Panel meeting and signed off by all members apart from Hertfordshire Police. Subsequent meetings took place between the author and Hertfordshire Police on 25th June and 22nd October 2024 to reach sign off, which was achieved on 21st November 2024. Following this, on 12th December 2024, Three Rivers CSP convened a RAG meeting for sign off, before being submitted to the Home Office Quality Assurance Panel on 5th February 2025.

[3] www.gov.uk/government/uploads/system/uploads/attachment_data/file/575273/DHR-Statutory-Guidance-161206.pdf

1.2.3 The Home Office guidance advises that a DHR should be completed within six months of the initial decision to establish a one. The rationale for this time frame not being met:

- The delay in forming the first panel, which sat for the first time in December 2023, hindered by the panel members being resourced out to a high number of concurrent DHR processes.
- The delay in forming all panel meets thereafter, owed to the above.
- To allow for family and friends to contribute to the process.
- Whilst the decision to commission a DHR was relatively expedient, the COVID pandemic contributed to delay.
- An additional delay experienced by the CSP was recruiting DHR Panel Chairs and Authors. To meet this need, the CSP funded an Action After Fatal Domestic Abuse DHR Chair training.

1.3 Confidentiality

1.3.1 The findings of this DHR are confidential until approved for publication by the Home Office Quality Assurance Panel. In the interim, information regarding the DHR has been available only to participating professionals and their line managers.

1.3.2 This DHR has been anonymised in accordance with the statutory guidance. The specific date of the suicide and the sex of any children have been removed (with anonymity further enhanced by Fiona's adult children being referred to as Child A and B). Only the chair and Review Panel members are named.

1.3.3 The following pseudonyms have been used throughout this review, in order to protect the identities of the victim, other parties, family members and the perpetrator/partner:

Name	Relationship to Fiona
Fiona	n/a
George	Partner
Antonia	Sister
Carol	Sister
Child A	Adult child

Child B	Adult child

1.3.4 The author choose the pseudonym for Fiona. The Chair was unsuccessful in contact attempts with the family, in his endeavour to have this pseudonym approved by the family.

1.3.5 At the time of the fatal incident Fiona was 53 years of age white British female and George was a 46 year old white British male.

1.4 Terms of Reference

1.4.1 The full Terms of Reference are included at Appendix 1. This DHR aims to identify the learning from this case, and for action to be taken in response to that learning. The overarching goal is to prevent future domestic abuse related suicides and ensuring that individuals are better supported.

1.4.2 The Review Panel comprised of both statutory and non-statutory agencies from Hertfordshire, as Fiona and George were resident to that area at the time of the suicide. Agencies were contacted in March 2022 to inform them of the DHR and to secure their records.

1.4.3 At the first panel Meeting, information was shared by agencies that alluded to the relationships between Fiona and George commencing in Jan 2013. So the Review Panel reach consensus that the review period that this DHR would focus on is from Jan 2013 to the date of the suicide, in Dec 2021. IMR and Chronology authors were asked to also include any incident or information that could be pertinent to the key lines of enquiry that fell outside of this time frame.

1.4.4 Key lines of enquiry

- A review of any the information held by agencies that indicated the victim could be at risk of suicide as a result of any coercive and controlling behaviour
- 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 in relation to victims of coercive control, intimate partner abuse, stalking and suicide – to build up a picture of what should have happened.
- A review of any barriers experienced by the families in reporting any abuse or concerns, including whether they or anyone else involved

knew how to report coercive control, intimate partner abuse and stalking had they wanted or felt able to.
- To review national best practice in respect of protecting adults from coercive control, intimate partner abuse, stalking and suicide.
- An evaluation of any training or awareness raising requirements that are necessary to ensure a greater knowledge and understanding of coercive control, intimate partner abuse and stalking processes and/or services in Hertfordshire.

1.4.5 The Review Panel is grateful for the specialist knowledge input from local commissioned specialist domestic abuse and suicide prevention agencies:
- Refuge[4], which holds the specialist domestic abuse support provision,
- Survivors Against Domestic Abuse[5], a Housing Navigator Service, working with housing sectors in Hertfordshire, to address housing needs of people experiencing domestic abuse.
- Mental Health and Suicide Prevention, which is part of Hertfordshire County Council, which has the strategic and operational portfolio of suicide prevention county wide.

1.5 Methodology

1.5.1 The Domestic Abuse Act 2021 defines domestic abuse as:
Behaviour by a person is "domestic abuse" if:
(a) Persons involved are aged sixteen or over and are personally connected to each other, and

(b) The behaviour is abusive.
Behaviour is "abusive" if it consists of any of the following:
- physical or sexual abuse;
- violent or threatening behaviour;
- controlling or coercive behaviour;
- economic abuse
- psychological, emotional or other abuse;

It does not matter whether the behaviour consists of a single incident or a course of conduct.

(c) Economic abuse is any behaviour that has a substantial adverse effect on the victim's ability to:

[4] https://refuge.org.uk/i-need-help-now/hertfordshire-idva-service/#:~:text=Need%20help%20in%20Hertfordshire%3F,voicemail%20operates%20on%20this%20number.
[5] https://www.stevenage.gov.uk/town-and-community/community-safety/survivors-against-domestic-abuse-sada/sada-domestic-abuse-service

- acquire, use or maintain money or other property, or
- obtain goods or services.

For the purposes of this Act, the perpetrator's behaviour "towards" the victim includes any conduct directed at another person linked to the victim (for example the victim's child).

e) 'Personally connected'

For the purposes of this Act, two people are "personally connected" to each other if any of the following applies:

- they are, or have been, married to each other;
- they are, or have been, civil partners of each other;
- they have agreed to marry one another (whether or not the agreement has been terminated);
- they have entered into a civil partnership agreement (whether or not the agreement has been terminated);
- they are, or have been in an intimate personal relationship with each other;
- they each have, or there has been a time when they each have had, a parental relationship in relation to the same child
- they are relatives.

1.5.2 Upon notification of the suicide by the CSP, agencies were asked to check for their involvement with any of the parties concerned and secure their records. A total of 15 agencies were contacted, in addition to Hertfordshire MARAC. Of these, four had limited to no contact and submitted a Summary of Engagement only. However, 11 organisations had more extensive contact and were asked to submit and Individual Management Review (IMR), and or a narrative chronology.

1.5.3 Independence and Quality of IMRs: The IMRs were written by authors independent of case management or delivery of a service to Fiona or George. The IMRs received were for the most part comprehensive and enabled the Review Panel to analyse the contact with Fiona and George and to produce the learning for this DHR. In some IMRs, a lack of detail meant that further questions had to be sought from agencies within the Review Panels and also via secure email.

- Whilst Hertfordshire Adult Safeguarding returned a summary of engagement detailing contact with Fiona and George, this was limited contact, as locally, Hertfordshire Partnership NHS Foundation Trust (HPFT) took the lead on service provision to Fiona and George. Therefore, a narrative chronology was sought from Hertfordshire Adult

Safeguarding, but a full IMR was sought from Hertfordshire Partnership NHS Foundation Trust.

- Hertfordshire Probation Service also returned a Summary of Engagement form advising of non-recent and limited contact with George. The Review Panel decided to seek a narrative chronology of the probation service, in order to build a picture of the risk and offending profile of George.

1.5.4 Of the seven IMR's returned, two agencies made recommendations on their own and in some cases reported changes in practices and polices over time. These are described in section 5.

1.5.5 Approaches were made to Fiona's family, but the author was unable to secure an interview.

1.6 Involvement of family and friends, perpetrator, work colleagues, neighbours and wider community

1.6.1 From the outset, the Review Panel decided that it was important to take steps to involve the family and friends.

Name	Relationship to victim	Means of involvement
Antonia	Sister	- Agreed to be updated on conclusion of the report. - Advised against contact with remainder of family, agreeing to be the main point of contact for the family.
Carol	Sister	See above
Child A	Adult child	See above
Child B	Adult child	See above

1.6.2 Following the decision to conduct a DHR in March 22, Three Rivers CSP notified Fiona's sisters, Antonia and Carol, of this decision by letter in October 22, along with information about support services; and again in May 2023, when no response was returned. Following no responses from the sisters, and sensitive to the time that elapsed, the Review Panel sought information on suitability of making further contact attempts from the Officer in Charge (OIC) of the case from Hertfordshire Police, who had built rapport, and had a pre-

existing relationships with Antonia. Following a suitability assessment, the chair made contact with Antonia, via telephone on 29.02.24.

1.6.3 Following the conversation with Antonia on 29.02.24 and again on 01.03.24, it was deemed that she would act as the point of contact for the family. However, Antonia advised that she was ambivalent about involvement in the review. It was agreed that she would be left with the contact details of the chair, telephone and email, and that the Chair would await contact from Antonia. However, that the Chair would contact Antonia again on completion of the report. Upon completion of the report, the author made contact attempts with Antonia on 24.01.25, 25.01.25 and 30.01.25 without reply.

1.6.4 Owed to the absence of family and friend involvement, the author comprised information from multiple sources to produce a pen portrait of Fiona.

1.6.5 Consideration was given to approaching friends, work colleagues, neighbours and wider community. However, it was not possible to identify any other contacts who could be approached.

1.6.6 Consideration was given by the panel to involve the perpetrator, family, friend, work colleagues, neighbours of or the community. However, owed to the significant level of need that George presented with, and the risk he posed to Fiona's family members, it was deemed not suitable to make contact with him. Additionally, there were no other parties identified from the wider community that would contribute to the review.

1.7 Contributors to the review

1.7.1 The following agencies were contacted, but recorded no involvement with Fiona or George:

- West Hertfordshire NHS Teaching Hospital
- East and North Hertfordshire NHS Trust
- Central London Community NHS Trust, West Herts Community Adults and Hertfordshire Sexual health service
- Hertfordshire Community NHS Trust, Safeguarding Adults.
- Hertfordshire MARAC

1.7.2 The following agencies made contributions to this DHR:

Agency	Contribution

Survivors Against Domestic Abuse[6]	IMR
Safer places[7]	IMR
Hertfordshire MARAC[8]	MARAC minutes and actions
New Hope[9]	IMR and chronology
Hertfordshire Police	IMR and chronology
CGL[10]	IMR and chronology
Adult Social Care	Summary of engagement and chronology
East of England Ambulance Service	IMR and Chronology
NHS Community Mental Health	IMR and Chronology
Probation	Summary of engagement and chronology
Refuge[11]	IMR and Chronology
Three Rivers Housing	IMR and Chronology

1.8 The Review Panel Members

1.8.1 The following staff represented their respective agency on the Review Panel:

Name	Job Title	Agency
Ildiko Cseri	Commissioning and development officer	Strategic partnership Team, HCC
Carol Harwood	Business Support Officer	Strategic partnership Team, HCC
Deborah Allen	Housing Operations Manager	Three Rivers District Council

[6] https://www.stevenage.gov.uk/town-and-community/community-safety/survivors-against-domestic-abuse-sada/sada-domestic-abuse-service
[7] https://www.saferplaces.co.uk/accommodation
[8] https://www.hertssunflower.org/information-for-professionals/multi-agency-risk-assessment-conference.aspx
[9] https://www.newhope.org.uk/
[10] https://www.changegrowlive.org/spectrum-hertfordshire-drug-alcohol-services
[11] https://refuge.org.uk/i-need-help-now/hertfordshire-idva-

Gavin Morris	Safeguarding Sector Lead	East of England Ambulance Service
James Luxon	Detective Chief Inspector, Organisational Strategy Team	Hertfordshire Police
Kate Johnson	Safeguarding Lead,	Hertfordshire Partnership NHS Foundation Trust
Keith Dodd	Head of Adult Safeguarding	Adult Social Care
Leanne McGrath	Senior Probation Officer	National Probation Service
Leanne Naughton	Senior Social Worker and County Safeguarding Lead	CGL
Louise Bayston	Senior Operations Manager	Refuge
Martin Witchard	Review Officer	Hertfordshire Police
Michelle Wright	Community Safety & Safeguarding Manager	Adult Safeguarding, Three Rivers District Council
Sukhi Khattran	Health Improvement Lead	Mental Health & Suicide Prevention, Public Health, HCC
Tania King	Domestic Abuse Liaison Officer	Survivors Against Domestic Abuse, Stevenage Borough Council
Theresa Heridia	Detective Inspector, Organisational Strategy Team	Hertfordshire Police

1.8.2 Independence and expertise: Review Panel members were of the appropriate level of expertise and were independent, having no direct line management of anyone involved in the case.

1.8.3 The review panel met on 3 occasions: 13th November 2023, 26th February and 11th June 2024. The overview report and executive summary were agreed, electronically, with the review panel members providing final comments by 11th June. At this third panel, Hertfordshire Police did not agree to sign off, so further meetings took place on 25th June and 22nd October 2024 between the author and Hertfordshire Police to achieve sign off. Hertfordshire Police signed off the overview report on 21st November 2024.

1.8.4 The chair thanks all who contributed their time and expertise to this review.

1.9 Chair of the Review and Author of Overview Report

1.9.1 The Chair and Author of the review are Luke Kendall, an independent consultant and DHR chair. Luke has received training from Advocacy After Fatal Domestic Abuse, the exclusive provider of Home Office Review Chair training. Luke has contributed as an expert in domestic abuse across numerous DHR's previously and has extensive experience working in domestic abuse and a specialist interest in suicide prevention. Luke has published research in suicide and holds a postgrad in Forensic Psychology.

1.9.2 Independence: Luke has no connection with the local areas or any agencies involved in supporting Fiona and George.

1.10 Parallel Reviews

1.10.1 There are no parallel reviews occurring alongside this DHR.

1.10.2 The Coroner's report: A Post Mortem was carried out two weeks following Fiona's death and therefore was completed in January 2022.

1.10.3 A serious incident review was also completed by HPFT, which was concluded in April 2022.

1.11 Equality and diversity

1.11.1 The chair and the Review Panel considered the Protected Characteristics of Age, Disability, Gender Reassignment, Marriage and Civil Partnership, Pregnancy and Maternity, Race, Religion and Belief, Sex, and Sexual Orientation during the DHR process.

1.11.2 At the first meeting of the Review Panel, it was identified that the Protected Characteristic of Sex required specific consideration. This is because Fiona was female, and George is male. The analysis of DHRs reveals patterns of gendered victimisation across both intimate partner homicides, with females representing the majority of victims and males representing the majority of perpetrators[12].

1.11.3 The Review Panel also identified that disability was also a relevant protected characteristic, owed to Fiona physical and mental health conditions. More specifically, Fiona was diagnosed with Paranoid Schizophrenia and Personality Disorder. However, Fiona did not agree with the diagnosis of Schizophrenia and attributed her distress George's abuse. Fiona was also suffering with chronic abdomen pain, due to a prolapsed bowel and a prolapsed womb. Resultant of the above, Fiona went through bouts of not being able to leave the confines of George's home.

1.11.4 Whilst age was not identified by the review panel as having a particular impact on this case, but it is noted that Fiona was 7 years George's senior.

1.11.5 Reflecting on these impacts of these factors together, it appeared that owed to Fiona's multitude of physical and mental health needs, there were significant barriers to her accessing support and therefore required additional consideration by services to help her access support. As this report identifies, some services sought to responsively overcome these barriers and some did not.

1.11.6 With regard to George, he experienced both physical health and mental health challenges. He had been diagnosed with bi-polar and depression. Throughout the report, there is evidence that George he was able to access

[12] "In 2014/15 there were 50 male and 107 female domestic homicide victims (which includes intimate partner homicides and familial homicides) aged 16 and over". Home Office, "Key Findings From Analysis of Domestic Homicide Reviews" (December 2016), p.3.
"Analysis of the whole Standing Together DHR sample (n=32) reveals gendered victimisation across both types of homicide with women representing 85 per cent (n=27) of victims and men ninety-seven per cent of perpetrators (n=31)". Sharp-Jeffs, N and Kelly, L. "Domestic Homicide Review (DHR) Case Analysis Report for Standing Together " (June 2016), p.69
Data were obtained for 66 countries shows 13·5% of homicides were committed by an intimate partner, and this proportion was six times higher for female homicides than for male homicides (38·6%, 30·8-45·3, vs 6·3%, 3·1-6·3). Stöckl, H., Devries, K., Rotstein, A., Abrahams, N., Campbell, J., Watts, C., & Moreno, C. G. (2013). The global prevalence of intimate partner homicide: a systematic review.
Data from 188 DHR's occurring between April 2011 and March 2013, in 86% of cases the perpetrator was male. Bridger, E., Strang, H., Parkinson, J., & Sherman, L. W. (2017). Intimate partner homicide in England and Wales 2011–2013: Pathways to prediction from multi-agency domestic homicide reviews. Cambridge Journal of Evidence-Based Policing, 1(2), 93-104. https://doi.org/10.1007/s41887-017-0013-z

services for these needs, yet he struggled to maintain engagement with services around his mental ill health needs.

1.12 Dissemination

1.12.1 Upon finalisation of the Overview Report and Executive Summary review, they will be presented to the Three Rivers CSP for approval and thereafter will be sent to the Home Office for quality assurance.

1.12.2 Once agreed by the Home Office, the Executive Summary and Overview Report will be shared with the local VAWG Steering Group, Multi Agency Risk Assessment Conference (MARAC) partners, the Domestic Abuse commissioner, the Police and Crime Commissioner, the family. There will be a range of dissemination events to share learning and the report will be published.

1.12.3 The recommendations will be owned by the CSP, with the Hertfordshire Violence Against Women and Girls Team being responsible for monitoring the recommendations and reporting on progress.

1.13 Previous case review learning locally.

1.13.1 This is the 42nd review commissioned across Hertfordshire.

1.13.2 The CSP is an unincorporated body and therefore it does not have a legal personality. A CSP is the collective term that describes a group made up of responsible authorities (police, local authorities, fire and rescue authorities, probation service and health) and often other partner agencies included locally.

1.13.3 One of the responsibilities of a CSP is to ensure that it fulfils its statutory duty under the 2004 Act, to undertake DHRs that may be required. Within Hertfordshire, the CSPs are the district and boroughs.

1.13.4 Within HCC, the Strategic Partnership Team (STP) coordinate DHRs on behalf of the county's ten CSPs, to ensure learning from these reviews is shared across Hertfordshire. The Strategic Partnerships Team are based in Hertfordshire County Council's department of Adult Care Services. Their role is to coordinate the countywide response to domestic abuse and Violence Against Women and Girls (VAWG) on behalf of the multi-agency Hertfordshire Domestic Abuse Partnership. Their aim is to bring together stakeholders from

all agencies to develop and continuously strengthen the response to these safeguarding issues. Key to this response is the learning gained through DHRs.

1.13.5 The author considered the learning and recommendations from previous reviews in the analysis and the development of recommendations for this DHR. Published DHRs can be found at: https://www.hertssunflower.org/information-for-professionals/domestic-homicide-reviews.aspx

2. Background information

2.1 The suicide

2.1.1 In late December 2021, Hertfordshire Police were contacted by Antonia, who was concerned, having not heard from Fiona for a couple of days. An hour after this call, police attended the home address of Fiona and after no response, forced entry. Fiona was located in the bathroom, unconscious and unresponsive. CPR was administered by officers, but no signs of life ensued. An hour after gaining entry, East of England Ambulance Service arrived, and pronounced Fiona deceased.

2.1.2 Post mortem: The Post Mortem, completed in January 2022, two weeks following Fiona's death listed the cause of death as a Tramadol overdose, with other drugs significantly contributing to the death: gabapentin, diazepam, quetiapine and cyclizine.

2.2 Background information Victim and Perpetrator

2.2.1 Victim: At the time of Fiona death, she was 53 years of age living on her own and within the confines of substance use (crack cocaine and heroin), physical health issues (collapsed bowel, chronic abdomen pain), mental ill health (Personality Disorder and Schizophrenia) and suicidality. She had two children from a previous relationship; both daughters are adults and did not reside with Fiona.

2.2.2 Perpetrator: At the time of death, George was 46, living on his own and also using crack cocaine and heroin. He was experiencing suicidality, reoccurring leg pain and was diagnosed with Bi-Polar disorder and depression. He had one adult child, from a previous relationship. But had limited contact with this child.

2.2.3 Synopsis of the relationship with the Perpetrator: Reports are limited with regard to information alluding to the onset of the relationship, but it appears Fiona and George may have met for the first time in 2009. Agency records show the first report of a concern between Fiona and George in 2013.

2.2.4 There are no records that Fiona or George worked throughout the duration of the relationship.

2.2.5 There are no records advising that, for the duration of the relationship, Fiona and George were registered as each other's carer. Therefore, there was a reliance on government based financial support.

2.2.6 Members of the family and household at the time of the homicide: Fiona and George were living in separate homes to one another, due to a recent separation in September 2021, due to George perpetrating a significant GBH assault on Fiona. Fiona had sought refuge provision and alternate safe housing with success, moving to Rickmansworth.

3. Chronology

2010

3.1.1 The first recorded contact with local service, in relation to both Fiona & George was in January. Whereby non-crime DA incident is recorded relating to 'shouting' between Fiona & George, and a member of the public tried to intervene and was assaulted. Both George and Fiona are charged with carrying an offensive weapon and common assault, respectively.

3.1.2 In May George mentions to his probation officer that he is in a relationship with a 41 year old, who has had a number of miscarriages during the first 10 months of their relationship. Highlighting the potential start of the relationships and how quickly, post the onset of the relationships they were trying for a baby. The speeding of relational milestones is a well-established risk factor for domestic abuse[13], and complications during pregnancy[14] and foetal injury[15] are also well documented. George also mentions that his partner overdosed in 2008. There is no evidence of the probation officer probing into who this party is, or any concerns about domestic abuse or safeguarding.

2012

3.1.3 May 2012 Fiona self-refers into Adult Social Care, the record cites "difficulties at home". The support offered from here is unclear, but the next entry is a closure to service in July 2012 at the time of being admitted to hospital for "major bowel surgery".

3.1.4 In December 2012, mental ill health is first raised by the GP, who refers Fiona to HPFT for support around depression and paranoid personality disorder.

2013

3.1.5 In January, Fiona is submitted to the local hospital following an overdose. She asks hospital staff to be interviewed away from George. She discloses verbal abuse from her father and states that George is "evil" and emotionally

[13] Monckton Smith, J. (2020). Intimate partner femicide: Using Foucauldian analysis to track an eight stage progression to homicide. Violence against women, 26(11), 1267-1285.
[14] Cook, J., & Bewley, S. (2008). Acknowledging a persistent truth: domestic violence in pregnancy. Journal of the Royal Society of Medicine, 101(7), 358-363.
[15] Guth, A. A., & Pachter, H. L. (2000). Domestic violence and the trauma surgeon. The American Journal of Surgery, 179(2), 134-140.

abusive. Fiona expresses that she remains in this relationship as she has no one else and that she is considering euthanasia in Switzerland. Despite this disclosure, no safeguarding concerns were submitted, or any safety advice given with regard to the domestic abuse or suicidal ideation. It has been shown that collaborating on a bespoke suicide intervention plan can reduce risk of suicide by up to half[16]. This is the first opportunity presented to enquire into the link between George's abuse and Fiona's resultant suicidality.

3.1.6 In August, Police are aware that Fiona is living with George, at his address in Watford. There are lots of used needles and knives lying around in every room. It is unclear what safeguards were put in place.

3.1.7 November, Fiona is admitted to hospital for abdominal pain and suicidality. Fiona advised that the relationship with George ended recently. She received a call from George whilst admitted, and is visibly upset following this call. Following this, George attends the hospital to advise that he is now in a relationship with another woman and will throw Fiona's belongings out. There is no evidence of an enquiry into whether the call was domestic abuse related, and no safety plan regarding suicide also put in place. HPFT detail the context of domestic abuse as "psychosocial issues", and therefore not appropriately understanding the complexity of Fiona's experience of abuse, nor where the accountability for the abuse sits.

3.1.8 In December, Fiona advises Police that she has had a gun held to her head by an unknown person, not George, but she later retracted the statement about a gun being present. Police continued to make contact attempts via home visits and telephone to ascertain Fiona's safety.

2014

3.1.9 In early February police are called via Fiona's parents as Fiona and George are having a "heated verbal altercation". "A male" (suspected to be George) is reported saying "I will put you in the grave, I will bury you, you have pushed your fucking luck". A "female" (suspected to be Fiona) replied "don't hit me". Upon arrival Fiona is reported to be intoxicated and presents as "verbally hostile" to officers. Earlier in the evening she reports being assaulted by an unknown female whilst in a night club, sustaining a cut to the back of her head. Fiona also alleged that George has assaulted her, but Fiona's parents denied knowledge of this occurring. As a short term strategy to de-escalate risk, George is taken to a friend's house for the evening by attending police

[16] Nuij C, van Ballegooijen W, de Beurs D, et al. Safety planning-type interventions for suicide prevention: meta-analysis. The British Journal of Psychiatry. 2021;219(2):419-426. doi:10.1192/bjp.2021.50

officers. Fiona declined the offer to give more information to officers, telling them to "fuck off". This incident is regarded as a "verbal argument only" and it is unclear what longer term follow up safeguarding was put place.

3.1.10 Mid-February 111 receive a call from Fiona, expressing suicidal ideation, saying she has a "horrible life" and that she has a violent partner who "beats me up". She details George giving her pills and telling her to "go kill yourself." She also advises that her house is being used by drug addicts. There is no evidence that a safety plan was put in place, but a safeguarding is raised with Adult Social Care. ASC referred onto HPFT and gave Fiona a number for a domestic abuse charity, but did not refer her. No adult safeguarding was raised by HPFT. Furthermore, there appears to be no consideration from 111, ASC or HPFT around the potential on an offence being committed. It is an offence[17] under section 2 of the Suicide Act 1961 if he or she does an act capable of encouraging or assisting the suicide or attempted suicide of another person, and that act was intended to encourage or assist suicide or an attempt at suicide.

3.1.11 At the end of this month Police raise a safeguarding concern with HPFT, following Fiona finding out George is messaging other women, resulting in Fiona threatening to stab George and herself. ACMHS conclude this was a "Facebook spat" and there is no evidence of safeguards being put in place. The following day, Fiona overdoses on crack cocaine and heroin, entering cardiac arrest, but is found on the pavement in Watford by a member of the public. She is taken to a local hospital. George attends hospital, and Fiona leaves early before completing course of treatment. We are unsure if Fiona left under her own free will of under duress. Following this, Fiona is provided with the Sunflower Centre domestic abuse phone number. This is the first documented mention of a specialist domestic abuse provision being signposted to.

3.1.12 April: George makes contact with HPFT, following a referral from the GP owed to anxiety and a 9 year heroin addiction. George is seeking counselling for "past experiences of trauma" and advises that he does not have a problem with substances so declined support from substance misuse services. George did not attend the follow on appointments with the Wellbeing team.

3.1.13 In May and June, Fiona is arrested for drink driving and public order offences. Whilst in police custody (May), she discloses to the HPFT Criminal Justice

[17] https://www.cps.gov.uk/legal-guidance/suicide-policy-prosecutors-respect-cases-encouraging-or-assisting-suicide

liaison Team that she is a victim of a rape. We are unclear if this is in the context of domestic abuse and who the accused is. There is no evidence of her being referred for specialist support for this rape, or advised of her right to report this offence formally, or the HPFT worker reporting this to police on a third party report basis.

3.1.14 Throughout July there are multiple missed or cancelled appointments with HPFT by both Fiona and George; citing physical health problems as barriers to attendance on one occasion, and no rationale provided for the remainder. The result is that Fiona and George are both discharged back to their respective GP's.

3.1.15 In August Fiona discloses to HPFT that she had taken her mother's anti-depressant medication. No safeguarding raised for the mother, or any recorded attempt to obtain the details of the mother. Fiona requests home visits, citing no access to a vehicle and poor public transport as the reason. No record of ACHMS planning a home visit.

3.1.16 In December, Fiona attends a George's probation appointment with him. George reports a significant heroin and crack cocaine problem. Reports a relationship of prolonged instability with Fiona. There is no record of probing further into these relational difficulties or offering Fiona or George specialist support with their relational issues.

2015

3.1.17 March, George attends an initial assessment but struggled to complete self-assessment questionnaire in relation to psychology wellbeing, but does demonstrate "good insights to his needs". However, George is subsequently discharged back to his GP. Expecting George to be able to complete written work appears to have hampered his access to psychological therapy.

3.1.18 In April, George attends probation appointment and discloses that he has a caring role over Fiona, who is "constantly in pain with her prolapsed bowel". In May, Fiona attends George's probation appointment with him, and is described as in "poor health". There is no safeguarding raised, no consideration of a carers assessment or consideration of the role of dependence and the potential for increased risk of domestic abuse.

3.1.19 In June, during a meeting with SPA (HPFT) George discloses suicidal ideation, insomnia for 10 years and thoughts of being extremely violent to people ("ripping skin of people's faces"). George also discloses he is frequently

stopped from overdosing by Fiona; alluding to the caring/protective role that Fiona plays, giving an insight into the difficulty Fiona may be experiencing when trying to leave the relationship. No evidence of a carers assessment raised or querying into the support that Fiona may need to manage George and her own suicidality. No evidence of a suicide intervention plan being established. No evidence of ascertaining who he thinks of being "extremely violent" towards.

3.1.20 In August, George attends his probation appointment and discloses he has a non-molestation order[18] out against him from an ex-partner, clearly demonstrating a domestic abuse risk. A non-molestation order are typically granted to protect the victim of domestic abuse from harm from the perpetrator of abuse. No enquiry into who this partner is, why there was a non-molestation order and if this was put in place by Fiona. Another missed opportunity in engaging him in interventions around domestic abuse.

3.1.21 In October Fiona attends the GP appointment and reports to rarely leaving George's address, owed to depression and that her support network is limited. No evidence of GP linking the depression and isolation to domestic abuse. Also, no evidence that the GP worked with Fiona to understand and overcome her barriers to attending mental health support appointments.

3.1.22 November, George advises HPFT that he was nearly killed by a man who lives "around his streets" and said he was in great danger. No evidence of a safeguarding referral raised. It appears that this danger has occurred in the context of buying illicit drugs, which he was seeking to "manage thoughts of suicidal ideation".

3.1.23 In December George attends an initial assessment with HPFT for another psychological assessment. There is no evidence of seeking to understand why he has not attended previous sessions, but notes reflect that his lifestyle is "chaotic". This narrative somewhat locates the issue of engagement mainly at the feet of the service user; a more professionally curious stance would have been beneficial here. Moreover, a stance that reflects "what can we do to help you enhance your attendance" may have been of benefit.

2016

[18] https://www.gov.uk/injunction-domestic-violence/eligibility-non-molestation

3.1.24 May is the next known record, and it's HPFT. George attends an outpatient clinical requesting "social help". This record does not advise what social helps consists of. George was advised he can self-refer to a complex needs team.

3.1.25 In October, Fiona calls HPFT distressed and suicidal. Fiona advised that she was possessed by a demon as a child and was subject to an exorcism. She is also homeless, assuming this is because she has no residency of her own and is residing with George. She also advised that she is too nervous to leave the home, has been "bed bound for a year and a half" and the house is "in the middle of nowhere". Fiona describes experiencing domestic abuse from childhood and having had a "horrible life". She feels "lonely" and "unhappy". Fiona discloses being vulnerable from others and being exploited for money and physically abused by drug dealers. This case is escalated to the attention of the team leader, but it is unclear what safeguarding is put in place following this incident. A home visit from GP is arranged as a result. However, there is no safeguarding concern for drug dealers exploiting and physically assaulting her for material gain, nor consideration for her isolation from professional services over the previous 18 months was due to domestic abuse and/or cuckooing.

3.1.26 The resultant home visit took place a week after the above call. GP and social worker attended to do an initial assessment. Fiona wants help with housing and psychotherapy. Fiona discloses hearing hundreds of demons voices and needing help with daily living functions and is supported by George, but George also has mental health difficulties. Fiona's benefits have also been reduced. There is no rationale in the initial assessment why clinicians did not feel Fiona was suitable for care and treatment with secondary mental health services, however it appears professionals were of a view her primary need was in the area of substance misuse. There are indications that Fiona has needs for care and support that may be being met by George. There is no acknowledgement of the heightened risk to Fiona being dependent for housing, financial support, daily care and emotional support. No carers assessment considered.

3.1.27 A week following the home visit, George calls HPFT and is described as "extremely abusive" toward therapy staff following his discharge from service. Fiona takes over the call to advise that she has hidden George's medication to lower the risk, but she is fearful he will become "violent again" – alluding to an episode of violence occurring. Fiona advises that they live "in the back and beyond with no transport". It is noted that George's child is at the address at the time of this incident. Fiona was not asked if she wanted to report to

Police, nor is a Police welfare visit considered, given the risk of harm to Fiona and the child reportedly being at the address.

3.1.28 Two days following the above call to HPFT, Fiona calls police from her parents' house advising that she has been in a state of hallucination and that she was previously raped by an ex-partner (not George). She is feeling suicidal. Officers attended, and record that Fiona was "confused and at times incoherent having abused alcohol and drugs over many years". It is unclear what evidence was produced, but officers stated the rape could not happen as alleged at her parents flat. Officers called an ambulance, as Fiona was experiencing chest pains. Fiona was referred to the Sexual Offences Investigation Unit, but it is reported that she declined to support any investigation. It is unclear if police officers offered non-criminal justice sexual offence specialist support service like Independent Sexual Violence Advisors (ISVA) or rape crisis.

3.1.29 The following day, more evidence presents of Fiona's caring role over George, as she calls the police to report George missing following an argument.

2017

3.1.30 Early January and Fiona calls 999 from her parents address following an overdose with intent to end her life. This is a record from HPFT, as EEAS hold no record of this incident. Fiona presented as heavily intoxicated. A rift had ensued between Fiona and George, and Fiona's family following George stealing £2500 from Fiona's parents. Fiona advises that she reported a rape to the police recently and has never come to terms with the loss of a baby 15 years ago. There is no further information provided regarding the rape. George is present during this call, advising that Fiona "turns abruptly" and was abusive to him yesterday. Fiona confirmed that she hit George over the head with a cologne bottle and a stiletto in the past, causing him "significant injury". Fiona is referred to Mind complex needs team. No evidence of safeguarding concerned raised regarding the rape disclosure, theft of £2500 or victimhood of George, or professional curiosity as to why Fiona had assaulted George. From this, we miss an opportunity to understand more of the abusive dynamics at play. By way of dignity, self-defence, or in an attempt to get the violence to stop, victims of coercive control can engage in violent resistance[19] against their abuser. No specialist support was offered to either party around domestic abuse.

[19] Kelly, J. B., & Johnson, M. P. (2008). Differentiation among types of intimate partner violence: Research update and implications for interventions. Family court review, 46(3), 476-499.

3.1.31 Early February, Fiona makes contact with the mental health team at HPFT, disclosing that she is lonely, isolated, suicidal and hearing voices saying "I can't breathe and want to get you". Fiona feels like she has nothing left. She is currently living with George, but he told her he can't cope with her anymore as he has mental health problems. Fiona also advises that she has to watch George "all the time" because of his suicide risk, which impacts her sleep. Email sent to ACMHS and initial assessment team in Dacorum. No evidence of a carers assessment for either party being considered.

3.1.32 On the 7th February ACHMS assessed Fiona, but it is not recorded where it took place, but George was present. Fiona advised that her bowel surgery was not being carried out because she does not have secure housing. It is recorded that there is evidence of "significant carer burnout". There is no follow up section 9 care act assessment recorded or referred. No record of a carers assessment being considered.

3.1.33 Five days later, Fiona calls HPFT mental health helpline reporting that her husband is "fed up" with her and that she is anxious. Once more, professional curiosity is absent here with regard to routine enquiry into domestic abuse.

3.1.34 27th February, Fiona calls the Police advising that her ex-partner (not George) has registered her car in his name without her consent. Police attempted to follow up on this crime, but could not get contact with Fiona, so the crime was finalised as no further action. These are two recorded offences, against the ex-partner in recent times. It is unclear if the ex-partner was considered as a secondary perpetrator and thus risk assessed as such.

3.1.35 13th March, a safeguarding referral is received by Adult Social Care by East of England Ambulance Service (EEAS). EEAS attend the address following three days of weakness in Fiona arm and legs. The living conditions are poor. The door lock is broken, and the door is held in place by a chair. There is no electricity and therefore likely no heating or means to cook meals or heat water. Fiona presented as unwashed, dirty nails, skin that was sticky and clammy. She advised having no money for food, no money to get to appointments or phone credit to call anyone. She is suicidal and has been searching for ways to end her life online. A referral was sent to HPFT.

3.1.36 17th March, Fiona reports to HPFT that she has been suffering with agoraphobia and not left the home for 6 months. This is not recorded, or considered as a risk factor for domestic abuse. Following, a letter is sent to

Fiona address, asking if she wishes to have an assessment, but records do not detail whether this is a care act assessment or initial assessment.

3.1.37 12th June, Fiona calls Police, advising that she has "had enough and wants to top herself". Officers attend. Fiona is intoxicated and wanting to return home (assuming this is George address), but her parents won't pay for her taxi. Unsure of what safeguards are put in place, or an evidence of a suicide prevention plan being put in place, but the officers advise there is "no real concern around suicide".

3.1.38 14th June, HPFT complete a planned home visit. There was evidence that Fiona was at home, but did not answer the door. HFPT advise that the door appeared to have been forced in. Later in the month, Fiona called the mental health helpline, reporting mental and physical ill health (recent mini stroke and exhaustion). Fiona reports missing appointments and getting confused by letters. No evidence of a safeguarding process being initiated.

3.1.39 Two days later, Fiona calls Police advising that George is threatening to kill himself and that they are upset due to ongoing issues with a neighbour. Officers attended and report "no concerns", advising both parties were being "paranoid". Police records note George and Fiona's accounts on their issues with this neighbour being "selective" and their statements being discredited by CCTV evidence. Due to this, no further action was taken against the neighbour. No record provided of any safeguards that were put in place following attendance.

3.1.40 7TH July, Fiona calls HPFT Support Treatment Team raising concerns that she is worried about suffering another mini-stroke. She wants to end her life due to stressors, but George was being supportive. Social outcomes assessment booked for 12th July. However, it appears that there is an expectation for Fiona to travel to the appointment, despite having no money and suffering with physical ill health and agoraphobia.

3.1.41 19th July Fiona's mother calls Support Treatment Team, to ask for the team to see Fiona again. Fiona is unable to have her bowel operation due to insecure housing status. She also details that George faces eviction as he is only allowed single occupancy at his address. The physical health issues Fiona is experiencing will impact her mental state. A complex case discussion would have been appropriate to understand and plan how her physical health needs could have been managed better. For example, where she could recover post-

op. It cannot be public policy to refuse treatment to homeless populations on the basis there is insecure housing that is unfit for recovery.

3.1.42 In December, George fails to attend an appointment with the psychology team. This is now 7 missed appointments and no evidence of a case review about how to engage him more effectively.

3.1.43 Later in December, George's landlords raises welfare concerns to HPFT. He is receiving complaints from the neighbours that Fiona and George are not taking care of the property, there is no hot water or heating and that Fiona is "bedridden". Contact is made to George by HPFT and an initial assessment is booked for 02.01.18.

2018

3.1.44 Early January, George attends initial assessment with HPFT and reports multiple significant childhood traumas. He notes night terrors and extreme anxiety and has overdosed 3 times in the last 18 months. According to George, Fiona only stays at his property 2/3 night per week. This may be inaccurate, owed to the concern that he is breaching his tenancy agreement of single occupancy. He no longer has access to his child, owed to his child's wishes, and inconsistent contact. He has debts of approximately £300. George is reported as showing a good insight into his risks and needs. Referral to psychology team to assess George ensues. Considering the vast amount of non-attendance over the years exhibited by George, there is no discussion on strategies to help George continually engage.

3.1.45 February, George attends the first appointment with the psychology team, accompanied by a support worker from housing (agency not recorded). George shows insights into his current behaviour being abusive. He describes himself as a "Jekyll and Hyde" character. There is no record as to what context, and therefore to whom, George's abusive behaviour is exhibited. This is a missed opportunity to refer George to specialist domestic abuse perpetration intervention services. In March, George does not attend a psychology appointment for lack of funds, and on the other occasion, no recorded rationale for not attending. George was discharged back to his GP.

3.1.46 In August George calls EEAS to report breathing problems, delirious and swollen legs which he had been experiencing for a week. George advised that the swollen leg is from an old injury. GP liaised with, and worsening advice given. Both these respiratory and leg complaints may impact George's ability to engage with community based services.

2019

3.1.47 January, George is referred to HPFT by his GP, following intent to end his life. He is residing with his mother. We are unclear what his residency status is, as it is not probed into. HPFT advised of indicators of manipulation, but it is unclear from records what these indicators are. Initial assessment offered.

3.1.48 2nd February, Police are called to Fiona's parents address by Antonia. Fiona and George have been drinking and an argument ensued, with George threatening to "rip people's heads off". Police attend and separate Fiona and George. Approximately an hour later, Fiona mother calls Antonia for assistance. Antonia removes Fiona's property from their mothers address. Following this, George threatened to "send people round to stab them". Later in that evening, Fiona calls the police back to advise that George has strangled her, held a knife to her throat and threatened to kill her. The call handler heard these threats to kill. Hertfordshire Police take positive action and arrest, conveying George to custody for interview, but Fiona and Antonia withdraw support for a police prosecution. An evidence led prosecution is considered, but the evidential standard is not met with the evidence at hand. Good practice from Hertfordshire police, who also consider a victimless prosecution on hearsay evidence too. A DVPO is considered, but not sought. A DASH RIC was completed, assessing this incident as a medium risk of serious harm and homicide.

3.1.49 4th February, Fiona calls HPFT to cancel George's initial assessment. Further evidence of the caring role/dependency that Fiona had with George. 10 days post this call, Fiona's GP referred to HPFT for suicidal ideation.

3.1.50 The following day (14th) Dacorum ACMHS offer an initial assessment at their offices. Fiona advised that she has been arguing with George and her parents, and that her sister (the record did not detail which sister) has sent death threats. It alludes to Fiona's medication being withheld by George, therefore Fiona feels she is not at risk this evening as she cannot overdose. Safeguarding concern not raised about the threats to kill and professional curiosity not present following the admission of arguing with George and family.

3.1.51 The very next day, Dacorum ACMHS complete a home visit. Fiona reports abuse from mother and sister towards her and George, that George looks after her and does most of the housework. The house was reported as

"cluttered with clothes and dishes". There is no evidence of Dacorum ACMHS exploring the abusive behaviour from family members, however, they report to GP the needs for a home visit in light of being unable to afford to travel to the GP.

3.1.52 23rd Feb, Fiona calls police advising that her sister, Carol, has threatened her and said "I hope you overdose and kill yourself". This is the second report of Fiona's sister being abusive. Police attend due to suicide concerns. Report advises Fiona was not feeling suicidal on attendance. Police records note discrepancies in the statement provided by Fiona, which appears to cast doubt on whether Carol actually provided the means, by way of medication, for Fiona to kill herself; therefore, no further action was taken. The record does not detail any follow on safeguarding actions with regards to Fiona's suicidality.

3.1.53 26th February, Dacroum ACMHS call Fiona, who reports there is no gas or food in the house. Fiona advises she cannot pay as George has her benefit money and is not sure what he does with it. She asks the Dacorum ACMHS worker not to speak to George about this, as he "buys everything for the house and looking after" her, as she "cannot do anything for herself". This is clear evidence that George has a caring role for Fiona and that she is unable to protect herself. This should have triggered a duty to undertake an enquiry under the care act. There is no evidence of this taking place.

3.1.54 20th March, George reports suicidal ideation to HPFT and self-harm. He does not attend appointment owed to lack of funds and anxiety impacting his ability to use public transport. It Is unclear what the plan of action was to aid George's engagement with mental health services. No record of a bespoke suicide intervention plan put in place.

3.1.55 On 26th April, George assaults Fiona. Fiona discloses "He hit me", "Punched my head off the wall", "He has battered me" and "He has dragged me down the stairs where I think I was unconscious", to officers. Fiona frequently goes off topic when disclosing and is intoxicated. Officers reported seeing no visible injuries, but took positive action and arrested George. Fiona refused to provide a statement at the time of the offence, and again the following day when police re-attend. Evidence led prosecution is considered. Owed to lack of evidence, George is released with no further action. A DVPO does not appear to have been considered, but safeguarding advice was given. The officers report that they were thanked by Fiona, who was "very grateful" of being told of the NFA decision and wanted George back with her. Coercive

control is likely at play here, making Fiona deeply fearful of repercussions from George, which may be guiding her decision making. This is a concerning cognitive distortion that may be beneficial for police officers to recognize that this could be symptomatic of coercive control - and coercive control is a high risk factor for serious harm and homicide[20]. This incident was graded at medium risk, and thus an opportunity was missed to get this case into to the Multi-agency Risk Assessment Conference (MARAC). Officers, using professional judgement, can refer to MARAC. In this instance, recent escalation in domestic abuse offences, the significant vulnerabilities that Fiona is facing, recent threats to kill, holding a knife to the victims throat, coercive control, suicidality, mental ill health, substance use and dependency could have formed part of the professional judgement.

3.1.56 8th May, Dacorum ACMHS called Fiona, who reports the relationship with George being over. She has been assaulted by a woman that she and George now live with. The onset of a separation is a well-known period of increased risk for domestic abuse victims[21] [22], at the hands of their abuser who now has lost control over their partner. There is no record of HPFT considering the increase in risk now that the relationship has ended. No safeguarding concern raised with regard the assault or professional curiosity as to who the female is. This is a missed opportunity for HPFT to safeguard this party with a Domestic Violence Disclosure Scheme[23] (DVDS) if this is a new partner. A DVDS, also known as "Clare's Law" enables the police to disclose information to a victim or potential victim of domestic abuse about their partner's or ex-partner's previous abusive or violent offending. On the same day, George fails to attend an appointment with HPFT, and once more, is discharged back to his GP.

3.1.57 14th May, Fiona failed to attend a meeting at Dacorum ACMHS offices and is, once more, discharged back to her GP. There seems to be little consistency in approach to engage Fiona. There is also a missed opportunity, following the assault, to complete a home visit and therefore better support Fiona and also better risk assess Fiona's current home environment.

[20] Monckton Smith, J. (2020). Intimate partner femicide: Using Foucauldian analysis to track an eight stage progression to homicide. Violence against women, 26(11), 1267-1285.
[21] Websdale, N. (1999). Understanding domestic homicide. UPNE.
[22] Regan, L., Kelly, L., Morris, A., & Dibb, R. (2007). If only we'd known': An exploratory study of seven intimate partner homicides in Engleshire. Child and Woman Abuse Studies Unit.
[23] https://www.gov.uk/government/publications/domestic-abuse-bill-2020-factsheets/domestic-violence-disclosure-scheme-factsheet

3.1.58 June 19th, the GP sends a referral to Dacorum ACMHS to review her medications and also raise a safeguarding concern, specifically referencing that George has been violent to Fiona and taking her benefit money. No evidence of the GP referring to MARAC, or a specialist domestic abuse service. Due to a delay, Dacorum did not get this referral until 10.07.19. However, there is no response to this referral recorded and no safeguarding enquiry opened. The referral process at the local GP also requires scrutiny; safeguarding referrals should be followed up to ascertain outcomes.

3.1.59 During October, there are a high number of contacts with HPFT. 9th October, Fiona if referred to HPFT by GP due to high risk of suicide, poor personal hygiene and a "very unhappy relationship". This is the second occasion that the GP has not highlighted the domestic abuse and somewhat minimises the risk associated with George's behaviour towards Fiona.

3.1.60 11th October, Fiona engaged with Crisis Assessment and Treatment team (CATT). Professionals observe self-neglect, poor chronic personal hygiene and that Fiona is underweight. Fiona discloses domestic abuse, with George assaulting her twice in the past 5 months, causing broken ribs. Safeguarding concern raised with Watford ACMHS. Emails between CATT and Dacorum ACMHS take place days after, regarding a potential referral to IDVA and refuges, but there is no record of this taking place.

3.1.61 18th, the GP makes contact with HPFT as Fiona has reported suicidal ideation and that George was very intimidating. This is the third occasion where Fiona presents to GP with reports alluding to domestic abuse, yet there is no record of a referral to specialist domestic abuse services. Later this day, CATT call Fiona who reports having a bad day, but would discuss in more detail in the next home visit. Again, potentially as the domestic abuse has been minimised, CATT may not have been sensitive to Fiona not being able to advise fully of her experiences at the time, for fear of George listening. On the 19th, CATT allow George to call on Fiona's behalf, despite knowledge of the domestic abuse, and cancel the appointment for her. CATT should have made attempts to seek the wishes and feelings of Fiona and not rely solely on George's account.

3.1.62 26th October, Police attend following a disclosure from HPFT of domestic common assault. This was listed as no further action due to Fiona declining to

support police prosecution. Evidence led prosecution considered. A DASH RIC was completed, assessing this incident as standard risk.

3.1.63 28th, HPFT Crisis Assessment and Treatment Team (CATT) complete a home visit. It is recorded that Fiona is "emancipated" and "unkempt" "struggling with the general activities of daily life" and this could be "long term". George is taking her money to buy drugs and regularly assaults her. Drug dealers attend the address and recently, a friend of George was aggressive and abusive towards her. She is "unable to freely express herself in the presence of her partner and seemed to be in a state of fear as though any open communication about her situation may lead to some form of repercussion". Fiona was whispering when explaining what she was going through and was using the television as a mirror to try and locate George when she was talking, to ensure he would be out of range to hear. This account clearly highlights the coercive control and Fiona's vulnerabilities. Following this, there is no evidence that a DASH risk assessment took place, nor a MARAC referral. The potential risk of cuckooing is not identified and therefore not explored. CATT and Dacorum consider the role of temporary housing for Fiona.

3.1.64 Three days later HPFT CATT close due to Fiona's "lack of clinical need" and note that Fiona is "refusing safeguarding intervention". Despite the clear presence of coercive control and the respective implications this has on capacity[24], there is no noted consideration of this, nor what the safeguarding intervention is, or why Fiona refuses. No record of a conversation taking place to establish secure methods of contact with Fiona.

3.1.65 HPFT did report the domestic abuse offences taking place to Hertfordshire Police. Officers attended on the same day they were notified by HFPT (28th October) and their report details that Fiona was under the influence of prescribed medication and struggled to communicate. Officers reattended the following day, but their focus appears to be on evidence gathering for the disclosed physical assaults, which there is no evidence of. This narrowed domestic violence stance to domestic abuse may have hindered the officers inquiry into exploring either the coercive control and financial abuse. However, the report from HPFT is unclear with regards how much of the abuse was disclosed to Hertfordshire Police. Hertfordshire Police record

[24] https://coercivecontrol.ripfa.org.uk/wp-content/uploads/Guidance_sheet_two_Mental_capacity_and_coercion.pdf

shows they were only passed on information about the alleged physical assaults.

3.1.66 1st November, is the first record of the potential of a high risk domestic abuse specialist, an IDVA (Independent Domestic Violence Advocate) being involved with Fiona.

3.1.67 Throughout November HPFT and Refuge specialist domestic abuse service liaise about a safe contact method. HPFT are the first agency to identify that coercive control is present. Refuge declined HPFT invitation to complete a joint home visit, advising that it would not be safe as George lives at the address. Refuge were willing to meet Fiona at a community office or hold a telephone call. There has been a number of professionals meeting with Fiona at her address to discuss domestic abuse, and under the circumstances of poor mobility, agoraphobia, limited resources and Fiona and George sharing a phone; Refuge could have reconsidered their approach to support Fiona, using more effective engagement strategies. For example, seek to risk mitigate, as much as possible, the likelihood of George's presence at the address. There is evidence that Fiona is able to engage with support and detail the domestic abuse she is subject to, albeit covertly, whilst George is in the address. Refuge were not able to offer Fiona specialist support in November or December and, via HPFT in January 2021, Fiona declines IDVA support. An alternative stance could have been taken, in inviting the IDVA to remain open to the case, but provide professional support and insights to the support worker which would have uplifted the domestic abuse practice of the support work and therefore allowed Fiona access to indirect specialist support.

3.1.68 In early December, Dacorum ACMHS invite Fiona out to their car to discuss housing options, which allows for a more enhanced conversation to take place with regard to housing.

3.1.69 George is also referred to HPFT by his GP due to risk of self-harm. He describes the relationship as over, and has knowledge of Fiona seeking to move soon. He is aware that Fiona is getting support with mental health, and it is benefitting her, and would like mental health support too. He advises he gets very agitated and gets "very argumentative in a very aggressive way".

Their relationship is described as “difficult”, minimising the abuse occurring. There is also no evidence of exploring the ‘very aggressive’ presentation of George towards Fiona, and therefore a missed opportunity to discuss specialist domestic abuse support for him.

2020

3.1.70 In January, George does not attend his initial assessment with HPFT and is discharged back to GP. Multi-agency working is occurring between Care Coordinator, GP, Dacorum ACMH support worker and Pharmacy to help coordinate care for Fiona’s health concerns. Fiona advises she feels unable to go to Safer Places Refuge as her health issues won’t be catered to.

3.1.71 In February, Fiona reports to HPFT having to give George’s “friends” £170. She has no money for food or heating, she doesn’t feel safe and that George is emotionally and financially abusing her. Food vouchers are explored (and later obtained for Fiona) but no safeguarding raised in relation to the emotional and financial abuse. No evidence of a safety plan being put in place or DASH risk assessment being done. Dacorum ACMHS and Safer Places refuge are liaising to offer Fiona a refuge space in Essex, but due to the distance, and Fiona’s health needs, she feels this placement is not accessible.

3.1.72 In late February, Fiona details to Dacorum ACMHS support worker that George has been quite caring towards her. This is potentially a missed opportunity to discuss an alternate rationale with Fiona about George’s behaviour; that he may indeed be losing his control over Fiona, and the benefits associated with this control (financial gain) and therefore offer Fiona an opportunity to resist this potential attempt from George to get Fiona to not leave.

3.1.73 In early March, George suffers more physical ill health episodes and requires ambulance attendance.

3.1.74 1st June, Fiona is contact with her HPFT support worker advises George seeing another woman. No enquiry into who this woman is and therefore no attempts to safeguard her are made. Fiona advises that her nose is broken and teeth need replacing, yet refers to herself as a “hypochondriac”. Here is potential evidence of the coercive control - psychological undermining and

de-sensitisation to George's abuse and violence. There is no evidence of a DASH risk assessment or report to the Police. Safe accommodation via refuge is offered.

3.1.75 3rd June. Fiona mental health team report to Police that Fiona is having a psychotic episode and have welfare concerns about her. Police attend. Fiona wants to know if her family were in her neighbours garden. Police record that they have no concern that Fiona was a risk to self.

3.1.76 4th June, Antonia calls HPFT to advise of the extent of Fiona's mental illness but that she is also being financially abused by George. It is unclear what HPFT did with this disclosure. In calls with HPFT, Fiona advises she is paranoid that her phone is bugged.

3.1.77 10th June, George calls Dacorum ACMHS support worker to cancel Fiona's meeting. Once more, the support worker could have made concerted efforts to directly obtain the wishes and feelings of Fiona, rather than solely rely on George's account. A home visit still could have taken place, as a means of a welfare check attempt, in light of the domestic abuse.

3.1.78 Over the following few days, there is contact from Fiona with both the GP and the care-coordinator about increasing paranoid thoughts and auditory hallucinations. These are quite isolating in nature, as they pertain to her family talking about her. Again, the potential here is further isolation felt by Fiona, but also the additional risk of psychosis and the vulnerability to domestic abuse.

3.1.79 On 29th June 2020 Fiona called Hertfordshire police stating she and George have received threats to be "Kicked the shit out of" by numerous family members. Officers have attended and have read the messages, which state "What shit are you causing, you don't want me to be pissed off". No offences were committed and safeguarding advice was given.

3.1.80 3rd July, amid concerns for Fiona deteriorating mental health, Care Coordinator and Support Worker do a house visit. George advised that Fiona was unwell and would not be able to see them today. The workers persisted,

and were able to speak to Fiona on the phone. Indications of increased risk owed to mental health deterioration, and inability, despite attending the property to see Fiona.

3.1.81 6th July, call with Fiona and support worker. Fiona presented as distressed but could talk as George had gone out of the address. She wants to move out, but not to refuge. She wants to get treatment for her teeth and her health issues. She is feeling suicidal but has no intentions to act. This is a missed opportunity to safety plan with Fiona.

3.1.82 13th July, George reports to Hertfordshire Police that he has taken an overdose the week before, for being scared of Fiona's family; advising he'd been told by Fiona's sister: "Why don't you do us all a favour and take an overdose so we don't have to worry about you". Police sought to obtain evidence of a crime, but no messages to the above effect were located.

3.1.83 26th July, Fiona calls Police to report that her sister is talking about her, saying she is crazy and paranoid. Welfare check completed. Fiona is noted as "safe and well" and not suicidal.

3.1.84 In August there are two Police reports in relation to George. One from the Landlord advising of welfare concerns for George and damage to the property. Landlord is concerned about sending in a contractor to do damage repair. Police pass this information onto the safer neighbourhood team and advise given to the landlord regarding contacting GP or mental health services. The second is police intelligence. From the information provided, the author is unsure if criminality is occurring, but George and another male made off when spotting the officer. Perpetrator interventions such as the Drive project[25], who employ an intensive case management intervention with DA perpetrators, often work with Police to target other areas of offending to create opportunities to either minimise the potential chances for the perpetrator to be abusive (e.g., in this instance, it's known that George is a regular user of illicit substances, pursuing for drug related offences, and coordinating with IDVA's/care-coordinators of Fiona to get support to her when George is in custody), but also offer engagement opportunities with

[25] Hester, M., Eisenstadt, N., Ortega-Avila, A. G., Morgan, K. J., Walker, S-J., & Bell, J. (2019). Evaluation of the Drive Project: – A Three-year Pilot to Address High-risk, High-harm Perpetrators of Domestic Abuse.

specialist DA perpetrator services to aid with their abstinence from substances and cessation of abusive behaviour.

3.1.85 September, two calls to Police by George to report that Fiona's family are threatening to break into the address and remove him and Fiona and they are spreading rumours to break them up. No offences detailed, and referred to safer neighbourhood team to monitor. There is no record on acknowledging the risk increase owed to perceived external forces trying to split them up.

3.1.86 2nd October, a home visit was conducted by the Care Coordinator and Psychiatrist. Fiona reports that her family are trying to break her and George up, so that she can go care for her parents. She reports hearing them outside their address multiple times a day; George validates this claim. She is only getting two hours sleep a night. Psychiatrist is of the view that Fiona is not psychotic, but having paranoid thoughts. Evidence to substantiate Fiona's claims were not found when Fiona showed professionals her phone. This could be an attempt by George to feed Fiona's paranoia, but this is not considered by professionals; they merely considered that George needs mental health support too. The picture of ostracising Fiona from her family continues to build.

3.1.87 On the 5th, Fiona makes contact with HPFT to report concerns over George, and the need for his medication to be reviewed. Neighbours have recently called police and ambulance requesting they be moved into alternative accommodation and for drug use. Here is further evidence of the role that Fiona takes in trying to meet George's needs, creating barriers for her to leave the relationship. A multi-agency discussion on how George's needs can be met by services, to lessen the burden on Fiona, and potentially facilitate her leaving the relationship or accessing specialist support, would have been a desirable outcome. George also calls police to advise that someone is in their address and they are extremely scared, when he and Fiona return from being out and find a window open. Upon Police arrival, no persons is located at the address and no burglary has taken place. Safeguarding referrals submitted.

3.1.88 The day after, Fiona advises the mental health team that George has overdosed. An ambulance attends and George denies overdosing. Fiona also

calls police to log that her partner has had a nervous breakdown. There is no further information provided as to the support offered.

3.1.89 23rd October George has an initial assessment with care coordinator. Distressed and anxious from hearing the negative things Fiona's family say about him. Following this, medications are significantly reduced and counselling to be arranged by GP to explore past traumas. George reports being drug free for 5 years.

3.1.90 In November there are multiple contact with both Fiona and George with HPFT and Police. Fiona and George advise that the neighbours are trying to separate them, that Fiona's family are spying on them and want to harm them. HPFT shared information with police about two of these instances. HPFT sought to understand if Fiona wanted to revisit getting away from George into safe temporary accommodation, which she declined. Both organisation cite growing paranoia and mental ill health. During police attendance, there is no record of speaking to the implicated parties (neighbours or Fiona's family); indeed, neighbours and family may indeed have a significant amount of information about the presenting concerns, anti-social behaviour, domestic abuse or may even be criminally liable themselves. It is also unclear if officers considered the risk increases to Fiona from George, as others were trying to separate them. Police advise George to speak to other residents in the block to ensure that the communal security door remains closed. Fiona also self-refers to Spectrum substance misuse service, advising she would like support with her heroin and crack use. Fiona advises that she uses both substances approximately 2-6 times per week.

3.1.91 December, Fiona calls to Dacorum ACMHS care coordinator, advising that they are due to be evicted. Liaison occurs between care coordinator and homeless prevention teams and it appears that the tenancy has run out and needs to be renewed. Mid December and George leaves voicemail for the care coordinator angered by them being seen not at risk of eviction, he retorts: "You better fucking call me back bitch because you're a fucking liar and I need answers". Here is an insight into the negative attitude towards women and manner in which he conducts himself.

2021

3.1.92 January, there is good multi-agency working between care-coordinator, CGL and GP seeking to obtain contact with Fiona, following recent difficulties and trying to seek support from substance abuse services. Towards the end of January, the new care coordinator reaches Fiona, who advised her mother is on life support due to COVID. Spectrum substance misuse service closed Fiona's case for support owed to lack of engagement.

3.1.93 4th February, George calls police to report issues with neighbours (they are allegedly throwing stones at the property) and that he fears returning home, so is living with Fiona at her father's address. No safeguarding raised for the father. Neighbours are not spoken to; assessment from police that this is a "ongoing neighbour dislike". George is advised to call 101 and that a SafetyNet case can be opened if the situation "flares up again".

3.1.94 8th February, Fiona advises the care coordinator that her mother died of COVID, that George is now residing in Dagenham and that she wishes to reside with him. No evidence of bereavement support being considered or offered to Fiona.

3.1.95 Later in February, Fiona shares with the care coordinator that her and George are being made homeless, by George's mother, alluding to them leaving their previous premises and now residing with George's mother in Dagenham. There is no evidence of safeguards being considered for George's mother. Fiona has also been receiving abusive messages from her family. No discussion detailed about how Fiona would like to deal with the messages from family.

3.1.96 Early March: Fiona details to the care coordinator that she attends her mother's funeral. Her family are wishing she returns to live at her father's address and assist with his care needs. This is another opportunity to present bereavement support to Fiona, yet none is offered. Additionally, it is not clear if safeguarding was raised for her father.

3.1.97 23rd March, George informs Fiona care coordinator that Fiona has taken an overdose and is in a local hospital.

3.1.98 24th March, as Fiona has no local connection is Dagenham, the local homeless prevention team will be referring back to Dacorum housing.

3.1.99 25th, care coordinator calls to discuss housing. Fiona does not wish to live in Dagenham and will return to live with George at this flat. This is a missed opportunity for the care coordinator to talk about other safe housing provision away from George.

3.1.100 26th March, Fiona texts her care coordinator to advise she has been sectioned and has given permission to share information with Antonia. Fiona advised that George referred to her late mother as a "cunt" and Fiona as a "major fucked up cunt". We have another insight into the derogatory attitudes George applies to women.

3.1.101 29th March, George calls Fiona's care coordinator and told him not to speak with Fiona's family as they are "bad for her". Evidencing an attempt from George to further isolate Fiona, as this is against Fiona's explicit wishes for Fiona's care coordinator to share information with her sister. Later that day, Fiona is discharged and following no other suitable accommodation returns to live with George. This is a missed opportunity to offer Fiona safe accommodation away from George. The last entry from HPFT on this day, is that Fiona has withdrawn her consent for the care coordinator to share information with her sister; showcasing the level of influence and control that George has over Fiona.

3.1.102 22nd April, Fiona calls police to report having a recording of her sister threatening to "fuck you up", calling her a "nutter" and that her sister is talking to her neighbours. She reports wanting to end her life because of it. Fiona did not want anyone to attend the address, but wanted "justice". Fiona is advised to record it again, if it happens again. The record does not advise if suicide safety planning was carried out and it is unclear what follow on action occurred. Yet, this also alludes to the very isolated place that Fiona must be in, limiting her ability to leave the relationship with George.

3.1.103 May, Fiona reports to the Dacorum ACMHS care coordinator that they are living back with George's mother. George is taking his mother's bank card

without her consent and blaming it on Fiona. There is no safeguarding report re the alleged financial abuse of George's mother.

3.1.104 29th June, Fiona calls Dacorum ACMHS to advise she is living in a single room in Dagenham. The room is divided into two, by a curtain, so that another lodger can also live there. These housing arrangements required scrutiny, as Fiona may be being exploited. No record of the care coordinator professional curiosity into reason for now living alone.

3.1.105 6th July, Fiona advises the care coordinator that she is subject to eviction, as she has no tenancy agreement in place, despite paying nearly £1700 up front. There is a lack of clarity sought into the current housing predicament by Dacorum ACMHS.

3.1.106 26th July. Fiona calls ACMHS to advise that she was sexually assaulted in March 21 and that this will be going to court in April 22. No support offered around the sexual offence or follow up safeguarding with police recorded. Hertfordshire Police show no record of this case in March 21. George's tenancy is at risk as he owed money to his landlord. Fiona advises that she would like to be housed with George.

3.1.107 5th August. Dacorum ACMHS called Fiona, who reported abuse from neighbours, which resulted in her and George fleeing to Dagenham. A safeguarding concern was not raised re this incident. Another missed opportunity to speak with neighbours.

3.1.108 22nd August, EEAS attend as George has overdosed. Fiona has ended the relationship, and he has to move out of his flat. He advises ambulance crew "can't take anymore and wanted to kill himself". George is taken to Watford General Hospital.

3.1.109 26th August, Fiona is transferred to hospital for an overdose. Fiona feels that she was spiked, and that it was not an attempt to end her life. Fiona had consumed alcohol, her medications and crack cocaine. Following, Fiona is referred to refuge and CGL. Fiona speaks with CGL re substance misuse

support. Fiona declines ongoing support, advising that she is not dependent on substances, but is influenced by her partner, as he was dependent on crack and heroin and purchases it for her. She associates her suicidal ideation to her family and friends: "I don't want to live anymore. I have had enough of what they are doing to me". Fiona declined ongoing support. She advises HPFT that she did not intent end her life. On the same day, George self-refers to SPA with suicidal ideation, admitting an overdose in the previous week. He was referred back to his GP.

3.1.110 27th August, Refuge make contact following hospital admission. Fiona discloses she is terrified of George and is suffering physical, emotional, financial, and sexual abuse from him, but states "Can't cope with the pain if I leave". George also disclosed that her sister was very controlling. The IDVA discusses a bespoke suicide safety plan and attempts contact on the 3rd and 9th of September without success.

3.1.111 30th August, George makes contact with the Police advising that he is suicidal and frustrated that his pain medication is lacking. Welfare check completed.

3.1.112 14th September, a neighbour call police after hearing a female screaming. On arrival Fiona discloses that she lost consciousness during a prolonged assault. George has strangled, dragged her around by the hair, kicked her in the ribs and head. Fiona has a black eye, a cut to the head and a tooth missing. EEAS advise that police took photographs of all injuries. DASH completed, with an actuarial score of 15 – high risk. MARAC and IDVA referral made. Ambulance attends to transfer Fiona to hospital. HPFT trigger section 42 safeguarding. George arrested, but went 'no comment' under interview. Police bail conditions put in place, not to attend Fiona's father's address, where she current resides, or to contact directly or indirectly. Record does not advise on a bail date. Fiona supports police prosecution, but neighbour declines to make a statement.

3.1.113 20th September, the IDVA makes contact with Fiona who advises she is living with her dad and that George has got another woman pregnant, whom is now his girlfriend. Refuge is being sought for Fiona and non-mol was discussed but not wanted. There is no record of the IDVA seeking to safeguard the woman and child at risk from George.

3.1.114 21st September is the first MARAC conference concerning Fiona and George. St Albans & Dacorum MARAC minutes state as part of the rationale for hearing the case at MARAC: "Victim (Fiona) considered as vulnerable, AP (George) is very controlling and victim is at high risk of harm from AP, as well as victim's family members." MARAC minutes state that following hospital admission on 27th August, Fiona disclosed that she does not know what happened to her but she was found in the grass/bushes in the garden. She states that she can't remember anything and is frightened that George has spiked her/violated her in some way. She stated that he controls her financially, is a regular crack cocaine user and is emotionally, verbally and physically abusive. The MARAC also discussed the incident on 15.09, which included a violent assault. George dragged Fiona out of the flat; kicked her in the stomach twice, breaking her ribs, head butted, giving her a black eye, hair gouged out, teeth knocked out and called Fiona a "pussy", "an ugly dirty cunt" and said "I don't fucking love you" and "I don't want to live with you". Historical abuses are also detailed: "nearly ran her over with a vehicle; battered her; broken her ribs and nearly killed her; punched and broke her jaw and eye socket; strangled her until she was unconscious." Safety plans in place and multi-agency working underway. MARAC identifies "coercive and controlling behaviour" as present, but does not guide or task agencies to begin evidence gathering to this effect. There is also no action recorded in relation to the perpetrator accessing specialist intervention for domestic abuse.

3.1.115 The remainder of September, more stresses amount. Fiona moves in with her father who has a stroke, and her health conditions also worsen, causing an increase in her suicidal ideation, which is noted by Fiona's sister and reported to HPFT. Safe accommodation is sought by Refuge and Survivors Against Domestic Abuse; Refuge also discuss a bespoke suicide prevention plan with Fiona. Fiona advises HPFT that she is in emotional pain, having not been able to grieve her mother's death. There is a missed opportunity here to offer Fiona bereavement support.

3.1.116 2nd October, two weeks following physically and emotionally abusing Fiona and allegedly having a new partner who is pregnant, George sends a picture to his landlord of his penis and is seeking sexual relations. George's landlord reports to Police. Following an investigation, the crime was "no further actioned" due to lack of mens rea (proof of intent to do harm).

3.1.117 The week following, Fiona is staying with her daughter in Hemel Hempstead. She has support from Refuge (IDVA service), HPFT and a psychiatrist. St Albans refuge decline to support Fiona, stating that her needs are too complex. During the appointment with psychiatrist, she attributes her schizophrenia diagnoses as a symptom of her abusive relationship with George. She details repeated traumatic experiences under the influence of crack and heroin, often injected by George. Fiona disclosed waking up in a state, with no recollection of events and that George would invite other men and she was not certain what happened in their company. There is no record of being advised that Fiona can report these incidences to the police. In line with the separation, Fiona advises that she has not used illicit substances in a "couple of months". She reports being "brought back to life" 6 weeks ago, by ambulance service. A comprehensive risk assessment for suicide is recommended, but no mention of a bespoke safety plan.

3.1.118 13th October, Fiona explains to Refuge that she has not had an update from police as she understands that his bail conditions end today. St Albans and Decorum MARAC minutes ratify the bail conditions end on 13.10.21. Fiona is advised to call 101. This is a missed opportunity for the IDVA and the OIC to complete some pro-active safeguarding and safety planning around the bail conditions ending. The IDVA did email DAISU on this date requesting an update. IDVA records show receiving an email from police on 15th October that George's bail conditions have been extended to 23rd November. The IDVA attempts to contact Fiona to update, but the call goes through to voicemail. No message is left. The author notes Hertfordshire Police Athena records advise that Fiona 'opted out' of updates, which is the rationale for not updating Fiona as per the victims code stipulated timeframes. Within Athena, a narrative justifying why Fiona is not to be updated, and any other plans to informs other key safeguarding stakeholders is recommended.

3.1.119 14th October, Fiona calls the police following an argument with her child, whom alleged to have called her a 'Shit mother', a 'cunt' and threatened to "fucking kill you and beat the shit out of you". Fiona also advises that George controls her finances and she cannot access her own money. Police records show that Fiona is intoxicated and refuses to answer DASH assessment. This incident was referred to DAISU to investigate. There is no evidence of a safeguarding referral to social care, nor any inquiries taking place with regard to the financial abuse. Hertfordshire Police IMR states "no evidence of

coercive and controlling behaviour". The author notes 7 domestic abuse related incidents (not including the one detailed above) that have been recorded by the police, 5 of which were post the insertion of specific legislation around coercive control in December 2015[26]. These incidents include, fear, significant assault, threats to kill, holding a knife to Fiona's throat, having teeth knocked out and loss of consciousness. The author notes that Police were also present at the MARAC on 21st September 2021, whereby comprehensive information was shared, detailing controlling behaviour, physical, emotional, financial abuse, sexual abuse and access to a firearm. Police pass details onto EEAS who advise they "cannot respond due to female being able to walk". Later this day, EEAS is called and conveys Fiona to hospital following an overdose. Fiona replies to assessment, if left alone she will harm herself further.

3.1.120 The week following, Fiona is working with Refuge and Three Rivers Housing to obtain safe accommodation, which ends in Fiona accepting a property. On the 15th police notify Refuge of an extension of the bail conditions to 23.11.21. George also makes contact with HPFT advising that his landlord is selling the property he resides in and he needs to find new accommodation in 4 months' time. It is not clear if HPFT consider the risk increase to Fiona – in that he may be motivated to rekindle the relationship, in the light of using Fiona for his financial gain for many years previous.

3.1.121 21st October, Fiona advises Refuge of suspected harassment online from George. A fake profile that George is suspected to have set. One photo on this profile is of Fiona with her sister, and under the photo it says Fiona "is a lying cunt". Fiona's child also found a fake profile on LinkedIn, with Fiona's photo advising she is a benefit advisor. MARAC referral triggered for new incident. Fiona advises HPFT on the 28th that people have been contacting her, following being in contact with George. Despite IDVA advice around tech abuse and for Fiona to contact police, by taking screen shots etc of the evidence, there is no log of this incident occurring with the police, and therefore no opportunity to investigate this suspected crime or suspected breach of bail.

[26] https://www.cps.gov.uk/legal-guidance/controlling-or-coercive-behaviour-intimate-or-family-relationship#:~:text=Section%2076%20Serious%20Crime%20Act,penalty%20of%20five%20years'%20imprisonment.

3.1.122 2nd November, George reports poor sleep, housing worries and a dramatic increase in alcohol consumption to HPFT. There is no evidence of understanding how this could increase the risk to Fiona, and therefore no information is passed onto safeguard Fiona.

3.1.123 4th November, there is one account of breach of bail and one suspected account of a breach of bail. Fiona's sister inform HPFT that a friend of George has been in contact with Fiona to advise how great he is doing and looking. Following this, Fiona has contacted George, inviting him over to her new property in Rickmansworth. Police were informed of this by a neighbour as they heard a male banging and kicking the front door and screaming at a female at the address. He also started "kicking down the neighbours door". During the police enquiry, George is not located, but Fiona discloses being raped by George at his mother's address (no date of this rape given).

3.1.124 Later this day Fiona advised that this allegation was not true and it was consensual sex. Investigation was closed. Fiona's sister also made contact with police following Fiona posting the following message on social media: Facebook "I Can't take no more pain; I have had enough pain for a million people I am just so fucking lonely in my heart. It's unreal WTF was I put on this world for just to be totally abused no matter what I do no matter how much I fight, no matter how kind I am and let people get away with abusing me or not loving me? Fuck my life. I want my mum". Officers made contact with Fiona, who advised she was on the way to a friend's house and had no intent to harm self. Domestic abuse markers placed on the address. There is no evidence of police seeking to investigate further the breach of bail, or the crimes associated with the breach (breach of peace/public order/criminal damage/violence to secure entry).

3.1.125 9th November, Watford & Three Rivers MARAC is held for the incidents of malicious communications and George attending Fiona's new address. Risk of coercive control not identified at this MARAC. With regards the breach of bail a statement has been forwarded to the current OIC in DAISU, but it is not clear on what the outcome of this is. No action set to interrupt George's domestic abuse offending.

3.1.126 13th November, George has an initial assessment with HPFT, where he discloses that he "hit" Fiona, is feeling guilty and wants to be "a better person". Here George offers a rare insight, potentially feeling remorseful and wanting to take action. There is no record of discussion specialist domestic abuse perpetrator provision with George, which is a missed opportunity to reassure that support for his harmful behaviours are out there.

3.1.127 16th November, New Hope are notified by Fiona that her family have "turned against her" and having trouble with her neighbour, for recently sticking up for her ex-partner. This alludes to the cognitive dissonance that victims can exhibit, owed to the long term psychological manipulation of their respective perpetrator. Even when George is being violent and abusive to both her and a neighbour, Fiona seeks to defend him against others that may be seeking to hold him to account (neighbour and friends). This is a significant marker of the risk that the Fiona is in.

3.1.128 Over the previous week several successful attempts at telephone contact with Fiona are made by CGL. But on the 16th November CGL speak with Fiona, who declines support for substances misuse. CGL closed the case.

3.1.129 Towards the end of November, Fiona advises New Hope that she is in a "bad place", "heartbroken" and her family have "turned against" her. She discloses to HPFT and Refuge that she has been in contact with her ex-partner, who is now being nice to her, telling her he loves her "to drop the charges against him". There is no discussion here about reporting this breach of bail to police. Fiona advises IDVA's that's he gave George her new address as he said he was suicidal. Professional meeting arranged by IDVA, following Fiona advising that she would benefit from meeting all safeguarding workers, because she feels she can engage better face to face.

3.1.130 29th November, Fiona calls OIC and advises that she is in contact with George. Words of advice given, but no action on these breaches taken.

3.1.131 8th December, Three River Housing are advised that Fiona has spoken to the solicitor they share, who advised that "he does not deserve it and has tried to kill himself twice". This is concerning practice, and a conflict of interest under

the Solicitors Regulation Authority (SRA) Standards and Regulations[27]. Fiona feels that George doesn't deserve prison, but needs therapeutic support. Fiona was advised to speak with her social worker and IDVA for support. Fiona also makes contact with HPFT, advising she is ambivalent about withdrawing support for police action against George. 5 days later, she advises New Hope that she has dropped her support for the charges against George. Fiona fears she may have cancer, and is awaiting a diagnosis.

3.1.132 9th December, George leaves a voicemail with Dacorum ACMHS advising that he is "spiralling out of control" and he was "very angry all the time". The following day a request for psychiatry support and review of medication is lodged.

3.1.133 14th Fiona is airing concerns with New Hope that she is worried about losing her housing, as she obtained that as a domestic abuse victim and since dropping the charges she fears no longer qualifying for this support. New Hope reassure her that this will not be the case.

3.1.134 Mid December, an online professionals meeting held with Fiona. Mental health, housing, Refuge and New Hope all present. Support actions discussed around accessing GP. Of note, Fiona advises she no longer supports the charges against George, as she feels "he has changed" and is "no longer a risk". Fiona reports to pausing her bereavement counselling. This is the first mention of this on record, as such, there is no indication of how Fiona sourced this support, and how long this had been going on for. Fiona advises she would like to build her skills and confidence, but she is struggling to manage her property. A Connected Lives assessment was not considered, despite Fiona's admission to experiencing difficulties managing her home. This multi-agency meeting took place 3 months after raising the section 42 concern. The following day, Fiona advises Police of her wish to no longer support prosecution. At this time, George is still on bail for this offence. As recent as the 29th November, the OIC is giving support and advice regarding proceeding with the prosecution, but it is unclear if this was repeated during this call.

[27] https://www.lawsociety.org.uk/topics/client-care/conflict-of-interests

3.1.135 Two days later, New Hope make contact with Fiona's GP surgery, who advise that they are concerned Fiona is overusing medications and therefore it is important for Fiona to attend surgery to collect medications so they can monitor. Fiona is also on a fast track to be seen by the Colorectal Team for suspected bowel cancer.

3.1.136 A few days after Fiona calls Social Worker to advise that she is seeing George again, and he has supported her to collect her medications. Social Worker advises to consult with IDVA and revise her safety plan.

3.1.137 Shortly after IDVA calls Fiona. Fiona has been unwell with a chest, liver and kidney infection. She is with George, and will be spending Christmas together. This has impacted her relationship with her family. She reported feeling lonely. IDVA did not safety plan with Fiona, as George was in the address with Fiona at the time of the call. On the same day, George assaults door staff at a local public house. Police attend, but door staff do not support prosecution.

3.1.138 The following day, after an argument with George the night before, Fiona overdoses, taking 2-3 times more of her prescribed medication and George's medication too. Ambulance attend and complete a capacity form with Fiona. She was assessed as able to understand, retain and use information to communicate against crew concern and decision that they wanted her to attend hospital. She was given worsening advice which included if she felt any pain, any vomiting, or loss of sensation then she should call 999. GP referral completed. It is unclear if ambulance spoke to Fiona about her suicide intervention plan or if she had intent on harming herself further if left alone or if she had someone that could be with her at this time, to help keep her safe.

3.1.139 The very next day at 16:36 Fiona's sister was at Fiona's address but could not get a response from her, despite lights being on in the property. Police arrived at 17:32 and entry was forced to the address. Fiona was found unconscious in the address with no signs of life. EEAS arrived at 18:52 with time of death given at 18:53, with cause of death being a tramadol overdose, which is confirmed by the coroner's report.

3.1.140 Police sought evidence of foul play, via reviewing CCTV footage between the respective timeframes of concern, which confirmed that nobody approaches the address other than neighbours. Fiona phone was also reviewed, and there was no evidence of assisting or encouraging suicide.

4. Overview

4.1 Summary of information from family, friends and other informal networks

4.1.1 The relationships with Fiona's family, primarily sister and daughter were at times fractious. Antonia makes contact with both HPFT and Hertfordshire Police on multiple occasions to advise of her sisters vulnerability. In June 2019, George threatens to kill the sister, and the sister tries to safeguard her parents by removing Fiona's belongings out of their address. In June 2020, she reports to HPFT that Fiona is being financially abused by George and that her sister is of mental ill health. In September 2021 Antonia makes contact with HPFT advising her sisters health is worsening, as is her suicidal ideation. In November 2021, she makes contact with HPFT to advise that, despite bail conditions being in place, it appears that George is getting friends to contact Fiona and advise how well he is doing/looking – this leads to Fiona giving him the address of her safe housing. He attends and is violent.

4.1.2 Fiona's child and other sister wasn't deemed appropriate to contact by Antonia, who agreed to be the single point of contact for the family.

4.2 Summary of information from the perpetrator

4.2.1 As detailed in section 1.6, the panel deemed George was not deemed suitable for contact, for fear of increasing the risk that George poses to himself and Fiona's family.

4.3 Summary of information known to the agencies and professionals involved.

4.3.1 Fiona and George had contact with a wealth of agencies throughout the duration of their relationship; a summary is presented below.

Police:

4.3.2 George has been known to the police since 1993, involved in crimes including common assault, malicious communications, carrying an offensive weapon, theft, shoplifting, breach of orders, criminal damage, supply of class A drugs, drink and drug driving offences and causing harassment, alarm or distress.

4.3.3 Since 2004, police hold over 200 incidents police have attended concerning Fiona. Domestic abuse, violence, drugs and alcohol have been the main cited crimes. A number of these related to an ex-partner, who is also listed as a perpetrating domestic abuse against Fiona.

4.3.4 Information is held that Fiona and George's relationships commenced in 2009, with the first recorded domestic incident in 2010, where George calls the

Police following an argument over monies owed between them. The vast majority of incidents recorded are from 2013.

4.3.5 From (and including) 2013, a further 23 crimes are reported and recorded, 11 calls to the address. George has a further 10 crimes recorded, with 5 further calls to the address. The crimes/incidents recorded range from rape, malicious communications, concerns for welfare, ABH, drugs activity, overdose and threat with a firearm.

HPFT:

4.3.6 HPFT provided information since 2012 on Fiona, when she was referred to service by her GP for depressions and paranoid personality disorder.

4.3.7 George was first known to service in 2014, whereby he self-referred for psychological support on helping him with childhood trauma.

4.3.8 From 2012 to the date of Fiona's death, there are over 300 recorded contacts with both parties.

4.3.9 HPFT were, at various times, supporting Fiona with Emotionally Unstable Personality Disorder, Paranoid Schizophrenia, depression, suicidality and bowel related health issues.

4.3.10 HPFT were supporting George with (self-professed) emotional regulation/anger, suicidality, childhood trauma and paranoia. There were sustained period of non-engagement which hindered the level of support that HPFT were able to offer both parties.

4.3.11 The domestic abuse that George was subjecting Fiona to was well known to HPFT, following a wealth of disclosures from Fiona, but also direct observation of Fiona's fear of George by professionals. On a number of occasions George had also disclosed harming Fiona.

Refuge:

4.3.12 Fiona was first known to Refuge in November 2019, as referred by HPFT for concerns around domestic abuse. At this time, contact was not deemed safe and despite efforts to support Fiona in the community, Refuge were not able provide support.

4.3.13 There is then a further referral from hospital in August 2021, for concerns around domestic abuse. From this date, until the month of her death, Fiona

receives support from her Independent Domestic Violence Advocate (IDVA) and continues to disclose a wealth of abuse that George has subjected her to, both recent and non-recent. There are a total of 21 contacts between the IDVA and Fiona. The support includes good multi-agency working with HPFT, Housing and Tenancy Support Teams. The IDVA support with specialist safety planning, suicide safety planning and seeking safe emergency accommodation.

East of England Ambulance Service:

4.3.14 EEAS had 21 contacts with Fiona and George from January 2013 to the time of Fiona death in December 2021. On 8 occasion, ambulance crews attended to Fiona, where she was assessed and transported to hospital. The range of support offered were around domestic assault, overdoses, pain to abdomen, stroke symptoms and self-harming with a knife.

4.3.15 On 6 occasions EEAS attended in relation to George. On one occasion, they conveyed George to hospital. They supported him with overdoses, chest and leg pains, self-harm using a knife and a broken arm (non-DA related).

4.3.16 There was the one singular attendance on 14th September 2021 for a domestic assault. EEAS paramedics attending do not raise any safeguarding concerns with regards to domestic abuse on any other occasion.

Change, Grow, Live:

4.3.17 CGL (Spectrum) first were referred to Fiona's Community Psychiatric Nurse in May 2015 for poly substance misuse. Following numerous failed attempts to engage Fiona, CGL closed the case within a month.

4.3.18 In November 2020, Fiona self-referred into CGL for support with her heroin and crack cocaine use – which ranged from 2-6 weekly. Following more failed attempts to engage Fiona, she was once again closed to service.

4.3.19 In August 2021 and again in November of that year, Fiona was referred into CGL by Spectrum's Hospital liaison team and Dacorum Adult Community Mental Health Team (ACMHT), respectively. Fiona denied having substance dependency, associating her drug use to George, who was dependent and her increased in suicidal ideation to her issues with family and neighbours. She declined support in August, but she accepted support for her alcohol use, linking an increase consumption due to the breakdown of her relationships and feelings of isolation. Mid November, Fiona declined ongoing support from CGL and was closed to service.

Three Rivers District Council Housing Services:

4.3.20 Three Rivers District Council Housing provided support to Fiona from September 2021 to the time of her death. Refuge referred owed to her homeless status after leaving George, fleeing domestic abuse. Three Rivers District Council had a total of 15 contacts with Fiona, aiding her with safe temporary accommodation in Rickmansworth. They also provided a starter pack, including bedding, kitchen equipment and toiletries to help Fiona settle into her temporary accommodation. At the time of her death, Three Rivers District Council were still supporting her with the process of finding more permanent housing.

Survivors Against Domestic Abuse:

4.3.21 SADA were open to Fiona from September 2021, referred to by Dacorum Borough Council for safe refuge provision. SADA had contact with Fiona on 6 occasions with the aim of seeking safe housing for her in Safer places refuge. Fiona also shared that she would like support around re-building her confidence, independence, and resilience as she felt had not dealt with her trauma's. In October 2021, Fiona had accepted safe accommodation with Three Rivers, and this therefore concluded their service offer in October 2021.

National Probation Service:

4.3.22 The probation service was only open to George. They held records dating back to 1991. Whilst it is unclear if the record related to Fiona, in 2008 George mentions that his partner had an overdose and that they are trying for a baby. In 2010 he advises that he has only known his fiancé 10 months, but they have been trying for a baby, and she has miscarried 4 times in this time. Again, it is unclear if he was referring to Fiona. In 2010 is the first mention of Fiona, who attends some probation appointments with George. In December 2015 a pre-sentence report is completed, which details daily alcohol use. George advises he has been clear of illicit drug use for 7 years, which is at odds with the previous convictions in this time period which indicate continued drugs use and acquisitive offending to fund. George discloses he was diagnosed with bi-polar in 2014. In August 2015, George advises that a past partner has a non-molestation order out against him. He also advises of an 11 year old child. Drug use, suicidal ideation and potential pregnancies continue to be discussed in the meetings with Probation until the last contact in 2016. There were only 7 recorded meetings in this timeframe.

Adult Social Care:

4.3.23 Records show that ASC were referred to a total of 4 times from their first records in 2012, until their last in 2019. Upon receipt of each referral, ASC referred to HPFT, as at the time of each of these referrals HPFT were working with each party.

5. Analysis

5.1 Domestic abuse

5.1.1 It is evident, beyond doubt, that Fiona was a victim of domestic abuse; subject to years of coercive control, physical, emotional, sexual and financial abuse at the hands of George. As suicide is about ending unbearable pain, it is highly likely that the domestic abuse George subjected Fiona to exacerbated the feelings of overwhelming psychological pain and loneliness, which so often are the backdrop in which suicide takes place[28].

5.1.2 Tragically, we shall never know the full extent of Fiona's experience. However, woven throughout this report are clear evidence of the following:

- Coercion, threats and intimidation: the full range of tactics that George employed to control Fiona are unknown, yet the ones the panel came to learn about were clearly effective. Fiona remarked to a range of professional, on numerous occasions, that she was fearful of George, dating back to February 2014, when she advises that George is violent to her. In March 2019, George made threats to kill members of Fiona's family, stole money from them in January 2017 and seemed to support notions that Fiona's family were out to harm and separate them. In February and March 2019, George made threats to kill Fiona. In October 2019, professionals note that Fiona is "unable to freely express herself in the presence of her partner and seems to be in a state of fear as thought any open communication about her situation may lead to some form of repercussion". Fiona was whispering when explaining what George was doing to her, and was using the television as a mirror to try and locate George when she was talking, to ensure he would out of range to hear. This account clearly highlights the coercive control and the vulnerabilities Fiona was subject to by George. In August 2021, Fiona advises that she is terrified of George. In November, 2021, when George is subject to police investigation following his assault of Fiona, she notes that he seeks to be nice to her, telling her he loves her in order to get the charges dropped.

- Emotional and psychological abuse: this abuse is frequently occurring from January 2013, when Fiona states to hospital staff that George is

[28] O'Connor, R. (2021). When it is darkest: Why people die by suicide and what we can do to prevent it. Random House.

"evil" and emotionally abusive. Throughout their relationships George either has, or makes attempts to have, intimate relationships with other women, which includes impregnating one woman in September 2021 and having his new girlfriends live alongside Fiona at their shared home. In January 2013, George allegedly supplies Fiona with drugs and advises to "go kill yourself." In March 2021, whilst Fiona is mourning the passing of her late mother, George calls her mother a "cunt", and Fiona a "major fucked up cunt". In June 2020, Fiona advises professionals that her nose is broken and teeth need replacing, but then refer to herself as a "hypochondriac". Here is potential evidence of the psychological undermining and de-sensitisation to George's abuse and violence. In September 2021, whilst George is physically abusing Fiona, he calls her a "pussy", "an ugly dirty cunt" and said "I don't fucking love you" and "I don't want to live with you".

- Physical abuse: assaults by George include holding a knife to Fiona's throat and strangulation in February 2019. In October 2019, Fiona reports that George assaults her regularly, pointing towards the abdomen; which appears to be targeted at parts of the body that can be covered up by Fiona and where she has particular health related vulnerabilities. In September 2021 George knocks Fiona's teeth out and breaks her ribs, pulls her hair, gives her a black eye, headbutts her and gives her lacerations to the head.

- Financial, economic abuse and isolation: On numerous occasions, Fiona reports feeling isolated from family and friends because they did not approve of her relationship with George. Fiona also resided at George's home, which was in a remote location. With Fiona's mobility issues, agoraphobia and financial abuse from George, Fiona faced significant barriers to accessing help and support. In October 2016, Fiona discloses being vulnerable from others and being exploited for money and physically abused by drug dealers. In February 2020, George forces her to pay his "friends" £170. She reports to aggressive drug dealers being at her address in October 2019 too. There are concerns of cuckooing. In February and October 2019, Fiona advises that George takes her money to buy drugs. In September and October 2021 she discloses that George controls her finances.

- Sexual abuse: In October 2021 Fiona details repeated traumatic experiences under the influence of crack and heroin, often injected by George. She disclosed waking up in a state, with no recollection of events and that George would invite other men and she was not certain what happened in their company. In November 2021, Fiona alleges that George has raped her. In August 2021, Fiona disclosed that she does not know what happened to her but she was found in the grass/bushes in the garden. She states that she can't remember anything and is frightened that George has spiked her/violated her in some way.

- Other: in February 2014, Fiona threatened to stab George and herself, following finding out that George has been messaging other women. In Jan 2019, Fiona discloses using weapons to harm George.

5.1.3 It is evident that George posed a significant risk to Fiona prior to her death by suicide. The abuse types that George subjected Fiona to are well documented high risk factors for serious harm and homicide[29] [30] [31].

5.2 Domestic abuse and suicide

5.2.1 Research examining the role of domestic abuse within suicides is growing. Women who had experienced domestic abuse are three times more likely to attempt suicide than their peers. Those who experienced sexual intimate partner abuse were found to be seven times more likely to attempt suicide[32].

5.2.2 A 2023 published Home Office Commissioned report[33] cites coercion and control (which involved emotional and psychological manipulation), strangulation, sexual assault/rape, financial abuse, depression and Post Traumatic Stress Disorder as highly correlated with domestic abuse victim suicide.

[29] https://safelives.org.uk/sites/default/files/resources/Dash%20for%20IDVAs%20FINAL_0.pdf
[30] Chopra, J., Sambrook, L., McLoughlin, S., Randles, R., Palace, M., & Blinkhorn, V. (2022). Risk factors for intimate partner homicide in England and Wales. Health & Social Care in the Community, 30(5), e3086-e3095.
[31] Matias, A., Gonçalves, M., Soeiro, C., & Matos, M. (2020). Intimate partner homicide: A meta-analysis of risk factors. Aggression and violent behavior, 50, 101358.
[32] McManus, S., Walby, S., Barbosa, E. C., Appleby, L., Brugha, T., Bebbington, P. E., ... & Knipe, D. (2022). Intimate partner violence, suicidality, and self-harm: a probability sample survey of the general population in England. The Lancet Psychiatry, 9(7), 574-583.
[33] Christie, C.,Rockey, J. C., Bradbury-Jones, C., Bandyopadhyay, S. & Flowe, H. D. (2023). Domestic Abuse links to Suicide: Rapid Review, Fieldwork, and Quantitative Analysis Report. Home Office Report. Retrieved from osf.io/4t9ab

5.2.3 Suicide risk factors are well documented: physical and emotional/psychological pain, hopelessness, lack of connectedness and suicide capability (the means to take your own life) [34] [35].

5.2.4 In relation to the risk factors for domestic abuse victim suicide listed in 5.2.2, both emotional and psychological manipulation was present and longstanding abuse tactic that George subjected Fiona to. George had strangled, sexually assaulted and financially abused Fiona. It is noted that, Fiona suffered with chronic bouts of depression and had experiences significant and varied relational trauma's at the hands of George.

5.2.5 With regard to the suicide risk factors detailed in 5.2.3, in November 2021, this social media post strongly alludes to the presence of each of these risk factors: "I Can't take no more pain; I have had enough pain for a million people I am just so fucking lonely in my heart. It's unreal WTF was I put on this world for just to be totally abused no matter what I do no matter how much I fight, no matter how kind I am and let people get away with abusing me or not loving me? Fuck my life. I want my mum". Moreover, Fiona has suffered significant physical pain with regard to a number of serious health complaints. The physical pain associated with significant assaults is evident too. George uses substantial levels of emotional and psychological abuse throughout the duration of the relationship, employing language designed to harm Fiona: [you are a] "major fucked up cunt". She refers to not being able to cope on her own without George on a number of occasions and frequently alludes to feeling hopeless. Feelings of isolation and abandonment are a common themes in Fiona's experiences.

5.2.6 The role of the domestic abuse and coercive control in Fiona's suicide is clear - this is the context in which her suicidality exists. It is the observation of the author, that Fiona's existence was well defined/classified by way of medical/psychiatric labels, but the domestic abuse and coercive was not so well defined. This medical model seemed to dominate the approach taken to meet Fiona's presenting needs. An over focus on this model has come at a

[34] ibid

[35] O'Connor, R. (2021). When it is darkest: Why people die by suicide and what we can do to prevent it. Random House.

cost - not fully recognising and understanding the relational context of George's behaviour: a horrific campaign of abuse, control and exploitation.

5.3 Key Lines of enquiry

5.3.1 **A review of any the information held by agencies that indicated the victim could be at risk of suicide as a result of any coercive and controlling behaviour:**

Police:

5.3.2 The first recorded domestic incident in 2010, yet the vast majority of incidents recorded are from 2013. The crimes/incidents recoded range from rape, malicious comms, concerns for welfare, ABH, drugs activity, overdose and threat with a firearm.

5.3.3 Throughout Police involvement with Fiona, there is evidence that officers understood Fiona's vulnerabilities, with regards to mental ill health, substance abuse and suicidality. Many incidents are reported as concerns for welfare or conflict with other parties (family members, associates and neighbours). As domestic abuse is not as well defined, there is no evidence of consideration of the impact of the domestic abuse on Fiona's suicidality. Indeed, an incident led, violence model of abuse appears to have been followed, which is synonymous with finding in other studies[36] that suggest police are well equipped to respond to acts of physical violence, but not patterns of abusive behaviour. Meaning that both the wider patterns and context have been missed; in this case, coercive control has not been placed as a central driver for George's offending behaviour.

HPFT:

5.3.4 From 2012 to the date of Fiona's death, there are over 300 recorded contacts with both parties. The domestic abuse that George was subjecting Fiona to was well known to HPFT, due to disclosures from Fiona, direct observation of Fiona's fear of George and George also disclosing harming Fiona. The risk of suicide was also well documented throughout the period of support HPFT were offering.

5.3.5 There were a total of nine episodes where HPFT staff had recorded information known to be signs and indicators of domestic abuse. However, in

[36] Barlow. C, Johnson. K, Walklate. S, Humphreys. L (2020) Putting Coercive Control into Practice: Problems and Possibilities, The British Journal of Criminology, Volume 60, Issue 1, pp. 160-179.

the period between 2013 and 2019, there is a lack of explicit reference to domestic abuse; evidenced by the language used to describe domestic abuse Fiona was subjected to. For example, terms such as “psychosocial issues”, “social help”, “significant social issues” and “a very unhappy relationship” were used. This language sanitizes the abuse present and as a consequence, a lack of safeguarding around domestic abuse within this time period was commonplace. As a result, many opportunities were missed to engage with the safeguarding process to protect Fiona. This safeguarding process, of course, is also a potential mechanism for which to change the abusers behaviour too.

5.3.6 In February 2014, an understanding of George’s active role in Fiona’s suicidality is made clear. Fiona discloses she has a “horrible life”, a partner who is violent and “beats me up” and gives her medication to “go kill yourself.” Yet, there is no evidence of a recognition of the role of George’s domestic abuse on Fiona’s suicidality.

5.3.7 There was evidence held on record that George was manipulating Fiona against her wider family, however this was not recognised as strategy perpetrators use to isolate their victim and therefore the increase risk associated with suicidality was not understood.

5.3.8 In October 2015 Fiona attends the GP appointment and reports to rarely leaving the George’s address, owed to depression and that her support network is limited. No evidence of GP linking the depression and isolation to domestic abuse and suicidality.

5.3.9 In October 2019 Fiona disclosed two assaults within the previous five months. This disclosure triggered s42 duties to undertake a safeguarding enquiry into domestic abuse. It is noteworthy this was within the period an unknown female had also been living at the address with Fiona and George; however, this was not identified at the time as a precipitating factor to the incident. Nevertheless, staff identified controlling and coercive behaviour and financial abuse. Subsequently intervention of a support worker was introduced to provide regular support at home. Fiona was supported to engage with an IDVA from Refuge and Housing. Regrettably Fiona did not wish to be referred to an IDVA at the time, however following referrals to Housing services and Refuge there is evidence of effective cooperation between the HPFT and external professionals.

5.3.10 In March 2021, the level of coercive control present is showcased. Following an incident whereby, following Fiona being sectioned and him calling her late mother a "cunt" and Fiona a "major fucked up cunt", Fiona gives consent to HPFT to share information with her sister. Yet merely three days after this, Fiona is living back with George and he calls Fiona's care coordinator and told him not to speak with Fiona's family as they are "bad for her". On the same day, Fiona calls HPFT to withdraw her consent to share information with her sister. Not only does this highlight the significant level of control that George has over Fiona, but also how he is able to isolate her from her family support – even in the light of recent significant emotional abuse. This must have been a deeply confusing, lonely and isolated time for Fiona, which the author notes is highly likely to have doubt compounded Fiona's suicidality.

Refuge:

5.3.11 The support of Refuge, owed to deeming it not safe to contact in 2019, didn't begin until August 2021. From this date, until the month of her death, there are a total of 21 contacts between the IDVA and Fiona. The support includes good multi-agency working with HPFT, Housing and Tenancy Support Teams. The IDVA support with specialist safety planning, suicide safety planning and seeking safe emergency accommodation. Whilst the impact of George's coercive control on Fiona's suicidal ideation is not explicitly detailed on record, the IDVA did engage Fiona in a bespoke suicide intervention plan.

5.3.12 27th August 2021, Refuge make contact following hospital admission. Fiona discloses she is terrified of George and is suffering physical, emotional, financial, and sexual abuse from him, but states "Can't cope with the pain if I leave". It is unclear of this statement is interrogated any further, as this alludes to the risk increase of suicide if the relationship were to end.

Change, Grow, Live:

5.3.13 CGL were first referred Fiona in May 2019 for poly substance abuse, but the service was unable to engage Fiona. In November 2020, Fiona self-referred to service citing wanting support with her heroin and crack use, that she was residing with her partner in poor living conditions and both affecting her mental health – there is no evidence of probing further into the impact of living with her partner on her, the extent this impacted her mental ill health, substance abuse or suicidality. Due to challenges maintaining contact with Fiona, CGL closed to her in Jan 2021.

5.3.14 In August 2021 CGL hospital liaison team were referred to, owed to an overdose and consequent hospital admission. Fiona advised she has been suicidal and that her drug use was "influenced by her partner who was dependent on illicit substances who purchased heroin and crack for her". Whilst Fiona attributed her suicidality to the treatment of her by her family and neighbours, there is no evidence of professional curiosity into the role of the George in Fiona's suicidality – even after it is disclosed he has a role within her substance abuse. Fiona declined ongoing support, and therefore she was closed to CGL.

5.3.15 The last contact was in November 2021, where Fiona self-referred again, citing increased alcohol consumption because she was struggling to adapt to life without George. Fiona also mentioned that she felt isolated in her new accommodation and that it was far from her family. Despite the increase in substance abuse being linked to George, it is unclear if there was probing further into George's the role, the relationship breakdown and any post separation coercive or controlling behaviours and the impact of this.

Three Rivers District Council Housing Services:

5.3.16 From September 2021 to the time of her death, Three Rivers housing worked responsively with Fiona. The organisation showed a good awareness of the domestic abuse that Fiona was subject to and were actively supporting her with increasing her safety and wellbeing; and were liaising with a host of multi-agency partners to bring the aforesaid about.

5.3.17 In November 2021 and December 2021, there were two incidences in Three Rivers Housing case records that allude to coercive control being a present dynamic. One whereby Fiona gives George the address of her safe accommodation where he then turns up and violence ensues. The other is a disclosure from Fiona who wishes to drop charges against George, advising that she's been in contact with the solicitor who advised that George has tried to kill himself twice and that he doesn't deserve to go to prison. She also shows signs of taking responsibility for the abuse she suffered, by advising that she was "difficult to live with", but did not want to be with him. It is unclear if professional curiosity into the role and impact of coercive control on Fiona's suicidality is considered by the practitioner; however, support was sourced via Social Care and IDVA. Indeed, we've already established that domestic abuse and relationship breakdowns are high risk factor for suicidality[37].

[37] https://www.cdc.gov/suicide/factors/index.html

Survivors Against Domestic Abuse:

5.3.18 From September 2021, SADA sought to help Fiona obtain safe accommodation. During contacts in the same month, Fiona disclosed physical abuse, financial abuse and exploitation. She was also waiting for a potential cancer diagnosis. Throughout October, Fiona discloses that she would like support building her confidence, independence resilience and dealing with past traumas. These asks, are symptomatic of a victim of coercive control who has been psychologically abused and undermined[38]. Referrals are made to a college to look at higher education based support. There is no evidence of any further exploration of the coercive control or any mention or enquiry into the clients suicidality.

National Probation Service:

5.3.19 Whilst there is limited evidence that NPS were concerned about domestic abuse, they were presented with a multitude of risks factors for domestic abuse; for example, the reliance on substances, miscarriages and previous perpetration of abuse. Incidence rates of DA in alcohol dependent samples, compared to non-alcohol dependent samples are four to six times higher[39]. Significant associations between women's drug use and their victimization from IPV are noted[40] as well as men's opioid use and DA perpetration[41]. Prevalence rates of DA range between 25% and 57% among women in drug treatment, compared with rates of 1.5%–16% found in community-based samples[42]. They were also aware of pregnancy early in relationships and multiple miscarriages[43], including George being a perpetrator of abuse against a previous partner[44] and of Fiona's vulnerabilities related to her debilitating ill health. They were aware George's suicidality, but not explicitly aware of Fiona's.

Adult Social Care:

[38] https://www.womensaid.org.uk/information-support/what-is-domestic-abuse/coercive-control/

[39] Murphy, C. M., Winters, J., O'Farrell, T. J., Fals-Stewart, W., & Murphy, M. (2005). Alcohol consumption and intimate partner violence by alcoholic men: comparing violent and nonviolent conflicts. Psychology of addictive behaviors, 19(1), 35.

[40] El-Bassel, N., Gilbert, L., Schilling, R., & Wada, T. (2000). Drug abuse and partner violence among women in methadone treatment. Journal of Family Violence, 15, 209-228.

[41] Stone, R., & Rothman, E. F. (2019). Opioid use and intimate partner violence: A systematic review. Current Epidemiology Reports, 6, 215-230.

[42] El-Bassel, N., Gilbert, L., Wu, E., Go, H., & Hill, J. (2005). Relationship between drug abuse and intimate partner violence: a longitudinal study among women receiving methadone. American journal of public health, 95(3), 465-470.

[43] Cook, J., & Bewley, S. (2008). Acknowledging a persistent truth: domestic violence in pregnancy. Journal of the Royal Society of Medicine, 101(7), 358-363.

[44] Stith, S. M., & McMonigle, C. L. (2009). Risk factors associated with intimate partner violence.

5.3.20 The first recorded contact is in May 2012, where it is described that Fiona is having “difficulties at home”, which somewhat trivialises the DA. The record is limiting, and therefore it is not known the extent of what the disclosed “difficulties” are.

5.3.21 In February 2014, Herts urgent Care Team refer to ASC for support needs related to DA. Fiona discloses she said she wanted to kill herself as she has a "horrible life" and that George "beats me up" and he has also given her medication to kill herself in the past. This case is referred to HPFT to lead, but there is no evidence of a safety plan being put in place with Fiona to address the DA or suicidal ideation, nor a referral to specialist domestic abuse victim support (she is merely given a number for a DA service). This is the first indication that George has an active and functional role in Fiona’s suicidal behaviours – yet, there is no evidence of an understanding of this dynamic.

5.3.22 There are two further case notes, both in 2017 referencing health and welfare concerns for Fiona, alluding to her not being able to meet her own needs, protect herself from harm or abuse or access service provision to increase her safety and wellbeing. Within this case note, much is detailed about her poor living conditions, health, her ability (or lack of) to meet her own needs and current suicidal intentions, yet the domestic abuse is not noted or any professional curiosity is not observed. The last contact ASC had with Fiona, she disclosed much about the relational context in which her suicidal ideation was taking place, yet practitioners did not follow up on this, despite the relationship with George continuing and the growing welfare concerns for Fiona since their last contact.

GP:

5.3.23 In June 2019 and October 2019 the GP is aware that George violent towards Fiona and financially abusing her, and the impact of this upon Fiona’s suicidality. Whilst referrals are sent to ACMHS and HPFT, an opportunity to refer to specialist DA support services and MARAC based on professional judgement are missed. GP records that Fiona is in a “very unhappy relationship” and a “difficult” relationship reflecting a limited understanding of the risk that Fiona is at due to George’s abuse.

5.3.24 **A review of any barriers experienced by the families in reporting any abuse or concerns, including whether they or anyone else involved knew how to report coercive control, intimate partner abuse and stalking had they wanted or felt able to.**

5.3.25 There was just the one singular time that Fiona's mother called police for concerns of violence, and it appears no systemic barriers were present in the reporting.

5.3.26 Fiona's sister made the most contact with services with regard to her Fiona. The majority of these are to report welfare or safeguarding concerns. Again, there is no evidence of systemic barriers to reporting to services.

5.3.27 **To review national best practice in respect of protecting adults from coercive control, intimate partner abuse, stalking and suicide.**

5.3.28 Suicide, like domestic abuse, is 'everybody's business' and the National Suicide Prevention Strategy details that domestic abuse is a 'priority area'[45] following the recognition of the increased risk to those subjected to domestic abuse. The Hertfordshire Suicide Prevention Strategy[46] does not list domestic abuse as a 'priority' despite discovering that approximately half of those who died of suicide in Hertfordshire between 2017-2019 having relationship problems as an identified risk factor.

National best practice suicide prevention guidance

5.3.29 The National Institute for Health and Care Excellence (NICE) guidelines offer a best practice framework for professionals responding to suicidality. EEAS is the most frequently cited responder, providing care to Fiona, and by way of example NICE provide the following guidance to paramedics:

5.3.30 When attending a person who has self-harmed but who does not need urgent physical care, ambulance staff and paramedics should:

- discuss with the person the best way that the ambulance service can help them
- follow the person's care plan and safety plan if available
- seek advice from mental health professionals, where necessary
- record relevant information about the following, and pass this information to staff if the person is conveyed, or share it with other relevant people involved in the person's ongoing care if the person is not being conveyed:
    - home environment

[45] https://www.gov.uk/government/publications/suicide-prevention-strategy-for-england-2023-to-2028/suicide-prevention-in-england-5-year-cross-sector-strategy#executive-summary
[46] https://www.suicidepreventionherts.org.uk/media/hertfordshire-suicide-prevention-strategy-2020-25-final.pdf

- social and family support network
- history leading to self-harm
- initial emotional state and level of distress
- any medicines found at their home.

5.3.31 When attending a person who has self-harmed but who does not need urgent physical care, ambulance staff and paramedics should discuss with the person (and any relevant services) if it is possible for the person to be assessed by or receive treatment from an appropriate alternative service, such as a specialist mental health service or their GP.

5.3.32 When deciding whether the person can receive treatment from an appropriate alternative service, ambulance staff and paramedics should assess immediate safety concerns, as well as the availability and accessibility of alternative services at that time.

5.3.33 NICE also advocate against the use risk assessment tools and scales to predict future suicide or repetition of self-harm[47] and emphasise a shift to assessment of client need and implementation of a bespoke suicide safety plan. Indeed, it has been shown that collaborating on a bespoke suicide intervention plan can reduce risk of suicide by up to half[48]. Therefore, practitioners should seek to collaborate on bespoke safety plans with both victims and perpetrators of abuse that profess to suicidality – given their heightened risk.

5.3.34 NICE[49] and lead academics in the field[50], advise that bespoke suicide prevention plans should incorporate the following:

- establish the means of self-harm
- recognise the triggers and warning signs of increased distress, further self-harm or a suicidal crisis
- identify individualised coping strategies, including problem solving any factors that may act as a barrier
- identify social contacts and social settings as a means of distraction from suicidal thoughts or escalating crisis

[47] https://www.nice.org.uk/guidance/ng225/chapter/Recommendations#risk-assessment-tools-and-scales
[48] Nuij C, van Ballegooijen W, de Beurs D, et al. Safety planning-type interventions for suicide prevention: meta-analysis. The British Journal of Psychiatry. 2021;219(2):419-426. doi:10.1192/bjp.2021.50
[49] https://www.nice.org.uk/guidance/ng225/chapter/Recommendations#interventions-for-self-harm
[50] O'Connor, R. (2021). When it is darkest: Why people die by suicide and what we can do to prevent it. Random House.

- identify family members or friends to provide support and/or help resolve the crisis
- include contact details for the mental health service, including out-of-hours services and emergency contact details
- keep the environment safe by working collaboratively to remove or restrict lethal means of suicide.

National best practice responding to coercive control

5.3.35 The Controlling or coercive behaviour statutory guidance framework[51] is issued under section 77 of the Serious Crime Act 2015 (the 2015 Act). It gives information on coercive and controlling behaviour, to assist identifying, evidencing, charging, prosecuting and convicting the offence. The guidance also provides information on reducing the risk of harm to and supporting the victim and their family; including how other agencies and support services can assist; and managing the perpetrator.

5.3.36 The parts of the guidance, that have most relevance to this DHR are presented by way of summary:

5.3.37 The 2015 Act details B) The pattern of behaviour has to have a "serious effect" on the victim. This means that the perpetrator has caused the victim to either fear that:

- Violence will be used against them on two or more occasions (section 76 (4)(a)); and/or;
- Caused serious alarm or distress which has had a substantial adverse effect on the victim's usual day-to-day activities (section 76 (4) (b)).

5.3.38 Examples of where the perpetrator's behaviour has a "serious effect" on the victim includes cases where the victim is subjected to repeated and/or physical violence, sexual assault, coercion, abuse, or threats of such acts. However, violence and/or threats of violence do not need to be present for controlling or coercive behaviour to take place.

5.3.39 Examples of series effect on the victim that are both listed under this guidance and present on this case are:

- Physical abuse
- Sexual abuse
- Emotional abuse

[51] https://www.gov.uk/government/publications/controlling-or-coercive-behaviour-statutory-guidance-framework/controlling-or-coercive-behaviour-statutory-guidance-framework-accessible

- Verbal abuse
- Threats
- Mental health and physical health deterioration
- Having their financial independence restricted
- Becoming socially isolated
- Impacting contact with family and other support networks
- Living in fear

5.3.40 Section 36 stipulates that attending officers look beyond physical or any other type of assault. The officer should consider whether there may be a pattern of controlling or coercive behaviour or other forms of abuse being perpetrated.

5.3.41 Section 53 refers to the importance of considering and responding to victim vulnerability factors; stating that professionals often do not understand victims behaviours. The guide calls officers to familiarise themselves with a College of Policing[52] document upskilling them on victim presentations.

5.3.42 The need for officers to correctly assess who the primary victim and primary suspect are is also detailed in section 55, signposting officers to the framework in table 1 of the Toolkit for Prosecutors on Violence Against Women and Girls Cases Involving a Vulnerable Victims [53].

5.3.43 Section 63: When attending to a victim, rather than only asking 'what happened' to prompt the specific call to police, police officers should ask questions to identify if controlling or coercive behaviour is being perpetrated. This includes understanding:

- Whether there are any rules, expectations or monitoring that the victim is subject to
- The amount of control that the victim has in the relationship, including on financial decisions and the victim's access to internet and communication devices
- The access that the victim has to essential documents, e.g. passport, child's birth certificates
- The impact that the behaviour has on the victim and any children
- The access that the victim has to family members and friends, or other support

[52] https://assets.production.copweb.aws.college.police.uk/s3fs-public/2021-11/Recognising-responding-vulnerability-related-risks-guidelines.pdf

[53] https://www.cps.gov.uk/sites/default/files/documents/publications/toolkit_for_prosecutors_on_vawg_cases_involving_vulnerable_victims.pdf

- Evidence of any other abusive behaviours e.g. physical violence or sexual assault
- It is also important to ask about past behaviour of the perpetrator, as the victim may not realise that this may have been part of a pattern of abuse.

5.3.44 Section 70: Whilst victim and witness statements are key pieces of evidence, the best practice guidance stipulates officers should also seek (not an exhaustive list):

- Phone records (whilst ensuring limited disruption, if any, for the victim, ensuring appropriate redaction and not risking further harm);
- Text messages (whilst ensuring limited disruption, if any, for the victim, ensuring appropriate redaction and not risking further harm);
- Device logs (whilst ensuring limited disruption, if any, for the victim, ensuring appropriate redaction and not risking further harm);
- Evidence of abuse over the internet, digital technology (e.g. smart speakers) and social media platforms;
- Copies of emails;
- Photographs of injuries such as: defensive injuries to forearms, latent upper arm grabs, scalp bruising, clumps of hair missing;
- Photographs of damage to property such as broken doors, holes in plasterboard, doors pulled from cupboards or signs of forced entry into rooms;
- 999 tapes or transcripts;
- CCTV and home video footage – e.g. smart doorbells;
- Body Worn Video (BWV) footage;
- Lifestyle and household including at scene photographic evidence – e.g. the things that they usually do, where they live, who they interact with, how they spend their money;
- Records of interaction with services such as support services (even if parts of those records relate to events which occurred before the new offence came into force, their contents may still, in certain circumstances, be relied on in evidence);
- Medical records;
- Bank records to show financial control;
- Previous threats made to children or other family members;
- Suicide threats from the perpetrator – e.g. via text, email, or postings on social media or multi-media sites;
- Abusive postings on public platforms, including social media Diary kept by the victim;

- Evidence of isolation such as lack of contact between family and friends, victim withdrawing from activities such as clubs, perpetrator accompanying victim to medical appointments;
- GPS tracking devices installed converted an/or overtly on mobile phones, tablets, vehicles etc.;
- Where the perpetrator has a carer responsibility, the care plan might be useful as it details what funds should be used for – e.g. caring for a child, caring for a parent or a sibling.
- Evidence of protection orders

5.3.45 Section 109 - 111 details the role of specialist support for victims from DA specialist services and also services to help perpetrators to change their behaviour, available from Respect[54].

5.3.46 Section 114 advises of the role that a range of agencies and support services have in providing relevant evidence case building. For example case notes from health services, including mental health, drug and alcohol services, local authority social care services, housing services and financial services**.**

5.3.47 Within Annex 1, the following are also related guidance for this case:

- Controlling or coercive behaviour impacts a victim's ability to make decisions freely.
- Impact of alcohol, drugs or substance misuse – the victim may have developed a reliance on substances to try and cope with the abuse, or be in a position where the perpetrator supports and/or facilitates the addiction to maintain control over them
- Living in a rural or isolated community – a victim may face increased isolation from support networks and lack of access to services if they are living in a rural community compared to an urban setting or if they have not been allowed to mix freely with wider society;
- Economic dependence/instability – the victim may not have access to resources they need to support themselves
- Impact of controlling or coercive behaviour and trauma – the abuse may make the victim feel isolated, worthless, to feel they are to blame for the abuse and/or be convinced they cannot look after themselves;
- Mental health – domestic abuse can lead to a number of health-related issues for the victim, including the development of a specific

[54] https://www.respect.org.uk/

mental health condition or multiple conditions. Perpetrators may tell a victim they won't be believed due to their mental health;

- Disability – For disabled victims, the abuse they experience is often directly linked to their disability and perpetrated by the individuals they are most dependent upon for care, such as intimate partners, ex-partners or family members who may be acting as a carer.

5.3.48 **An evaluation of any training or awareness raising requirements that are necessary to ensure a greater knowledge and understanding of coercive control, intimate partner abuse and stalking processes and/or services in Hertfordshire.**

Police:

5.3.49 "Some of the domestic incidents reported with George, Fiona was as much an instigator as he"[55]. This highlights an area of training to support police officers more accurately assessing who is the primary perpetrator of domestic abuse. This training would aid police practice in managing counter allegation, unclear abuse dynamics or so called 'bi-directional abuse'[56]. If our vision is narrowed to the incident led model, we will fail to explore the patterns and wider context these abusive incidents occur within – resultantly, we miss who is the primary victim.

5.3.50 In April 2019, George assaults Fiona. Fiona discloses "He hit me", "Punched my head off the wall", "He has battered me" and "He has dragged me down the stairs where I think I was unconscious", to officers. George was arrested, but released with no further action. This incident was graded at medium risk, meaning an opportunity was missed to get this case onto to the Multi-agency Risk Assessment Conference (MARAC), the enhanced specialist domestic abuse safeguarding forum for multi-agency risk assessment and risk management strategizing. Police have a growing picture of the domestic abuse with recent threats to harm, holding a knife to the victims throat. The officers report remarks that they were thanked by Fiona, who appeared "grateful" of being told of the no further action decision. This is a concerning cognitive distortion that would be beneficial for police officers to identify as symptomatic of coercive control. It indicates a concern that, owed to experiencing coercion and control, Fiona's decision making and her ability to keep herself safe is compromised. There are a number of high risk of harm

[55] Police IMR

[56] Kelly, J. B., & Johnson, M. P. (2008). Differentiation among types of intimate partner violence: Research update and implications for interventions. Family Court Review, 46(3), 476–499. https://doi.org/10.1111/j.1744-1617.2008.00215.x

indicators here, and this case could have been referred to MARAC on professional judgement.

5.3.51 A weakness of actuarial assessments are numerous – response bias, victims fear, victim distrust in the professional/organisation, shame, lack of assessor skill etc. But actuarial assessments also merely accumulate risk factors, and there is little support for the idea that a sheer number of risk factors accurately predict homicide[57]. Also, not all the risk factors are equally weighted. So, enhanced risk assessment training to look at how risks interact, which includes an evaluation of the victims vulnerability factors too, is needed. By way of example, the presence of control, violence and a separation after living together, there is said to be a 900% increase in the potential for murder[58]. This would be a DASH score of just three.

HPFT:

5.3.52 There was evidence held on record that George was manipulating Fiona against her wider family. Whilst this does not appear to have influenced professionals, it was not recognised as strategy perpetrators use to isolate their victim and therefore the increase risk associated was not understood.

5.3.53 There is evidence of further tactics employed by George in 2020, whereby he may be seeking to distort Fiona's perception of reality. This is in reference to a period of mental health deterioration of Fiona, who asserts her family are in her neighbours garden discussing her. Whilst there are a number of potential explanations for this, George takes a stance to reinforce this view. HPFT do not note an awareness of such endeavours being a plausible explanation.

5.3.54 Following George's assault of Fiona in September 2021, which instigated the subsequent breakdown of the relationship, George reported to HPFT an increased use of substances and had requested an initial assessment to manage his mental distress. He disclosed struggling with "everything" and the "loss of his long-term partner." A face-to-face appointment was scheduled for George in January 2022, however the risk he posed to his ex-partner, at a time where risk escalation for fleeing victims is significantly higher[59], was not recognised in any risk assessment. If the post-separation risk he posed to Fiona had been better understood, an earlier appointment may have been

[57] Shapiro, D. L., & Noe, A. M. (2015). Risk assessment: Origins, evolution, and implications for practice (SpringerBriefs in Behavioral Criminology). London, England: Springer
[58] National Center for Injury Prevention and Control. (2003). Costs of intimate partner violence against women in the United States. Atlanta, GA: Centers for disease control and prevention
[59] https://www.femicidecensus.org/wp-content/uploads/2022/02/010998-2020-Femicide-Report_V2.pdf

arranged for him and/or safeguarding referrals like a MARAC referral may have ensued.

Change, Grow, Live:

5.3.55 Information specifically advising that Fiona was at high risk of serious harm and homicide from George was known from September 2021, as CGL attended a MARAC conference which detailing significant abuses. Yet, prior to this time, in both November 2020 and again in August 2021, George was cited as impacting her use of illicit substances and her mental ill health. There is no evidence of practitioners probing further into George's role in Fiona's substance abuse, mental ill health or suicidality.

Survivors Against Domestic Abuse:

5.3.56 There is evidence of Fiona disclosing domestic abuse related crimes to SADA. SADA completed safety planning with Fiona, but she declined to completed a DASH owed to not wanting to re-live the trauma of having to retell the abuse.

National Probation Service:

5.3.57 In the time period NPS were supervising George, whilst there was information that pointed towards concerns for Fiona (and her unborn children) being at risk, domestic abuse was not yet disclosed, nor therefore defined within this case. This may have hindered the respective supervising officers enquiries – in that the domestic abuse was not obvious. However, from 2015 we had knowledge that George had a non-molestation order out against him from a previous partner, which is quite an explicit warning sign for intimate partner abuse risk. This disclosure did not spring the supervising officer into action to seek to assess risk of domestic abuse or therefore safeguard Fiona.

5.3.58 There are further risk markers for risk of domestic abuse present in this case, which could be construed as more subtle than the above non-mol disclosure, but none the less, with a more enhanced understanding around DA and coercive control, could have prompted the supervising officer to probe further into the relations between George and Fiona (multiple pregnancies miscarried in quick succession and soon after starting the relationship, offending that is synonymous with funding drug use, Fiona suspected overdose, conflict between George and Fiona's family, significant drug and alcohol use).

5.3.59 Domestic abuse is cited as the leading cause of injury to developing foetuses[60] and thus it is no surprise that women who experience domestic violence have been found to have a 37% higher risk of obstetric complications[61]. It is also well documented that significant risk increased in miscarriages if the mother consumes alcohol during pregnancy: use of 5 or fewer drinks per week, each additional drink per week was associated with a 6% increase in miscarriage risk[62]. Whilst the jury is still out to the extent in which drug abuse harms the unborn baby, compared to the harms deriving from the situational and environmental factors in which the mothers is using the drugs, the risk increase of harm to the unborn baby is not in contention[63].

5.3.60 **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 in relation to victims of coercive control, intimate partner abuse, stalking and suicide – to build up a picture of what should have happened.**

Police:

5.3.61 Hertfordshire Police have made significant strides in improving understanding of coercive control by training all frontline officers and detectives in the law regarding coercive control as per section 76 of The Serious Crime Act 2015. As of 1st July 2023, Hertfordshire Constabulary also moved to using the DARA[64], in order to improve risk assessment of coercive control.

5.3.62 Despite this, police had attended numerous incidences of domestic abuse related call outs, been party to shared intelligence and present at multi-agency meetings where coercive control was identified, like MARAC in September 2021, no investigation for coercive control ensued.

5.3.63 However, when there were clear acts of physical violence, positive and protective action was more likely to be taken. This alludes to a 'violence

[60] Guth, A. A., & Pachter, H. L. (2000). Domestic violence and the trauma surgeon. The American Journal of Surgery, 179(2), 134-140.
[61] Cook, J., & Bewley, S. (2008). Acknowledging a persistent truth: domestic violence in pregnancy. Journal of the Royal Society of Medicine, 101(7), 358-363.
[62] Sundermann, A. C., Zhao, S., Young, C. L., Lam, L., Jones, S. H., Velez Edwards, D. R., & Hartmann, K. E. (2019). Alcohol use in pregnancy and miscarriage: a systematic review and meta-analysis. Alcoholism: Clinical and Experimental Research, 43(8), 1606-1616.
[63] Jones, H. E. (2006). Drug addiction during pregnancy: Advances in maternal treatment and understanding child outcomes. Current Directions in Psychological Science, 15(3), 126-130.
[64] The Domestic Abuse Risk Assessment (DARA) is a "revised primary risk assessment tool for first response officers, with the aim of helping officers focus attention on dangerous patterns of behaviour, improve consistency and completeness of risk data, and improve the accuracy of subsequent risk assessment." (College of Policing, 2022).

model'[65] of domestic abuse being followed, which can be a significant barrier to officers identifying coercive control.

5.3.64 However, there were also multiple incidences where additional preventative and protective measures, in light of George physically abusing Fiona, that were not executed. DVPN's/DVPO's were not put in place to protect the victim in incidences where on 02.02.19 George strangled, held a knife to Fiona's throat and threatened to kill her; less than three months later on 26.04.19, Police attend as Fiona has reported being physically assaulted: "He has battered me" and "He has dragged me down the stairs where I think I was unconscious".

5.3.65 Bail is one tool that can be used with or without conditions and should be used as a risk management or safeguarding tool. Following George's significant assault on Fiona on 14.09.21, bail conditions were put in place. However, despite Police attending Fiona's address on 4th November, as George was being violent and was suspected of raping Fiona, no action on the breach of bail took place. Furthermore, on 29.11.21 Fiona disclosed to Hertfordshire Police that she had been seeing George, no action was taken was taken on these disclosed breaches either. It is important that police take positive action when a suspect has breached their bail conditions, in order to effectively safeguard victims and send clear messages to perpetrators of domestic abuse that are subject to police investigation.

5.3.66 Lastly, as part of the victims code[66] enhanced rights[67], "police should inform domestic abuse victims within one working day of relevant developments: including …release on police bail, including any conditions, and any change to the conditions (this applies to both pre- and post-charge)". This was not adhered to, and may be due to Fiona opting out of updates. However, considering Fiona's vulnerability and the potential risk of ongoing harm, it is advisory for the OIC to provide an accompanying narrative/rationale for this decision, which is inclusive of the safeguards that are in place – like liaison of bail conditions to the IDVA. There is a record of Hertfordshire Police updating Fiona, via the IDVA service, of an extension of bail on 23.11.21. However, this is 10 days after the first bail review date was set (13.11.21).

[65] Stark, E. (2012). Looking Beyond Domestic Violence: Policing Coercive Control. Journal of Police Crisis Negotiations, 12(2), 199–217. https://doi.org/10.1080/15332586.2012.725016
[66] https://www.met.police.uk/SysSiteAssets/foi-media/metropolitan-police/disclosure_2021/may_2021/current-victims-code-of-practice2
[67] https://www.college.police.uk/app/major-investigation-and-public-protection/domestic-abuse/victim-safety-and-support

HPFT:

5.3.67 Between 2013 and 20019, there were examples suggesting Fiona and George have a co-dependency dynamic in their relationship, characterised by Fiona having an appearance of needs for care and support e.g. collecting medicines, managing the home environment, developing and maintaining relationships, accessing services in the community. However, there was one attempt to undertake a social care assessment under s9 Care Act in June 2017 and there was no outcome of that assessment found on record. The lack of s9 assessments may have impacted future interventions/plans about how Fiona's care and support needs could be met if she were to separate from George.

5.3.68 In February 2019 Fiona refused the intervention of HPFT because of the dependency on George to meet her needs for care and support. There was evidence staff missed opportunities to undertake s9 Care Act assessments to explore in more detail how her needs could be met were she to separate from George. It is noteworthy in the two safeguarding enquiries into the abuse, Fiona was not asked whether she wished to have a s9 Care Act assessment. Nor was there evidence to suggest the team had considered the duty to undertake one under s11 (2)(b) Care Act if she had refused an assessment and s42 duties had been triggered.

5.3.69 There are also a number of incidents where Fiona or George had expressed suicidal ideation and HPFT had identified the non-suicidal party as a 'protective factor.' The use of this term has practice implications for mental health services and requires a more nuanced assessment in situations where people are at risk of domestic abuse.

5.3.70 Despite the numerous references to George meeting Fiona's care and support needs, and vice versa, there is no reference to a carers assessments in either record.

5.3.71 Whilst there were references to domestic abuse, no application was made for a Claires Law Disclosure to either Fiona, or new female partners of George that HPFT were made aware of.

5.3.72 George had missed 7 appointments to address his psychological needs. Similarly, Fiona struggled to attend appointments. On occasion staff would sometimes attend her home address. But there was limited thinking towards a consistent approach to support the clients, until 2021, when HPFT and IDVA began coordinating support efforts to Fiona.

5.3.73 There were four occurrences where there was evidence of risk to a child and other adult family members too. Neither of these incidences led to a safeguarding referral. On one occasion, in October 2016, George is "extremely abusive" to staff, Fiona discloses she is worried he will become "violent again" and there is also a child present. No safeguards are raised.

5.3.74 In May and June 2019 there are indications the risk to Fiona escalated when an unknown female moved into the address with George (assumed to be a new intimate partner). Fiona was assaulted by the female and there were new risks of financial abuse, however neither of these were responded under a safeguarding adult framework.

5.3.75 Following the s42 inquiry in October 2019, there was effective multi-agency working by HPFT, increased support offered, which included more frequent visitation to Fiona's home, but there was a lack of direct safety planning with Fiona around actions to keep her safe in the home with George. In cases where a victim is engaging with an IDVA, staff can defer to those specialist domestic abuse services to provide the safety advice. However, while Fiona was not engaging with the IDVA service throughout the vast majority of the time HPFT were open to Fiona, it would have been appropriate and beneficial for staff to provide basic advice in place of an IDVA. Indeed, they could have liaised with a local IDVA service for help and guidance around implementing domestic abuse safety plans.

5.3.76 From 2019 there were four incidents that would have amounted to a safeguarding concern that were not reported. Some of these involved new risks to Fiona, for example, Fiona giving George's associates her money without consent, an assault by a female living at the address and, George consuming supplies from the food bank without her consent, which was intended for Fiona's sole use. In addition to poor reporting of these incidents, risk assessments were not updated to reflect these changes.

5.3.77 In 2020 Fiona's issues with the local community and neighbours were becoming more frequent. There was a missed opportunity to refer to the Community Safety Action Group (CSAG), a multi-agency forum which aims to develop a local approach to deal with issues such as anti-social behaviour, drug and alcohol abuse, and domestic abuse. Consequently, in the year leading up to Fiona's death, there was considerable transience in Fiona and

George's lifestyle; however the community impact of living at the address was not identified as one of the contributing factors of this change in lifestyle.

5.3.78 In September 2021, following George assaulting Fiona, Fiona moves to her father's address to meet her father's care and support needs because of vascular dementia and declining physical health. There is no evidence of a referral for a carers assessment, or evidence of a conversation with Fiona about referring her to the local authority where her father resides.

5.3.79 Good practice is observed by ACMHS who commenced a safeguarding enquiry for Fiona on 15 September 2021 in response to reports of a domestic assault. Information was gathered promptly, supporting a decision to commence a safeguarding enquiry within statutory timeframes. Multi-agency working between the Trust and respective safeguarding partners is evidenced and safety plans were put in place, including a referral to MARAC and seeking safe emergency accommodation.

5.3.80 Mid December 2021 a case conference was convened involving Fiona and external agencies. It was Fiona's view the enquiry could cease, as she felt no longer at risk from George. Fiona also explained she would like to build up her skills and confidence, as well as struggling to manage her property and be around her home. There is no evidence of a s9 Care Act assessment following this. As George was trying to access ACMHS locally, Fiona was to be transferred to another area for care. Such a strategy raises broader questions whether it is appropriate to disrupt the care and treatment of survivors of domestic abuse in place of the perpetrator.

GP:

5.3.81 On at least two occasions (June 2019 and October 2019) the GP is aware that George is being violent to Fiona and financially abusing her, and the impact of this upon Fiona's suicidality. However, referrals are sent to ACMHS and HPFT, and an opportunity missed to referral to specialist DA support services and MARAC based on professional judgement. Notes records that Fiona is in a "very unhappy relationship" and a "difficult" relationship reflect a limited understanding of the risk that Fiona is at due to George's abuse.

5.3.82 Furthermore, the GP was visited by George numerous times, but in December 2019 following George disclosing he gets "very aggressive", there is no evidence of professional curiosity here about his risks to others and therefore referral to specialist support services.

Refuge:

5.3.83 Working with victims of domestic abuse who are still with their partner poses a variety of risks for the IDVA service, especially around safe contact. In November 2019, specialist support was not given to Fiona, because it was deemed that safe contact could only occur if Fiona met with an IDVA in the community. It was evident that Fiona faced significant and multiple barriers to being able to access community based support; hence in November 2019 the HPFT support worker asked the IDVA to do a home visit to Fiona. By 2019, the domestic abuse was well known by agencies, and both Fiona and George were receiving support, often at home, for a multitude of support needs. Fiona also demonstrated a willingness and ability to talk, albeit covertly, at the address when George was present about the abuse she was suffering. It wasn't until 2021 that more effective specialist support was given to Fiona.

5.3.84 It is advisable that IDVA teams take a responsive, case by case stance on supporting clients who have multiple barriers to accessing service and require home visitation where a relationship maybe ongoing. For example, with the help of multi-agency partners, to plan to risk mitigate, as much as possible, the likelihood of George's presence at the address. Liaise with another service (HPFT for example) and get George out of the address when then IDVA is visiting Fiona. An alternative stance, rather than just offering telephone contact or community based appointments, which both resulted in closure, could have been taken. For example, the IDVA could remain open to the case, but provide professional support and insights to the HPFT support worker which would have uplifted the domestic abuse practice of the support work and therefore allowed Fiona access to indirect specialist support. Indeed, the cost of not engaging clients effectively, that are at substantial risk, has to be weighed up with the potential risk of activity too.

5.3.85 Proactive safety planning and responsive client work includes the awareness of and responding to key dates where increases in risk may ensue. In November 2021, the ending of George's bail conditions is one of these. Regrettably, there is no record of the IDVA pro-actively working with criminal justice partners or the victim around the ending of bail conditions. It was Fiona who reached out to the IDVA on the day of George's bail conditions ending, to find out what was going on. The next record with reference to updated bail conditions, is owed to the IDVA emailing the Domestic Abuse Investigation Support Unit (DAISU) following a call from Fiona, but this is not until the 15th November, advising of an extension of bail until 23.11.21. This must have a been a time of considerably uncertainly and concern for Fiona. It

is noted that on the 14th November, following an argument with family members, Fiona is conveyed to hospital after overdosing.

5.3.86 The IDVA had frequent contact with Fiona, from September 2021 until her death, and engaged in an effective working relationship with HPFT to join forces to support Fiona. Regular Domestic Abuse Stalking and Harassment (DASH) risk assessments (monthly, for the most part) were completed with Fiona, and this is in line with SafeLives best practice guidance[68].

5.3.87 However, not having a standardised and shared assessment framework between the two agencies who will be completing risk assessments with domestic abuse victims in Hertfordshire most frequent, isn't without issue. As mentioned above, Refuge are using the SafeLives DASH RIC and Hertfordshire Police are using DARA. Having a 'common assessment framework' has a multitude of benefits: integrated and shared understanding of risk across agencies, all agencies talking the same risk 'language', a consensus on risk levels and thresholds, reducing duplication and increased coordination[69] [70]. Therefore, it is recommended that this inconsistent approach to risk assessment, and thus a knock on impact to risk management, be reconciled across Hertfordshire.

5.3.88 Whilst it's evident that Fiona was being subjected to coercive control by George, it is recommended, as part of the IDVA's independent role, they employ individual advocacy (and institutional advocacy if this is a wider systemic issue) with criminal justice partners for a more strategic, course of conduct based investigative stance that focuses evidence gathering for coercive control; evidence gathering with the victim to press for this crime; or speaking with multi-agency partners about collating the existent evidence from other agencies to surmount collective evidence for this crime. Owed to the specialist knowledge that IDVA teams hold, they are likely to have an enhanced aptitude for identifying coercive control and this knowledge can be used to good effect to advocate for mobilising other safeguarding stakeholder.

East of England Ambulance Service:

[68] https://safelives.org.uk/practice_blog/why-review-regularly-domestic-abuse-and-good-case-management#:~:text=The%20Leading%20Lights%20standard%20asks,circumstances%20change%20and%20at%20closure.

[69] Miller, E., & Cameron, K. (2011). Challenges and benefits in implementing shared inter-agency assessment across the UK: A literature review. Journal of interprofessional care, 25(1), 39-45.

[70] Holmes, L., McDermid, S., Padley, M., & Soper, J. (2012). Exploration of the costs and impact of the Common Assessment Framework. London: Department for Education.

5.3.89 Over the period of review, there were 36 paramedics/clinicians that attended to Fiona and George. Of those paramedics/clinicians, none of them attended the address on more than their one occasion. The majority of the attendances were for suicidal behaviours, and thus mental ill health was much of the frame that paramedics and clinicians saw this case through. It is also noted that EEAS attending staffs professional opinion was that Fiona and George were supportive of one another's struggles with ailments and mental ill health. Indeed, George was being seen as a protective factor for Fiona.

5.3.90 The EEAS have a Frequent Caller Team, who operate under and implement the Policy for the Management of Patients with Defined Individual Needs. EEAS staff can make contact, where it has been identified that the person may meet the criterion for intervention and can result in multi-disciplinary meetings, contact with the GP and in certain cases the formulation of an Individual Plan for the patient. Fiona and George did not meet the criteria to be considered as frequent callers, which is a ratio of 15 calls in 3 months. The most calls that were ever made within the 3-month period was between 25th July 2021 and 14th October 2021 when there were 5 calls.

5.3.91 In late December, 2021, the evening prior to her death, ambulance crew attended has Fiona had overdosed. On arrival, Fiona did not want to attend hospital. Mental capacity was tested and Fiona was deemed to be able to understand, retain and use information to communicate against paramedics concern and decision that they wanted her to attend hospital. She was given worsening advice which included if she felt any pain, any vomiting, or loss of sensation then she should call 999. The CAD notes for this incident detail "slurring words, took partner meds, argument last night with partner", but there was no further information within the Patient Care Record to suggest that this CAD note was acknowledged or explored by the crew. At this time EEAS were aware of the domestic abuse, and the CAD clearly alludes to relational conflict as a potential rationale for the overdose.

Change, Grow, Live:

5.3.92 Substance misuse support was offered to Fiona on a consenting basis, meaning that should Fiona decline service, then CGL would be obliged to follow the clients wishes. Whilst CGL followed their protocol of engagement attempts via letter and telephone calls, it is unclear what other assertive engagement/outreach techniques were employed to try and facilitate engagement with Fiona who had both multiple and longstanding barriers to accessing community based service.

Three Rivers District Council Housing Services:

5.3.93 Three Rivers Housing worked responsively with Fiona's in aiding with her housing applications. They were aware of her experiences of domestic abuse, and pro-actively working with agencies such as IDVA, HPFT and Stevenage Against Domestic Abuse to increase her safety and wellbeing. The ending of support to Fiona, was brought about by her suicide.

5.3.94 In December, just prior to her death, Fiona feared losing her right to safe housing away from George, because she had begun contact with him again; Three Rivers reassured her that this was not the case, validating that the abuse was not her fault, nor the suicide attempts by George either.

Survivors Against Domestic Abuse:

5.3.95 In September Fiona disclosed coercive controlling behaviours, but there is no record of advising to report to the Police or discussions of a safety plan being put in place. There is no evidence of a safeguarding referral being raised. Domestic abuse is everybody's business, and all professionals have a role in safeguarding DA victims. I discuss in the report section 5.3.47 the role of agencies in collating evidence of coercive control, by way of hearsay evidence. However, Referrals are made to a college to look at higher education based support. There is no evidence of any further exploration of the coercive control or any mention or enquiry into the clients suicidality.

National Probation Service:

5.3.96 Throughout the period of supervision to George, there was a significant lack of activity from probation supervisors to follow safeguarding policies designed to safeguard vulnerable adults and children at risk. George reported that he was caring for his partner who had significant health problems, that she also had miscarried their children a total of 4 times in the first 10 months of their relationship and that she was using illicit substances and had overdosed. Each of these, arguably, in their own right amounted to enough of a concern to raise a safeguarding enquiry. Having knowledge of George's needs and offending behaviours (overdoses, assaults on Fiona's daughters partner, major health concerns, illicit drug use and supply), his ability to have a caring role over George also raises concern.

5.3.97 With regard to responding to domestic abuse, which was not well detailed by NPS, there was a disclosure of an ex-partner being protected from George by a non-molestation order – yet, this did not inspire reflections on the risk that George could be posing to Fiona, and thus no safeguarding efforts seem to have been made.

5.3.98 To increase the potential effectiveness of monitoring and therefore capability to assess risks and need, the supervising officer could have embarked on regular home visitations.

Adult Social Care:

5.3.99 In February 2014, Herts urgent care team refer to ASC for support needs related to DA. Fiona discloses not only suicidal ideation, but having a "horrible life" and a violent partner who "beats me up" and supplies her with medications to end her life. This case is referred to HPFT to lead, but there is no evidence of a safety plan being put in place with Fiona to address the DA or suicidal ideation, nor a referral to specialist domestic abuse victim support (she is merely given a number for a domestic abuse service).

MARAC:

5.3.100 Whilst MARAC is not a single agency, but a multi-agency safeguarding forum, some areas for improvement are noted by the review author. Whilst the domestic abuse and coercive control are well defined within this forum, and extensive information shared about the abuse tactics George perpetrators against Fiona, including Fiona's additional vulnerabilities, there are several areas for reflection.

- Locating coercive control and abuse as a central factor in Fiona's suicidal ideation.
- Despite George being the cause of the abuse, there is limited action to look to restrict his means to be abusive.
- Although the coercive control is named and well detailed, there is no apparent actions taken to build an evidence led investigation into coercive control.
- Even though Fiona's suicidality is a significant risk factors, there are no actions taken to put in place a bespoke suicide prevention plan.

5.4 Good practice identified

5.4.1 The author also notes areas of good practice:

5.4.2 In February 2018, George attends appointments with the psychology team and it's noted that he "shows insights into his current behaviour being abusive"; which is an indication that a space was provided for George to reflect on his harmful behaviours, albeit we don't know to what extent and it appears to little effect.

5.4.3 In February 2019, 2nd February, Hertfordshire Police take positive action and arrest, conveying George to custody for interview, following threats to kills with a weapon. However, two witnesses/victims (Fiona and her sister) withdraw support for a police prosecution. A victimless prosecution is considered, but the evidential standard is not met with the evidence at hand. Good practice from Hertfordshire police, who also consider a victimless prosecution on hearsay evidence too.

5.4.4 In October 2019 there is also good practice by HPFT CATT who attend an appointment at Fiona's home when George was present in the house. In comprehending that coercive control was present, the practitioner is sensitive to this dynamic but also balances the need to discreetly ascertain the risks posed to Fiona by George. The practitioner was able to elicit a wealth of information about Fiona's current situation. Indeed, for victims to live with an abuser, they are incredibly resourceful[71] and it appears in this exchange the practitioner stance facilitated Fiona's resourcefulness in getting her needs across covertly.

5.4.5 Following on from the above disclosure, Hertfordshire Police attended on the same day they were notified by HPFT of the abuses George is subjecting Fiona to. Attending officers are sensitive to Fiona's needs, who is under the influence of prescribed medication and is struggling to communicate. Hertfordshire Police re-attend the following day to investigate the disclosed abuse.

5.4.6 In early December 2019, Dacorum ACMHS invite Fiona out to their car to discuss housing options, in recognition that Fiona's free speech was significantly hindered when in the property. This evidences practitioners using creative engaging techniques with Fiona, to a safe and effective end.

5.4.7 In July 2020, amid concerns for Fiona deteriorating mental health, Care Coordinator and Support Worker do a house visit. George advised that Fiona was unwell and would not be able to see them today. The workers persisted, and were able to speak to Fiona on the phone.

5.4.8 January 2021, there is good multi-agency working between care-coordinator, CGL and GP seeking to obtain contact with Fiona, following recent difficulties and trying to seek support from substance abuse services. Towards the end of January, the new care coordinator reaches Fiona, who advised her mother is

[71] Bahadir-Yilmaz, E., & Öz, F. (2018). The Effectiveness of Empowerment Program on Increasing Self-Esteem, Learned Resourcefulness, and Coping Ways in Women Exposed to Domestic Violence. Issues in Mental Health Nursing, 39(2), 135–141. https://doi.org/10.1080/01612840.2017.1368750

on life support due to COVID. Spectrum substance misuse service closed Fiona's case for support owed to lack of engagement.

5.4.9 In August 2021 the IDVA service put in place specialist safety planning around domestic abuse which incorporated conversations around Fiona's suicidality.

5.4.10 Most particularly present from September 2021, effective multi-agency working took place between Refuge, HPFT and Housing and Tenancy Support Teams.

5.4.11 From Sept 2021 Three Rivers District Council aid Fiona with safe temporary accommodation, providing a starter pack which included bedding, kitchen equipment and toiletries to help her settle into her safe accommodation.

5.4.12 November 2021: Professional meeting arranged by IDVA, following Fiona advising that she would benefit from meeting all safeguarding workers, because she feels she can engage better face to face.

5.4.13 In December 2021 where Paramedics attended Fiona, following an overdose and ongoing suicidal intent, the ambulance technicians assessed Fiona as not having capacity to retain information and was stating ongoing intent to harm if left alone, she was conveyed to hospital by the Paramedics and kept safe for further harm at that time.

5.5 Agency improvements since the time of the incident

HPFT:

5.5.1 Since Covid, HPFT have run a minimum of one DA/stalking webinar every month for clinical staff on a range of DA topics including coercion and control, suicide and mental health. In addition to those offered through the general programme, HPFT also offer bespoke sessions on an ad-hoc basis for specific teams.

5.5.2 HPFT now have two DA policies; one for supporting service users and a standalone policy for staff experiencing DA. Both are updated 3 yearly or as significant changes arise (i.e. introduction of DA Act, new information re: non-fatal strangulation etc.).

5.5.3 In 2022 HPFT became the first NHS Trust nationally to partner with DA Alliance in the use of the WEPROTECT app, allowing consent based referrals for free at point of access legal advice for survivors of DA. HPFT launched this

with a multi-agency conference which included AAFDA presenting on Suicide and DA.

5.5.4 HPFT relaunched their Domestic Abuse Champions Network accessing the J9 training provided by Safer Lives.

5.5.5 Weekly IDVA co-locations within our ACMHS teams have also been restarted across 3 trusts, but accessible to all 8 ACMHS teams.

5.5.6 In 2023 HPFT launched a Domestic Abuse Resource Kit. This is due to be reviewed to include additional information re: suicide and DA and Clare's Law.

5.5.7 HPFT are currently 1 year into a project rolling out Routine Enquiry for DA across all Trust services, this includes launching Routine Enquiry webinars looking at how and when to 'ask the question' and including some basic safety planning and signposting information.

5.5.8 HPFT have been working with the local IDVA service to run a series of webinars on DA Risk assessment, aiming to give a basic understanding of the DASH and some basic safety planning advice.

5.5.9 HPFT are also core members of MARAC in Herts with reps attending all MARAC meetings. HPFT are working on making this process more robust to ensure that the information sharing accounts for services using different Electronic Patient.

Police:

5.5.10 In Feb 2022 Op Ipsum was launched which aims to identify clients who present with repeated suicidal behaviours. This flags the individual with a PNC marker for suicide risk, but also includes a suicide prevention plan

5.5.11 A DAISU Detective Sergeant moved to a dedicated training role in September 2022 and was tasked with providing training to increase knowledge to frontline officers on a wide variety of domestic abuse subjects. This included an update on processes, how to identify and investigate coercive and controlling behaviour, how to seek civil orders (including DVPN/DVPO's) as well as other safeguarding measures including reinforcing the Clare's Law process.

5.5.12 As of 1st July 2023, Hertfordshire Constabulary changed the way risk assessments are recorded and are now using DARA in place of DASH.

Research has suggested that the DASH does not produce consistent information on risk when used by frontline police officers[72]. The DARA attempts to address the issue of inconsistent and incomplete data by:

- Reducing the number of questions, so that only key questions for identifying risk and making an initial assessment are asked at the frontline.
- Changing the response options to scales where appropriate, in order to indicate the frequency of abusive behaviours and focus thinking on patterns of behaviour.
- Having a summary freetext box where officers are asked to explain their assessment of risk (with prompts for key issues to consider).

5.5.13 New victim guidance was published by Hertfordshire police in Dec 2023 with a mnemonic 'ACEit' to remind officers of what to include when speaking with a victim for the first time or updating them on the progress of their crime in a minimum of 28 days, or more often than that if vulnerable.

5.5.14 New guidance was published in December 2023 and accompanied by a bespoke video highlighting how important regular contact is with victims to maintain their confidence in the police, ongoing support for a prosecution and ultimately bring offenders to justice to prevent more crime in the future.

Three Rivers District Council Housing Services:

5.5.15 There is now a trained professional who is the point of contact for all domestic abuse victims approaching our Housing Service, to ensure they are provided with the correct support and guidance.

5.5.16 Officers now also follow up with Mental Health Services to ensure customers are gaining the support that they require or to ensure the customer has the relevant numbers to call should they need help when in crisis.

[72] https://library.college.police.uk/docs/college-of-policing/Domestic-Abuse-Risk-Assessment-Rationale-2022.pdf

6. Conclusions and lessons to be learnt

6.1 Conclusions

6.1.1 Whilst it is impossible to accurately divide up the proportion of responsibility for Fiona's death by suicide, what is clear is the impact of George's abuse towards Fiona as a significant factor. Fiona's suicide brought the end to any future with her beloved sisters, children and grandchildren. The Review Panel extends its deepest sympathy to the family of Fiona.

6.1.2 The Review Panel has endeavoured to understand the historical and more recent context in which Fiona's suicide occurred. The author wishes to extend his gratitude to all that helped in constructing Fiona's experience, in order to illuminate her life, analyse where lessons can be learned and subsequently present the lessons to be learned in order to enhance their response to victims of domestic abuse. This learning is detailed below.

6.2 Lessons to be learnt

6.2.1 The learning from this DHR shall be presented by way of key themes.

6.2.2 Theme 1: **Defining domestic abuse.** Mental ill health was well defined in this case, but the domestic abuse was less well defined. This raises a number of practice concerns. The context in which the mental ill health and suicidality is presenting, is somewhat missed. Amongst, and no doubt symptomatic of, suicidality is the domestic abuse and coercive control that George is subjecting Fiona to. The tragic outcome of Fiona needs to be a stark reminder to appropriately realise and respond to the abusive relational context that suicide so often takes place within. This increased risk for suicide is not only to the victim of DA[73], but also the perpetrator[74].

6.2.3 On the note of definition, the language we choose reflects our attitudes and beliefs; thus, care should be taken with regard to the chosen descriptive language. it is important to reflect on the sanitising of the domestic abuse, which was frequent in this case. Such terms are used as "difficulties at home", "psychosocial issues", "very unhappy relationship", "difficult" relationship and threats to kills being referred to as a verbal argument. Essentially, this language demonstrates a lack of adequate assessment and understanding of the impact of domestic abuse.

[73] Matias, A., Gonçalves, M., Soeiro, C., & Matos, M. (2020). Intimate partner homicide: A meta-analysis of risk factors. Aggression and violent behavior, 50, 101358

[74] Knipe D, Vallis E, Kendall L, Snow M, Kirkpatrick K, Jarvis R, Metcalfe C, Eisenstadt N, Bickham V. Suicide Rates in High-Risk High-Harm Perpetrators of Domestic Abuse in England and Wales. Crisis. 2023 Aug 22. doi:10.1027/0227-5910/a000925.

6.2.4 Theme 2: **Missed opportunities to safeguard**. It is the duty of each agency to independently and collectively safeguard victims of domestic abuse. After all, domestic abuse is everybody's business[75]. Throughout the years of abuse Fiona suffered at the hands of George, there were a significant amount of missed opportunities to safeguard not only her, but vulnerable others too.

6.2.5 Occasions to arrest, put in place protective orders like DVPO's, DVDS and enforcement of multiple breaches of bail conditions were missed.

6.2.6 Situations where vulnerable children, new partners (some of whom were pregnant) and also other vulnerable adults were known to be at risk from George, weren't safeguarded.

6.2.7 Instances to put in place bespoke suicide intervention plans, which are cited as reducing risk of suicide by almost half[76], were also not taken in the majority of circumstances.

6.2.8 On average, high risk victim of domestic abuse suffer for 3 years and for a total of 50 incidents before getting effective help[77]. An arrest by police in 2021 appeared to be a significant event and helped facilitate effective IDVA support. However, this support was only in place for a handful of months before Fiona's death. It appears that Fiona suffered for almost a decade before getting effective specialist domestic abuse support and a more robust criminal justice response to the coercive control she was subject to. However, this report not only details the many barriers that Fiona experienced in accessing and supporting police prosecution, and therefore the challenges that police were faced with in trying to bring George to justice were multiple.

6.2.9 Theme 3: **Domestic abuser as a protective factor.** Those who perpetrate domestic abuse should not be seen as a protective factor for their victims suicidality; they will be directly responsible to contributing to the victims symptoms of suicide. Therefore, a more nuanced stance is required. To obtain a more accurate understanding of the role in which an abusive partner plays in the victims suicidality, we need to locate and consider them as first of all, a contributory factor to the clients suicide (as well as a protective factor, if there is evidence of this) and enquire with the victim as to their specific role they play within the suicidal ideation.

[75] https://domesticabusecommissioner.uk/domestic-abuse-is-everyones-business/
[76] Nuij C, van Ballegooijen W, de Beurs D, et al. Safety planning-type interventions for suicide prevention: meta-analysis. The British Journal of Psychiatry. 2021;219(2):419-426. doi:10.1192/bjp.2021.50
[77] SafeLives. (2022). Insights Outreach dataset 2021-2022. SafeLives: Bristol.

6.2.10 Theme 4: **Bespoke suicide interventions plans save lives**. The National Institute for Health and Care Excellence (NICE) guidelines suggest 'Do not use risk assessment tools and scales to predict future suicide or repetition of self-harm'[78] and emphasise a shift to assessment of client need and implementation of a bespoke suicide safety plan. Indeed, it has been shown that collaborating on a bespoke suicide intervention plan can reduce risk of suicide by up to half[79]. Therefore, practitioners should seek to collaborate on bespoke safety plans with both victims and perpetrators of abuse that profess to suicidality – given their heightened risk.

6.2.11 NICE[80] and lead academics in the field[81], advise that bespoke suicide prevention plans should incorporate the following:

- establish the means of self-harm
- recognise the triggers and warning signs of increased distress, further self-harm or a suicidal crisis
- identify individualised coping strategies, including problem solving any factors that may act as a barrier
- identify social contacts and social settings as a means of distraction from suicidal thoughts or escalating crisis
- identify family members or friends to provide support and/or help resolve the crisis
- include contact details for the mental health service, including out-of-hours services and emergency contact details
- keep the environment safe by working collaboratively to remove or restrict lethal means of suicide.

6.2.12 Whilst the Hertfordshire suicide prevention strategy[82] details that almost half of those people who died by suicide in Hertfordshire between 2017-2019 note that relational problems were a risk factor, and the body of knowledge[83] that advises of suicide risk in DA cohorts, domestic abuse is not one of the 9

[78] https://www.nice.org.uk/guidance/ng225/chapter/Recommendations#risk-assessment-tools-and-scales
[79] Nuij C, van Ballegooijen W, de Beurs D, et al. Safety planning-type interventions for suicide prevention: meta-analysis. The British Journal of Psychiatry. 2021;219(2):419-426. doi:10.1192/bjp.2021.50
[80] https://www.nice.org.uk/guidance/ng225/chapter/Recommendations#interventions-for-self-harm
[81] O'Connor, R. (2021). When it is darkest: Why people die by suicide and what we can do to prevent it. Random House.
[82] https://www.suicidepreventionherts.org.uk/media/hertfordshire-suicide-prevention-strategy-2020-25-final.pdf
[83] Christie, C.,Rockey, J. C., Bradbury-Jones, C., Bandyopadhyay, S. & Flowe, H. D. (2023). Domestic Abuse links to Suicide: Rapid Review, Fieldwork, and Quantitative Analysis Report. Home Office Report. Retrieved from osf.io/4t9ab

key priority areas. The author suggests that this is reconsidered in the next suicide prevention strategy.

6.2.13 Theme 5: **Coercive Control involves fear, duress and therefore compromised decision making**. The Care Act (2014) puts adult safeguarding on a legal footing. Under The Care Act, an adult at risk is someone over 18 years old who:
- has care and support needs
- is experiencing, or is at risk of, abuse or neglect
- as a result of their care and support needs is unable to protect himself or herself against the abuse or neglect or the risk of it.

6.2.14 Evident from this report is the severe care and support needs of Fiona, and how they amounted to requiring support of safeguarding stakeholders to protect her from abuse and neglect. Yet, further consideration around impaired mental capacity as a consequence of cumulative trauma and abuse is required, and thus a skilled assessment should incorporate whether a person is making unwise or unsafe decisions, or whether decisions are taken under duress, coercion, and control. There is limited evidence of this taking place on this case.

6.2.15 Theme 6: **Offering opportunities for Perpetrator to change**. Despite all agencies knowledge that George is a perpetrator of domestic abuse, he was not offered opportunities to engage with behavioural change programmes designed to reduce/eliminate his domestic abuse risk to Fiona. Therefore the approaches taken were to place all the focus, and therefore accountability for change onto Fiona with regard to the domestic abuse. This strategy has a number of flaws; essentially, the problem (George) doesn't change and the domestic abuse risk remains present.

6.2.16 There were a number of missed opportunities to probe into George's self-disclosed harmful behaviours, and therefore refer to specialist domestic abuse help. George advises he gets very agitated and gets "very argumentative in a very aggressive way" and he also discloses that he "hit" Fiona, is feeling guilty and wants to be "a better person". There are numerous other incidents where he discloses relational discord. There is no evidence that any of these are met with probing or an offer of specialist support.

6.2.17 Opportunities to target harden George, via his illicit drug use and (potential) supply were also missed. These may have prevented opportunities to hold him account for his criminality, acting as potential intervention points around

his use of abusive behaviour (very much like what we have been effectively executed on programmes like the Drive Project[84]) and importantly, give Fiona some respite and increase opportunities for her to engage with support services. Confronting the abuser at all available opportunities also sends a clear message to the victim, that the system can protect her and will hold her abuser to account – this is not only a route to safety but also somewhat of an antidote to the hold that psychologically manipulating, coercive and controlling abusers also have over their victims.

6.2.18 Theme 7: **MARAC is a space to make victims safer, by addressing the perpetrator.** SafeLives MARAC Principles explicitly outline the necessity to intervene with the perpetrator as an effective tactic to make the victim safer. Interventions like Drive[85] and MATAC[86] are showing promise in this area of work, bringing together statutory and non-statutory agencies to focus on perpetrator management and intervention, showing risk reductions of physical abuse by 82%, sexual abuse by 88%, harassment and stalking behaviour by 75% and jealous and controlling behaviour by 73%[87]. IDVA's reported risk reduction in 82% of cases.

6.2.19 Theme 8: **Ineffective outreach**. Fiona's difficulties accessing community based services are well documented throughout this report. Consistently, agencies took the stance that Fiona had to attend appointments in community based settings, despite being in chronic pain, having mobility issues, no access to money for transport owed to being financially abused and suffering with an anxiety of leaving the house. Whilst there was evidence of successful assertive outreach (attending Fiona's home address) this was not a consistent or standardised approach – despite it rendering the most success with regard to engaging Fiona in support.

6.2.20 Regrettably, Fiona was not able to access specialist domestic abuse support with any positive effect until the year of her death. In 2019 there were referrals to IDVA services, but owed to a rigid stance on no home visitations, or lateral thinking on how IDVA could co-work more closely with other professionals who were doing house visitations, Fiona was not supported by IDVA on these occasions. These are missed opportunities.

[84] Hester, M., Eisenstadt, N., Ortega-Avila, A. G., Morgan, K. J., Walker, S. J., & Bell, J. (2019). Evaluation of the Drive Project:–A Three-year Pilot to Address High-risk, High-harm Perpetrators of Domestic Abuse.
[85] https://drivepartnership.org.uk/
[86] Davies, P. (2018). Tackling domestic abuse locally: paradigms, ideologies and the political tensions of multi-agency working. Journal of gender-based violence, 2(3), 429-446.
[87] Hester, M., Eisenstadt, N., Ortega-Avila, A. G., Morgan, K. J., Walker, S. J., & Bell, J. (2019). Evaluation of the Drive Project:–A Three-year Pilot to Address High-risk, High-harm Perpetrators of Domestic Abuse.

6.2.21 Theme 9: **Working with those still in a relationship**. There is a hive of multi-agency working at the point in 2021 where Fiona wishes to separate from George and this activity consist of some effective practice from many multi-agency safeguarding partners. However, services need to reflect upon their ability to help people who are also remaining in a relationship. As referenced by SafeLives[88], dominant organisational cultures develop around domestic abuse cases which focuses on separate and isolate as a long-term strategy to manage risk – this often results in agencies missing opportunities to engage with clients who are still together and a reluctance to and/or lack of tactics to do so.

6.2.22 Upon conclusion of a DHR, Hertfordshire CPS will be responsible for embedding the learning detailed above, and the recommendations detailed below, across the local agency partners. Indeed, there is both individual agency learning and across multi-agency/collective learning for consideration. This is relevant to agencies both individually and collectively. Hertfordshire County Council has a strategy and action plan, which the finding of this DHR will feed into and therefore is the basis of development of local processes, systems and partnership working. The Review Panel asserts that it is all agencies responsibility to robustly tackle domestic abuse: we all have a significant duty and stakehold in making the future safer.

[88] https://safelives.org.uk/training/engaging-those-who-harm

7. Recommendations

7.1 Single agency recommendations

7.1.1 The single agency recommendations are listed below, many of which were made by the respective agency within their IMR.

Police

7.1.2 Reinforcement of DVPN/DVPO policies, to ensure consistency of practice, and early intervention for vulnerable victims and perpetrators of domestic abuse.

7.1.3 Officers to be reminded of their responsibility to investigate where reports are received of breaches of bail.

7.1.4 Supervisors to be reminded of their responsibility to monitor crimes and ensure breaches of bail are investigated thoroughly.

7.1.5 PNC admin to examine the process of bail conditions being granted and put on Athena and subsequently being placed on PNC.

7.1.6 Officers to revisit their requirements, as per the victims code, to update victims about bail conditions in a timely manner.

7.1.7 Officers to consider multiple breaches of bail to be a course of conduct offence amounting to harassment or stalking.

7.1.8 Current training on the nuance of the coercive control, and how this phenomenon impacts the victims capacity, free will and therefore ability to keep herself safe to be reviewed.

7.1.9 Current intervention strategies (like case management and multi-agency coordinated approaches of Drive or MATAC for example) to tackle persistent DA offending and/or persistent DA call outs to an address (identified by a recency, frequency and gravity assessment) to be reviewed.

7.1.10 Current training on assessing counter allegations or unclear abuse dynamics to be reviewed.

HPFT

7.1.11 Training opportunities for staff that address assessment of risk of social media platforms and other technologies will build upon practice in this specialist area.

7.1.12 Further promotion of existing resources on cuckooing, in order to ensure staff knowledge is up to date.

7.1.13 Existing training on domestic abuse could be reviewed to consider what specific value Section 9 Care Act and Carer assessments could offer adults at risk of domestic abuse.

7.1.14 The HPFT Safeguarding Team should continue to promote awareness of a Think Family response which would encourage staff to consider the needs of others within the family network. This could include consideration of family members who may also present with care and support needs.

7.1.15 It is recommended clearer guidance be issued on how service users and staff can submit Clare's Law applications and when is appropriate to consider this.

7.1.16 The reviewer found multiple missed opportunities to report safeguarding concerns. It is recommended training on Essential Safeguarding Adults Training is reviewed to further build on the emphasis of engaging in reporting processes and why this is important.

7.1.17 Domestic Abuse training and guidance to include further information on safety planning, particularly where IDVA's are not engaged in direct work with clients could reduce risk following contact with health professionals.

7.1.18 Clearer guidance to be issued for investigating managers concerning the principle of proportionality and respecting an adult's individual autonomy in making decisions about their experience of abuse.

7.1.19 The Policy section on domestic abuse relating to perpetrators could be revised to highlight more explicitly to staff that the needs and risks of service users who are perpetrators, according to research, increases at the time of separating in the relationship, and must not be confused as a 'historic' risk.

7.1.20 The review found professionals agreed with Fiona to transfer her to another ACMHS in the Trust because of links the perpetrator shared with the team. It is recommended guidance is shared with safeguarding leadership networks/ forums to discuss the appropriateness of introducing additional disruption to survivors of domestic abuse known to secondary mental health services.

7.1.21 HFPT to review its policy with regard to care pathways for those who require medical operations but who have insecure housing status.

Refuge

7.1.22 To review agency policy and stance around outreach to clients whom face significant disadvantage to accessing community based support.

Change, Grow, Live

7.1.23 To review agency policy and stance around outreach to clients whom face significant disadvantage to accessing community based support.

National Probation Service

7.1.24 Probation Officers to revisit domestic abuse training, specifically looking at its vast implications for victims and survivors (loss of pregnancies, substance abuse and suicidality to name but a few), therefore increasing their ability to identify (and thus respond) the more subtle symptoms of abuse.

7.1.25 Probation Officers to receive training on their adult safeguarding duties and options when they identify adults at risk of harm and abuse.

7.2 Multi-agency recommendations

Recommendation 1:

7.2.1 Hertfordshire DA Partnership to raise awareness with professionals of the link between domestic abuse and suicide, enabling better risk identification, assessment and intervention.

Recommendation 2:

7.2.2 Hertfordshire DA Partnership to raised awareness with professionals around best practice suicide intervention[89], which includes role of bespoke suicide intervention plans and how to implement them collaboratively with clients.

Recommendation 3:

7.2.3 Hertfordshire DA Partnership to advocate for domestic abuse being listed as a 'priority' in the Hertfordshire Suicide Prevention Strategy 2025-2030.

Recommendation 4:

[89] https://www.nice.org.uk/guidance/ng225/chapter/Recommendations#interventions-for-self-harm

7.2.4 In line with the SafeLives MARAC principle 6[90], Hertfordshire DA Partnership Risk Management Subgroup to review the effectiveness of the MARAC to safeguard victims by addressing perpetrators risks and needs.

Recommendation 5:

7.2.5 Hertfordshire DA Partnership Risk Management Subgroup to reflect on the impact of not having a common assessment framework for risk assessing domestic abuse across Hertfordshire. There is evidence of some of the key organisations using differing risk assessments (DARA & DASH) and whilst there may be some strength to this model, there will be weaknesses that will require mitigation.

Recommendation 6:

7.2.6 In light of the impending Perpetrator Strategy[91], as part of the DA Act 2021[92] Hertfordshire DA Partnership to review their local VAWG strategy, and resulting operational tactics around tacking perpetrators of domestic abuse more robustly.

Recommendation 7:

7.2.7 Hertfordshire DA Partnership to raise awareness of the need for agencies to be able to intervene in cases where domestic abuse is present and the parties involved are still in a relationship. Such programmes like Engage[93] by SafeLives are designed as part of a remedy for this particular issue.

Recommendation 8:

7.2.8 The Home Office, in collaboration with relevant criminal justice partners to review and reflect upon policies and practices which allow the same solicitors to take on legal representation for both victim and perpetrator.

Recommendation 9:

7.2.9 All agencies involved in the DHR to review their module on safeguarding and domestic abuse, including what role and powers their respective organisation has in relation to safeguarding victims of domestic abuse and how they can hold perpetrators to account for their behaviour.

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90 https://safelives.org.uk/sites/default/files/resources/The%20principles%20of%20an%20effective%20MARAC%20FINAL.pdf

91 https://www.gov.uk/government/publications/domestic-abuse-bill-2020-factsheets/tackling-perpetrators#:~:text=The%20act%20requires%20the%20Home,prosecuting%20offences%20involving%20domestic%20abuse

92 https://www.legislation.gov.uk/ukpga/2021/17/contents/enacted

93 https://safelives.org.uk/training/engaging-those-who-harm

Recommendation 10:

7.2.10 All agencies involved in this DHR to review their engagement policy, especially for clients who face multiple and severe barriers to accessing community based service provision. Services need to find ways to safely and effectively engage clients in need who are living with an abusive partner.

Recommendation 11:

7.2.11 Agencies now reviewing available research relating to the Covid Pandemic on victims of domestic abuse is evident. Agencies should therefore update their emergency operating procedures accordingly, resulting in enhanced practice in the face of future pandemics.

Appendix 1: Domestic Homicide Review Terms of Reference

Terms of Reference

Purpose of the panel

To establish the facts about events leading up to, and following the death of

Victim: Fiona

Perpetrator: George

- To examine the roles of the organisations involved in the case, the extent to which Fiona and George were involved with those agencies, and the appropriateness of single agency and partnership responses to the case.
- To establish whether there are lessons to be learnt from this case about the way in which organisations and partnerships carried out their responsibilities to safeguard the wellbeing of the deceased.
- To identify clearly what those lessons are, how they will be acted upon, and what is expected to change as a result.

To identify whether, as a result, there is a need for changes in organisational and/or partnership policy, procedures or practice in Hertfordshire in order to improve our work to better safeguard victims of coercive control, intimate partner abuse and stalking.

Background to the case

In December 2021, Fiona was found dead by Hertfordshire Police at her home address. Fiona died by way of an overdose. It is believed that this overdose followed an altercation with George.

There is an extensive history of domestic abuse between Fiona and George.

Three Rivers Community Safety Partnership made a decision to hold a Domestic Homicide Review March 2022.

The scope of the panel review

To produce a chronology of events and actions leading up to, and in relation to the death of Fiona from the period in January 2013 until December 2021.

Information will be sought from:

- Organisations who had contact with them
- Local community organisations
- Specialist national organisations
- Families and friends of Fiona and George.

    - To review current roles, responsibilities, policies, and practices in relation to victims of coercive control, intimate partner 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 weaknesses
    - To review national best practice in respect of protecting adults from coercive control, intimate partner abuse and stalking
    - To draw out conclusions about how organisations and partnerships can improve their working in the future to support victims of coercive control, intimate partner abuse and stalking.

<u>The review will also specifically consider:</u>

- An assessment of whether family and friends were aware of any abusive or concerning behaviour from the perpetrator to the victim (or other persons)
- An assessment of whether family and friends were aware of any abusive or concerning behavior from the victim to the perpetrator (or other persons)
- A review of any barriers experienced by the families in reporting any abuse or concerns, including whether they or anyone else involved knew how to report coercive control, intimate partner abuse and stalking had they wanted or felt able to.
- A review of any previous concerning conduct or a history of abusive behaviour from the perpetrator and the victim and whether this was known to any agencies.
- A review of any the information held by agencies that indicated the victim could be at risk of suicide as a result of any coercive and controlling behaviour
- A review of any Multi-Agency Risk Assessment Conference (MARAC) involvement.
- An evaluation of any training or awareness raising requirements that are necessary to ensure a greater knowledge and understanding of coercive control, intimate partner abuse and stalking processes and/or services in Hertfordshire.
- Whether the victim and perpetrator had any previous history of abusive behaviour towards each other or anyone else, and whether this was known to any agencies.
- Whether family and friends want to participate in the review. If so, find out if they were aware of any abusive behaviour by victim or perpetrator prior to the homicide/suicide.
- Communication to the general public and non-specialist services about available specialist services related to coercive control, intimate partner abuse and stalking.

- 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.
- The impact of coercive control, intimate partner abuse and stalking on children and young people.
- Any other information that becomes relevant during the conduct of the review.

Panel Membership

The panel will be made up of representatives of those organisations that had some involvement in the victim's life, and that of the perpetrator, those that have duties to care for adults at risk of domestic abuse, and those that will have local knowledge and insight:

Strategic partnership Team, Hertfordshire County Council (HCC)

Three Rivers District Council

East of England Ambulance Service

Hertfordshire Police

Hertfordshire Partnership NHS Foundation Trust

Adult Social Care

National Probation Service

CGL

Refuge

Mental Health & Suicide Prevention (HCC)

Survivors Against Domestic Abuse

Appendix 2: Single agency recommendations – action plan

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
Single agency recommendations						
Hertfordshire Police						
Reinforcement of DVPN/DVPO policies, to ensure consistency of practice, and early intervention for vulnerable victims and perpetrators of domestic abuse.	Local	Hertfordshire Constabulary has improved both processes and guidance in relation to DVPN's and other civil orders. There is a specialist team dedicated to processing Civil Orders established within DAISU to review all DA reports and look for opportunities to proactively use DVPO's. We recognised that as a force we were not using these sufficiently and a collective push within the safeguarding departments and the LPC has led to a vastly improved picture.	Hertfordshire Police	A dedicated DVPN/O officer has been placed in Domestic abuse Investigation and Safeguarding Unit (DAISU) for intimate DA, and one in CIT for non-intimate DA. These officers will prepare the cases identified and present the DVPN to the Magistrates Court to obtain DVPOs. DAISU review all DVPOs across the county, these are listed on a SharePoint page and Chief Inspectors are held accountable for ensuring that regular checks are conducted during the 28-day period of the DVPO. This is reported on daily at the Force Daily Management Meeting. New guidance and training of DVPN, Clare's Law and Stalking	Completed.	Completed.

				Protection Orders has been delivered to all Frontline and Neighbourhood Policing Teams including Supervisors and there are dedicated sections within the Vulnerability Information Portal. This can provide detailed information and advice on the process, including a simple visual flowchart. Further to this, officers are guided to information provided by the College of Policing, to re-enforce that these can be obtained without the need for arrest: 'Officers have a duty to take or initiate steps to make a victim as safe as possible. Officers should consider domestic violence protection notices (DVPN) and domestic violence protection orders (DVPO) at an early stage following a domestic abuse incident as part of this duty. These notices and orders may be used following a domestic incident to provide short-term protection to the victim when arrest has not been made but positive action is required, or where an arrest has taken place but the investigation is in		

				progress. This could be where a decision is made to caution the perpetrator or take no further action (NFA), or when the suspect is bailed without conditions'. To highlight the improvement in this area, the following are figures relating to DVPO's obtained by Hertfordshire Constabulary: 2022- 4 orders 2023- 29 orders 2024- 156 orders (as of 4th June) and rising This highlights that between 2022 and 2023 there has been a 624% increase and between 2023 and 2024 a 259% increase.		
Officers to be reminded of their responsibility to investigate where reports are received of breaches of bail.	Local	Recommendation briefed into Safeguarding Command.	Hertfordshire Police		20/09/2024	
Supervisors to be reminded of their responsibility to	Local	Recommendation briefed into Safeguarding Command.	Hertfordshire Police		20/09/2024	

monitor crimes and ensure breaches of bail are investigated thoroughly						
PNC admin to examine the process of bail conditions being granted and put on Athena and subsequently being placed on PNC.	Local	Recommendation briefed into Safeguarding Command.	Hertfordshire Police		20/09/2024	
Officers to revisit their requirements, as per the victims code, to update victims about bail conditions in a timely manner.	Local	Recommendation briefed into Safeguarding Command.	Hertfordshire Police		20/09/2024	
Officers to consider multiple breaches of bail to be a course of conduct offence	Local	Recommendation briefed into Safeguarding Command.	Hertfordshire Police		20/09/2024	

amounting to harassment or stalking.						
Current training on the nuance of the coercive control, and how this phenomenon impacts the victims capacity, free will and therefore ability to keep herself safe to be reviewed.	Local	Recommendation briefed into Safeguarding Command.	Hertfordshire Police		20/09/2024	
Current intervention strategies (like case management and multi-agency coordinated approaches of Drive or MATAC for example) to tackle persistent DA offending and/or persistent	Local	Recommendation briefed into Safeguarding Command.	Hertfordshire Police		20/09/2024	

DA call outs to an address (identified by a recency, frequency and gravity assessment) to be reviewed.						
Current training on assessing counter allegations or unclear abuse dynamics to be reviewed.	Local	Recommendation briefed into Safeguarding Command.	Hertfordshire Police		20/09/2024	
Hertfordshire Partnership NHS Foundation Trust (HPFT)						
Training opportunities for staff that address assessment of risk of social media platforms and other technologies will build upon practice in this specialist area.	Local	Information regarding Domestic Abuse and Technology to be included within training plan either through existing webinars or as standalone session	HPFT	HPFT Safeguarding team to liaise with IDVA service re: resources on this topic. Training plan developed for 2024-25 Webinar delivered as part of annual training programme	January 2024 January 2024	Completed Completed Completed. Information

					Ongoing throughout 2024-25	currently embedded within Risk assessment and Safety planning webinar.
The IMR Author recommends review and further promotion of existing resources on cuckooing, in order to ensure staff knowledge is up to date.	Local	Cuckooing and Complex Cases webinar to be included in 2024-25 training plan.	HPFT	Training plan developed for 2024-25 Webinar delivered as part of annual training programme	January 2024 Ongoing throughout 2024-25	Completed Ongoing throughout 2024-25.
Existing training on domestic abuse could be reviewed to consider what specific value Section 9 Care Act and Carer assessments could offer adults at risk of domestic	Local	Review Training to include information on Section 9 Care Act and Carer assessments where appropriate. Information on Safety Planning and basic risk assessment to be included within training.	HPFT	Training slides reviewed for delivery during 2024-25 Webinars delivered	April 2024 Ongoing throughout 2024-25	Completed Ongoing throughout 2024-25

abuse.						
The HPFT Safeguarding Team should continue to promote awareness of a Think Family response which would encourage staff to consider the needs of others within the family network. This could include consideration of family members who may also present with care and support needs.	Local	Think Family Slide to be added to all Safeguarding training webinars.	HPFT	Webinar slides amended	April 2024	Completed
It is recommended clearer guidance be issued on how service users and staff can submit	Local	Clare's law guidance included in DA resource Kit. Domestic Abuse policy reviewed to ensure clear guidance on Clare's law.	HPFT	Resource Kit amended DA policy updated	December 2023 Q.3 2024	Completed December 2023

Clare's Law applications and when is appropriate to consider this.						
The reviewer found multiple missed opportunities to report safeguarding concerns. It is recommended training on Essential Safeguarding Adults Training is reviewed to further build on the emphasis of engaging in reporting processes and why this is important.	Local	Essential Safeguarding Adults training slides reviewed to ensure that clear guidance is provided on raising concerns. Promotion of 7-minute briefing on making good safeguarding referrals slides promoting engagement with safeguarding processes.	HPFT	Essential safeguarding adults slides reviewed and updated. 7-Minute briefing circulated through Quality and Risk meetings and Patient safety groups.	April 2024 February 2024	Completed Completed
Domestic Abuse training and	Local	Update Domestic Abuse Policy to reflect higher risk points	HPFT	DA Policy updated	Q.3 2024	Completed

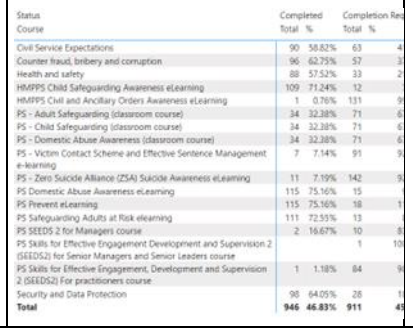
guidance to include further information on safety planning, particularly where IDVA's are not engaged in direct work with clients could reduce risk following contact with health professionals.		such as point of ending the relationship. Domestic Abuse Resource Kit to include consideration of factors which may increase risk.		DA Resource Kit updated	January 2024	Completed
Clearer guidance to be issued for investigating managers concerning the principle of proportionality and respecting an adult's individual autonomy in making decisions about their experience of abuse.	Local	Guidance note to be circulated to all investigating managers	HPFT	Guidance note circulated by email Guidance note discussed at Investigating managers peer supervision	February 2024 March 2024	Completed Completed

The Policy section on domestic abuse relating to perpetrators could be revised to highlight more explicitly to staff that the needs and risks of service users who are perpetrators, according to research, increases at the time of separating in the relationship, and must not be confused as a 'historic' risk.	Local	HPFT Safeguarding Team to review DA Policy and ensure that section on Perpetrators of abuse who may also be service users is robust. DA resource pack section on Perpetrators of abuse to be reviewed in re: the above.	HPFT	DA policy reviewed and updated as appropriate. DA Resource Pack reviewed and updated as appropriate.	Q.3 2024 Q.3 2024	Completed Completed
The review found professionals agreed with Fiona to transfer her to another ACMHS in the Trust because of links the perpetrator	Local	Discussion at Decision Maker's Peer supervision and other relevant forums such as Social Care Leads	HPFT	Discussed at Investigating manager's Peer supervision. Discussed at Social Care Leads.	October 2024 October 2024	Completed October 2024. Completed October 2024.

shared with the team. It is recommended guidance is shared with safeguarding leadership networks/ forums to discuss the appropriateness of introducing additional disruption to survivors of domestic abuse known to secondary mental health services.						
HFPT to review its policy with regard to care pathways for those who require medical operations but who have insecure housing status.	Local	HPFT to review existing connected Lives training to ensure that guidance is included re: the possible impact of individual factors such as Homelessness or physical illness on the assessment process and how these can be managed.	HPFT	To review existing connected Lives training.	June 2025	Ongoing.
Refuge						

To review agency policy and stance around outreach to clients whom face significant disadvantage to accessing community based support.	Local	Senior Operations Manager to review policy on home visits to clients with Heads of Services and Senior Operations Team.	Refuge	Added to agenda for Heads and SOM meeting on 17/09/24.	30/09/2024	Completed
Change, Grow, Live (CGL)						
To review agency policy and stance around outreach to clients who face significant disadvantage to accessing community based support.	Local	To review agency policy and stance around outreach.	CGL	CGL now has complex outreach teams to work with our clients who face significant disadvantage to access community based support.	August 2024	August 2024
National Probation Service (NPS)						
Probation Officers to revisit domestic abuse training, specifically looking at its vast implications for victims and	Local	•The mandatory safeguarding elearning events, which need to be recompleted by all staff every 3 years. To ensure all staff have completed this training.	National Probation Service	Share at all Herts conference. Accountability on all managers to ensure ALL practitioners complete relevant and additional training on DA and safeguarding.	November 2024	November 2024

survivors (loss of pregnancies, substance abuse and suicidality to name but a few), therefore increasing their ability to identify (and thus respond) the more subtle symptoms of abuse. Probation Officers to receive training on their safeguarding duties and options when they identify adults at risk of harm and abuse.		•The facilitated 'safeguarding' events, which need to be recompleted by staff for whom completion is required every 3 years. •All staff to attend PDP on Domestic abuse which is taking place in November 2024. This training covers the following topics: -Managing the risk of domestic abuse in custody: The importance of multi-disciplinary working -Understanding the Red Flags of Controlling and Coercive Behaviour: The Joanna Simpson Foundation -Working with domestic abuse: Understanding how our nervous system can help us -How MAPPA can support practitioners in the management of domestic abuse -Insights from those who are engaging with domestic abuse perpetrator interventions				

		Data correct as of 30/09/24. 				

Status Course	Completed Total	% 	Completion Rec Total	%
Civil Service Expectations	90	58.82%	63	4
Counter fraud, bribery and corruption	96	62.75%	57	3
Health and safety	88	57.52%	33	2
HMPPS Child Safeguarding Awareness eLearning	109	71.24%	12	
HMPPS Civil and Ancillary Orders Awareness eLearning	1	0.76%	131	9
PS - Adult Safeguarding (classroom course)	34	32.38%	71	6
PS - Child Safeguarding (classroom course)	34	32.38%	71	6
PS - Domestic Abuse Awareness (classroom course)	34	32.38%	71	6
PS - Victim Contact Scheme and Effective Sentence Management e-learning	7	7.14%	91	9
PS - Zero Suicide Alliance (ZSA) Suicide Awareness eLearning	11	7.19%	142	9
PS Domestic Abuse Awareness eLearning	115	75.16%	15	
PS Prevent eLearning	115	75.16%	18	1
PS Safeguarding Adults at Risk elearning	111	72.55%	13	
PS SEEDS 2 for Managers course	2	16.67%	10	8
PS Skills for Effective Engagement Development and Supervision 2 (SEEDS2) for Senior Managers and Senior Leaders course			1	10
PS Skills for Effective Engagement, Development and Supervision 2 (SEEDS2) For practitioners course	1	1.18%	84	9
Security and Data Protection	98	64.05%	28	1
Total	**946**	**46.83%**	**911**	**4**

Appendix 3: Multi-agency recommendations – action plan

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
Multi agency recommendations						
Recommendation 1: Hertfordshire DA Partnership to raise awareness with professionals of the link between domestic abuse and suicide, enabling better risk identification, assessment and intervention.	Local	For the Hertfordshire Domestic Abuse Partnership to link in with the Suicide Prevention Team to jointly raise awareness of domestic abuse and suicide, better risk identification, intervention and assessment.	Hertfordshire Domestic Abuse Partnership	A resource guide is already available, and the Suicide Prevention Team is looking at developing training modules that relate to domestic abuse. Risk identification, the link between suicidality and domestic abuse is being developed as part of this training module which also involves work with DA charities. The suicide prevention team will use the real time suicide surveillance system to identify suspected suicides and suicide attempts related to DA. This has already been addressed and systems of recording being improved to capture necessary information although conscious of Data Protection Impact Assessment requirements where appropriate.		Completed and ongoing.

Recommendation 2: Hertfordshire DA Partnership to raise awareness with professionals around best practice suicide intervention, which includes role of bespoke suicide intervention plans and how to implement them collaboratively with clients.	Local	For the Hertfordshire Domestic Abuse Partnership to link in with the Suicide Prevention Team to jointly raise awareness around best practice suicide intervention and bespoke suicide prevention plans.	Hertfordshire Domestic Abuse Partnership	Level 1 and Level 2 suicide intervention training is available, including how to do a safety plan with those at risk. The Suicide Prevention Team commission some services where a safety plan is provided, ie the discharge befriending service. The Suicide Prevention Team also commission 'Togetherall' that provides 24/7 support for those with low to moderate mental health issues, with clinicians available on the platform for those in crisis with a clear escalation process. Resources on the platform also include information on domestic abuse and support. This service is available to anyone living or working in Herts.		Completed.
Recommendation 3: Hertfordshire DA Partnership to advocate for domestic abuse being listed as a 'priority' in the Hertfordshire Suicide Prevention Strategy 2025-2030.		For the Hertfordshire Domestic Abuse Partnership to work closely with the Suicide Prevention Team to make sure that domestic abuse is included in Hertfordshire's Suicide Prevention Strategy as a priority.	Hertfordshire Domestic Abuse Partnership	Hertfordshire's Suicide Prevention Strategy 2025-2030 will include domestic abuse as a priority and domestic abuse charities should input into its development. The England Suicide Prevention Strategy released last September highlights domestic abuse as a priority and this will be echoed in the Hertfordshire Suicide		Plans to include domestic abuse in the strategy are completed and confirmed. Strategy to launch in April 2025.

				Prevention Strategy due to launch in April 2025.		
Recommendation 4: In line with the SafeLives MARAC principle 6, the Risk Management Subgroup to review the effectiveness of the MARAC to safeguard victims by addressing perpetrators risks and needs.	Local	In April 2019 SafeLives published a full review report which highlighted nine key themes and learning, as well as seven recommended actions. In June 2023 the Risk Management Sub-Group (RMSG) commissioned a follow up review to be conducted by members of Hertfordshire County Council, Strategic Partnership Team, to assess the current functioning of MARAC across Hertfordshire. • Assess the implementation of the key themes, learning and recommendations highlighted within the SafeLives 2019 report. • Reflect on each of the '10 principles of an effective MARAC' 1 to assess the effectiveness of Hertfordshire MARAC. • Consider good practice observed at MARAC meetings. • Highlight areas which could be strengthened or developed to improve outcomes further for victims at high risk.	Risk management Sub-group	The following 10 recommendation have been made which have more detail in the below attached audit: 1. Separate MARAC case discussion group. 2. Performance framework. 3. Administration. 4. Observation of other local counties MARAC. 5. Increased focus on safety and impact for children. 6. Enhancements to action planning. 7. Encouragement of more dynamic conversations. 8. Increased focus on the reduction of the risk posed by the perpetrator. 9. Representative training and support. 10. Clarification of referral pathways and linkages with safeguarding hubs. Herts Marac audit.pdf	Completed	Audit completed but work on the recommendations is ongoing. MARAC Task & Finish Group in place to deliver on recommendations from the review, meetings held on the following dates: • 21st March 2024 • 2nd May 2024 • 13th June 2024 Next meeting; • 24th Sept 2024

Recommendation 5: Hertfordshire DA Partnership Risk Management Subgroup to reflect on the impact of not having a common assessment framework for risk assessing domestic abuse across Hertfordshire. There is evidence of some of the key organisations using differing risk assessments (DARA & DASH) and whilst there may be some strength to this model, there will be weaknesses that will require mitigation.	Local	For the risk management subgroup to agree on how the DARA and DASH assessments will be reviewed.	Risk management sub-group	Risk management subgroup are meeting on 13th November 2024 and we will discuss then how to progress this.	November 2024	To be discussed in November 2024.
Recommendation 6: In light of the impending Perpetrator Strategy, as part of	Local	The process of developing the new DA strategy started. The DA Partnership to wait for the perpetrator strategy to	Hertfordshire Domestic Abuse Partnership	Our current DA strategy ends 2025, so we have started the process of developing our new strategy. Our current strategy includes 4 key priorities including	Ongoing.	Ongoing.

the DA Act 2021, Hertfordshire DA Partnership to review their local VAWG strategy, and resulting operational tactics around tacking perpetrators of domestic abuse more robustly.		come out to ensure it aligns with the new VAWG strategy or elsewhere.		identifying and stopping those that cause harm. Once the perpetrator strategy comes out then we can ensure this aligns with the work we do whether that it is our new VAWG strategy or elsewhere.		
Recommendation 7: Hertfordshire DA Partnership to raise awareness of the need for agencies to be able to intervene in cases where domestic abuse is present and the parties involved are still in a relationship. Such programmes like Engage by SafeLives are designed as part of a remedy for this particular issue.	Local	Hertfordshire DA partnership to look into programmes such as Engage by SafeLives.	Hertfordshire Domestic Abuse Partnership	Intervention where DA is present and the parties are still in a relationship is currently provided by the baby's sake in Hertfordshire but it is only provided to pre-birth up to 2 and a half years.	Ongoing.	Ongoing.
Recommendation 8: The Home Office, in collaboration with relevant	National		Home Office			

criminal justice partners to review and reflect upon a policies and practices which allow the same solicitors to take on legal representation for both victim and perpetrator.						
Recommendation 9: All agencies involved in the DHR to review their module on safeguarding and domestic abuse, including what role and powers their respective organisation has in relation to safeguarding victims of domestic abuse and how they can also hold perpetrators to account for their behaviour.	Local	**SADA** SADA to arrange a meeting with our safeguarding coordinator to review our safeguarding policy in respect of domestic abuse and suicide. Our action plan will include our role and safeguarding in respect of supporting victims and survivors of domestic abuse and how we hold perpetrators account for their behaviour. This could include working with partner agencies as well as our in house perpetrator programme.	SADA	To arrange a meeting with the safeguarding coordinator. Update our action plan and share plan with partners at next partnership meeting. Share with the team at the next team meeting.	01.09.24 16.09.24 16.08.24	
		CGL	CGL	CGL refer victims of domestic abuse to domestic abuse services such as IDVA, also have an IDVA sitting in service once a week.	October 2024	

				CGL will complete a safeguarding referral for domestic abuse victims. CGL will ensure an initial safety plan is in place with a victim of domestic abuse whilst awaiting other domestic abuse speciality services to engage with the victim. CGL attend MARAC meetings to share information of both victim and perpetrator if they are known to our service. CGL will offer perpetrator programme with Chrysalis to perpetrators who acknowledge they are a perpetrator of domestic abuse. Safeguarding training to be offered to all staff in CGL in Hertfordshire bimonthly.		
		Three Rivers Council The Council have renewed their Safeguarding Children and Adults at risk policy in 2023, the policy includes the responsibilities and expectations laid out in legislation, Guidance and local	Three Rivers Council			Completed January 2024.

	procedures including The Domestic Violence crime and Victims Act 2004 and the Domestic Abuse Act 2021. Three Rivers District Council are currently reviewing their internal Domestic Abuse and VAWG Policy. Which outlines the approach that will be taken to support victims of DA and to hold accountable perpetrators.				
	HPFT: HPFT Safeguarding Team to review existing webinar programme to ensure that where appropriate they include discussion regarding perpetrators of abuse who may also be service users.	HPFT	Discussion at Safeguarding Team meeting re: content changes and need to review. Webinars reviewed	September 2024 Q.3 – 4 2024/25	Completed September 2024.
	Refuge: Senior Operations Manager to review safeguarding adults training.	Refuge	Safeguarding Adults training reviewed and confirmed it covers the role and powers that the organisation has in relation to safeguarding victims of domestic abuse.	October 2024.	Completed October 2024- Safeguarding Adults training reviewed and confirmed it covers the role and powers that the organisation has in relation to safeguarding victims of domestic abuse.

Recommendation 10: All agencies involved in this DHR to review their engagement policy, especially for clients who face multiple and severe barriers to accessing community based service provision. Services need to find ways to safely and effectively engage clients in need who are living with an abusive partner.	Local	**SADA:** We have reviewed our engagement with hard to reach clients and we will further promote our partnership working with community based services and promote our various virtual and face to face drop in's.	SADA	Update our partners at the next partnership meetings. Promote our drop ins with partners. Update the team at the next team meeting.	01.09.24 16.08.24	
		CGL	CGL	CGL now have a complex outreach team who are there to provide support to individuals who are unable to engage in our "normal service". This could be due to severe mental health, severe physical health or homelessness. These teams engagement pathway is a little more flexible due to the understanding of the difficulties faced by the individuals. If a client is living with an abusive partner we would be creative in meeting in mutual place, during appointments asking the perpetrator to leave the room or planning ahead knowing when the perpetrator will not be around to	August 2024	August 2024

				have an appointment with out them.		
		Three Rivers Council Three Rivers District council understand that not all victims of DA are ready to separate themselves from the perpetrator of the DA and are taking an early intervention approach to encourage services that work within the family to engage perpetrators in interventions by providing a full day training course that has taught family workers to learn how to hold perpetrators accountable and engage them to make changes that support the whole family. Three Rivers run the Watford and TR DA forum which brings together DA services from across the double district to share resources and ask questions, make referrals and connections that support victims of DA. Three Rivers District council have employed a Domestic Abuse Caseworker to support housing needs of Victims of DA	Three Rivers Council			Completed and ongoing. Ongoing.

	to ensure they are supported to leave. Three Rivers have an internal reporting mechanism around safeguarding whereby we manage those with protected characteristics and work within the support provision to support each individual case.				Completed, everyday business.
	Refuge: Senior Operations Manager to review policy on home visits to clients with Heads of Services and Senior Operations Team.	Refuge	This action will be linked with a new action from DHR49 JM-Refuge to develop good practice guidance on reaching people with multiple disadvantages to access community-based services.	January 2025	To be completed in January 2025.
	HPFT: Safeguarding team to work with policy owners to review DID NOT ATTEND/NOT BROUGHT IN policy to ensure	HPFT	Safeguarding Team to seek guidance from Specialist agencies in regards to addressing cases	September 2024	Completed in September 2024.

	that consideration has been given to cases where non engagement may be driven by Domestic Abuse/ Coercion and Control.		where Non-attendance may be linked to DA Safeguarding team to support review of policies in conjunction with policy owners. Any necessary changes to be promoted through operational Quality & Risk Meetings.	Q.3 2024 TBC following above	
	National probation service: Completion of barriers to engagement during induction which identifies barriers and ways of working. This includes home visits, support etc. Regular liaison with partnerships such as DAISU/IDVA to ensure victim safety. I.e Victims attending office on their own (do not allow partners to attend session) and have partnerships available.	National Probation Service	Attended to agenda of Quality Matters Board to ensure further discussion at SLT.	December 2024	Ongoing.
Recommendation 11: Agencies now reviewing available research relating to the Covid Pandemic on victims of domestic abuse is evident. Agencies	**SADA:** Continue to update continuity plans every six months. This includes emergency operating	SADA	Already in place.	Completed.	Completed.

should therefore update their emergency operating procedures accordingly, resulting in enhanced practice in the face of future pandemics.	procedures and shared with the team.				
	CGL	CGL	Business continuity plan. CGL to review their current procedure. CGL to develop a safety plan performa.	January 2025	
	Three Rivers Council Three Rivers will use the research relating to the Covid pandemic to ensure that our Emergency operating procedures incorporate the findings to enable enhanced practice in the future.	Three Rivers Council			Ongoing, plan in progress.
	HPFT: HPFT safeguarding Team to liaise with Emergency Planning Lead to raise awareness re: relevant research. HPFT Safeguarding Team to review guidance issued during Pandemic regarding assessing risk of abuse during online/	HPFT	HPFT safeguarding team to review research HPFT Safeguarding Team to liaise with Emergency Planning Leads HPFT Safeguarding Team to review existing guidance	September 2024 September 2024 October 2024	

	telephone consultations to ensure that this reflects current best practice				
	Refuge: Senior Operations Manager to review emergency operating procedure for Herts IDVA service in relation to future pandemics and update accordingly.	Refuge		January 2025	To be completed by January 2025.
	National Probation Service The National Probation Service to review findings from Serious Further Offences report to gather research into practice during COVID – 19 pandemic to incorporate findings into practice in the future	National Probation Service		March 2025	Ongoing – plan in progress.

Appendix 4: Glossary

AAFDA	Advocacy After Fatal Domestic Abuse
ACHMS	Adult Community Mental Health Services
ASC	Adult Social Care
CATT	Crisis Assessment and Treatment team
CPS	Crown Prosecution Service
CSP	Community Safety Partnership
DA	Domestic Abuse
DAISU	Domestic Abuse Investigation Support Unit
DARA	Domestic Abuse Risk Assessment
DASH	Domestic Abuse Stalking & Harassment (risk assessment)
DVDS	Ambulance Service
DHR	Domestic Homicide Review
EEAS	East of England
GP	General Practice
HPFT	Hertfordshire Partnership Foundation Trust
IDVA	Independent Domestic Violence Advocate
IMR	Individual Management Review
MARAC	Multi-Agency Risk Assessment Conference
MATAC	Multi-Agency Tasking & Coordination
NPS	National Probation Service
OIC	Officer in Charge (police)
SPA	Single Point of Access
TRCSP	Three Rivers Community Safety Partnership
VAWG	Violence Against Women and Girls