

Domestic Homicide Review  
Executive Summary  
St. Albans Community Safety Partnership

Linda

Born: July 1993

Died: May 2022

Chair and Author: Christian Brazier

Date of completion: 14<sup>th</sup> June 2024

**Friend's Tribute:**

Tribute from Linda's friends Brenda and Patricia:

No one knew us like you did. We like to think no one knew you, like we did.

The moment you left us the world became so quiet. The sound of laughter gone, the terrible jokes disappeared, the memories frozen in time. The hardest part to date is that we still talk to you... but you can't respond with a sarcastic comment or terrible advice. No one insults us like you did; weird as it sounds, we miss that. We miss you. Everything about you.

We remember the random trip to the pub, that turned into a pub crawl. The one you said we "made you go on". The next morning you sent the last pictures you took that night, these consisted of a picture of the toilet door and a blurred photo of the lights in the bar. To be fair the state we were in these were the prettiest pictures from that night!

We wish you were here for the plans we had. New house, graduation, girls' trip, passing my driving test (seriously someone gave me a licence), and just the boring Tuesdays, just being here to talk to. We blame everything on you now, broken glass- your fault, stubbed toe- your fault, raining... your fault. Just because we can! Life sucks without our best friend.

We used to talk about death. How we needed to hide the phones, so no one saw our group chat conversations and have us committed, and how we were to scare off unwelcome guests at our funerals. P.S who were all those people at your funeral, we thought we were your only friends (bantz)! As you know that didn't go to plan. That was your fault too. \*Insert ironic laugh here\* We're kidding of course, I mean you know our sense of humour... but there are people outside of our bubble who will read this, so we can't be too authentic.

The boys miss their mummy so much, you were a fantastic mother and brought so much joy to their lives. You gave them what every child needs and this is love, security, acceptance, and happiness. Just so you know, even though we haven't been as present as we would have liked, we will be reunited with them again someday and they will know your story. The weird, the wonderful and the wacky.

So here we are, another opportunity to make everything about you. Of course we jumped on it! We wanted people to know you was imperfectly perfect. Not just a statistic, but a mother and best friend who lost her way along her journey, and unfortunately met people who took advantage of her kind accepting heart. We hope you know how loved you are! We vow to honour your memory and take you on our journey's, after all ghosts don't cost much!

We love and adore you always Boo!

Forever28

Love FP xox

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## Glossary of Terms

Acronym	Name
ACMHS	Adult Community Mental Health Service
AMHT	Adult Mental Health Team (as above but alternative acronym)
BDAAT	Barking and Dagenham Access and Assessment Team
BDAABIT	Barking and Dagenham Access and Assessment Brief Intervention Team
BDPS	Barking and Dagenham Psychological Therapy Service
CIN	Child In Need
CPP	Child Protection Plan
CSC	Children's Social Services
DA	Domestic Abuse
DASH	Domestic Abuse Stalking and Harassment Risk Assessment
DARAC	Domestic Abuse Risk Assessment for Children
DVPN	Domestic Violence Prevention Notice
DVPO	Domestic Violence Prevention Order
EH(W)	Early Help (Worker) <sup>1</sup>
FGC	Family Group Conference
HMH	Homes and Money Hub <sup>2</sup>
IDVA	Independent Domestic Violence Advisor
IFST	Intensive Family Support Team
IGVA	Independent Gender Violence Advocate
LBBB	London Borough of Barking and Dagenham
MASH	Multi Agency Safeguarding Hub
MARAC	Multi Agency Risk Assessment Conference
NELFT	North East London Foundation Trust <sup>3</sup>
NCD	Non Crime Domestic
OCD	Obsessive Compulsive Disorder
PPIMHS	Perinatal Parent Infant Mental Health Service <sup>4</sup>
SPA	Single Point of Access <sup>5</sup>
SAHWR	St Albans and Hertsmere Woman's Refuge
SOP	Standard Operating Procedures
SWKR	Social Worker
TAC	Team Around the Child
TAF	Team Around the Family
UC	Universal Credit

<sup>1</sup> [Early help | London Borough of Barking and Dagenham \(lbld.gov.uk\)](https://www.lbld.gov.uk)

<sup>2</sup> [Homes and Money Hubs | London Borough of Barking and Dagenham \(lbld.gov.uk\)](https://www.lbld.gov.uk)

<sup>3</sup> [Providing care for people in London, Essex, Kent and Medway. Employing over 7,000 staff, over 200+ locations. | NELFT NHS Foundation Trust](https://www.nelft.nhs.uk)

<sup>4</sup> [Perinatal parent infant mental health service-bdhvrbwf | NELFT NHS Foundation Trust](https://www.nelft.nhs.uk)

<sup>5</sup> [Single point of access service :: Central London Community Healthcare NHS Trust \(clch.nhs.uk\)](https://www.clch.nhs.uk)

# DHR EXECUTIVE SUMMARY INTO THE VICTIM SUICIDE OF LINDA - MAY 2022

## Preface

The author and panel wish to express their deepest condolences to Linda's friends, family and her children. The author would like to place on record special thanks to Linda's friends for their contribution to this review which has provided valuable insight. Their continued love and compassion for Linda shone through.

This was a cross border review. Linda had been in the commissioning area Hertfordshire for less than 1 year. As such, particular thanks goes to Barking and Dagenham local authority services for their involvement in this DHR and detailed Individual Management Reviews as it does for the honesty and transparency of all contributors.

## Introduction

- 1.1 Domestic Homicide Reviews (DHRs) came into force on the 13th April 2011. They were established on a statutory basis under Section 9 of the Domestic Violence, Crime and Victims Act (2004). The Act states that a DHR should be a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by-
  - (a) A person to whom she was related or with whom she was or had been in an intimate personal relationship or
  - (b) A member of the same household as herself; with a view to identifying the lessons to be learnt from the death.
- 1.2 Within Section 18 of the 2016 Multi Agency Statutory Guidance for the Conduct of DHRs, provision was made for DHRs to be conducted:

*“Where a victim took their own life (suicide) and the circumstances give rise to concern, for example it emerges that there was coercive controlling behaviour in the relationship, a review should be undertaken, even if a suspect is not charged with an offence or they are tried and acquitted. Reviews are not about who is culpable.”<sup>6</sup>*

Due to the knowledge Linda had fled Barking and Dagenham due to domestic abuse, it was deemed appropriate to commence a review in order to learn valuable lessons.
- 1.3 The purpose of a DHR is to:

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<sup>6</sup> [DHR-Statutory-Guidance-161206.pdf \(publishing.service.gov.uk\)](#)

- 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.
- Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result.
- Apply these lessons to service responses including changes to policies and procedures as appropriate; and identify what needs to change in order to reduce the risk of such tragedies happening in the future to prevent domestic homicide and improve service responses for all domestic violence victims and their children through improved intra- and inter-agency working.

1.4 This Domestic Homicide Review (DHR) examines the circumstances leading up to the death of Linda who ended her life in May 2022. The decision to undertake a DHR was made by St. Albans Community Safety Partnership. The Home Office was duly informed. An Independent Chair was appointed in September 2023 due to a lack of available DHR chairs. The Panel met for the first on 22<sup>nd</sup> September 2023 where relevant IMRs (Individual Management Reviews) were requested. There were further meetings of the panel in January, March, April and June 2024. This was to ensure all available information from Barking and Dagenham had been submitted to the review process.

## 2 Overview and Summary

Persons involved in this DHR. All names are pseudonyms, with Linda's name chosen by friends. The children's names may or may not be indicative of their birth sex:

Name	Relationship	Age at time of Linda's death	Ethnicity
Linda	Subject of review	28	White British
Graham	Ex-partner of Linda	29	White British
Freddy	Child number 1	6	White British
Felix	Child number 2	2	White British
Mary	Linda's mother	unknown	Unknown

### Overview:

Linda was found deceased in May 2022 after ending her life via hanging. She was found by her ex-partner Graham and their eldest child at the Hertfordshire home she lived in with their two children Freddy and Felix. Graham was returning the children after arranged child contact and had a key to the address. Linda had moved to Hertfordshire 11 months previously from Barking and Dagenham and moved to refuge. This was due to alleged domestic abuse from Graham.

Initial scoping revealed Graham and Linda had been in a relationship for at least ten years and had married in approximately 2014. They began a relationship in their mid to late teens. Both Linda and Graham had mental health difficulties which they sought support for. Even after Linda's death it was difficult to gain a consensus about her diagnosis as the report will highlight but, what was clear, was she experienced extensive trauma as a child including childhood sexual abuse from her mother's partner, parental domestic abuse and a mother with severe and enduring mental illness.

Linda had been a young carer to her mother although was never assessed as such. It became apparent during the initial information gathering stage there had been reports of domestic abuse from Linda in relation to Graham to a variety of agencies across the nearly decade long scoping period. There had been occasional police intervention but more common were disclosures to mental health professionals, social care and the GP.

This review sought to explore what was known, what interventions were put in place and what could be learned for the future.

### **Summary of the case**

Linda grew up in the London Borough of Barking and Dagenham (LBBB). She spent all her life there except for the final 11 months when she fled LBBB to move to a refuge in Hertfordshire with her two children. She grew up in challenging circumstances. Her mother had severe and enduring mental health issues. During a mental health appointment in later life Linda recalled being pulled out of school exams because her mother had taken an overdose. She said she had witnessed domestic abuse between her mother and boyfriends and had seen her detained under the mental health act. Her father left when she was young and had a severe alcohol problem. She had an older half sister who left when Linda was 13 to live with her biological father. Linda spent some time in foster care.

She was known to the Child and Adolescent Mental Health Team (CAMHS) via the GP when she was 13 years old. Deliberate self-harm, low mood, poor sleep and angry outbursts were recorded as the presenting difficulties as was a challenging relationship with her mother.

Linda and Graham were in a relationship from 2009 when Linda would have been 16 and Graham 17. She studied Health and Beauty at a local college.

Graham's childhood experiences and upbringing have remained more of an unknown to this review as he the panel decided he would not be approached due to safeguarding unknowns. However, from available information, his family, especially his mother, played a significant role within the context of their relationship often attending appointments with Linda. It is known Graham also struggled with his mental health as he was seen by Improving Access Psychological Therapies (IAPT) in August 2012 citing issues with anger. He was 20 at this time. He described being angry towards others and verbally abusive. He reported he would start physical altercations, hit walls and

mentioned a strained relationship with his girlfriend who was believed to be Linda. Within the same appointment he referenced experiencing financial worries and not going out although said he was undertaking an apprenticeship. Records suggest he was referred to therapy services with the referral closed after a month for an undocumented reason.

The first known call to the police in relation to domestic abuse occurred on 4<sup>th</sup> November 2013 due to a report of disturbance. Linda reported they had been arguing for several days about Graham cheating and texting other women. They had been together for four years and were due to get married next year but Linda had had enough, tried to end the relationship, and had gone to stay with her mother. She told police Graham wanted to know exactly where she had been and who with. She said he had taken her phone and demanded her password so he could gain access. He then grabbed Linda with both hands around the shoulders and neck. He threatened to cut her throat if she did not hand over her password. Linda told police she had seen violence previously from him when he'd smashed sentimental items and punched walls but this was the first time he had been directly physically violent towards her. She said he'd been seeking help with learning anger management strategies. She said Graham was employed as an electrician and brought most of the money into the household. She reported he would say things such as "It's my electricity so you can't watch the TV". The police recorded a crime of common assault and conducted a Domestic Abuse Stalking and Harassment Risk Assessment (DASH)<sup>7</sup> with Linda which was assessed as medium. Graham voluntarily handed himself into the police station later that night where he was arrested for common assault.

During his police interview he said he and Linda got on really well and initially denied any violence between them. He soon acknowledged there had been an argument where she had accused him of cheating. He told police he had asked to see her phone and for her passcode but she refused. He said he then grabbed her by the arm to "calm her down" but she became angrier. He then grabbed her by the throat and pushed her back against the cupboard. He said he immediately let her go and apologised. Police recorded that Graham expressed remorse for his actions and told them he was attending an anger management meeting giving a specific date of 5th November 2013 but no further details. He received an Adult Caution for this incident.

Over the next couple of years agency records indicate Linda attempted to gain further support for her mental health from her GP, Barking and Dagenham Access and Assessment Team (BDAAT) and Barking and Dagenham Psychological Therapy Service (BDPS). Linda was trialled on various medication such as sertraline – which is often used to treat mental health concerns such as depression panic attacks, obsessive compulsive disorder and post-traumatic stress disorder <sup>8</sup> and lorazepam which is used to treat anxiety and sleep problems. <sup>9</sup> There was limited therapeutic input up till this point. Both Graham and his mother deemed it necessary to contact mental health

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<sup>7</sup> <https://library.college.police.uk/docs/college-of-policing/Risk-led-policing-2-2016.pdf>

<sup>8</sup> [About sertraline - NHS \(www.nhs.uk\)](http://www.nhs.uk)

<sup>9</sup> [Lorazepam: a medicine to treat anxiety and sleeping problems - NHS \(www.nhs.uk\)](http://www.nhs.uk)

services on separate occasions during this time. Graham's mother cited a concern for Linda's mental health and self-harming. This is perhaps an early indicator of family centring issues solely on Linda's mental health.

Linda did have some therapy in mid 2015 but this was at the same time of her first pregnancy. There were a number of missed appointments from Linda which appear to be linked to her pregnancy. Subsequently she attended six sessions with another six either missed or cancelled by her. On one of these therapy sessions she stated Graham was the only one who would "put up with her".

Freddy was born in late 2015.

Linda continued to have therapeutic input in 2016 but this was not consistent and a longer term approach was not taken aside from trailing a variety of prescribed medication. Linda disclosed significant information in these appointments such as S being in and out of care as a child and maternal mental health which resulted in her mother's detention under the MH Act. Her father being an alcoholic whom she had no contact with. She disclosed sexual abuse by her mother's ex-boyfriend at age 5/6. She reported to have used cannabis to help her sleep two years previously, and experienced fears someone would take her child. She was asked about harm from others but referred only to concerns around the local area where family live. This was one of at least two occasions identified during the course of this review where Linda disclosed childhood sexual abuse and no appropriate signposting or support occurred.

The GP surgery had significant involvement with both Linda and Graham. On a day in March 2017 she attended her surgery for a planned contraceptive injection. She was very tearful and said her partner was swearing at her for attending this appointment. She told the nurse Graham wanted another child but she was not ready for another one. She said she was "fed up with the relationship" as her partner "didn't do anything for her nor their child". She said he will "not let her go". Linda reported self-harming a couple of weeks prior to this appointment although the nature of this was not recorded. There were multiple disclosures to the GP of this ilk indicating potential abuse. However, no DA (domestic abuse) related actions were taken.

There are several instances throughout the scoping period of Graham trying to gain mental health support for Linda. For example, on 3<sup>rd</sup> March 2018 Graham contacted the service Mental Health Direct and told them Linda had been on edge over recent weeks and said she was "having an episode". Graham listed various mental health diagnosis for Linda. He said she was blaming him for everything and this was out of character. Linda later attended the emergency department with Graham although it is unknown if he was present in the consult. Linda stated she was angry at mental health services for not listening to her.

Throughout 2018 there were several more interactions with mental health services who referred Linda for anxiety management and more therapeutic input. They described her communication as challenging with many unreturned phone calls or missed appointments.

Multiple calls were received to the police in mid 2018 with Graham calling due to a concern about Linda self harming and latterly Linda calling to say Graham had threatened to crash the car with both Linda and Freddy in it at the time. They described a situation of still living together but being separated.

These interactions prompted social care input. Linda told them Graham would not accept the end of the relationship and was still living with her saying he had nowhere else to go. He refused to remove his name from the tenancy. The phrase “would not accept the end of the relationship” was not explored further and the domestic abuse risk was not assessed. One action suggested was “*signpost father to appropriate support in relation to “living with a wife with mental health problems.”*” Latterly, Linda told Social Care Graham was threatening her saying if she left him he would take their child away from her.

Sporadic contact with mental health services continued and Linda told one practitioner one of the reasons she felt depressed was due to being “under a microscope” by her husband. She said she had stopped going to the gym as her husband would not let her go by herself. She reported that when she had gone with him he would compare her to other females.

In early Jan 2019 Linda informed the GP social care were no longer involved. Both Graham and Linda had withdrawn support for an early help plan. She notified the GP of her pregnancy and said she felt emotionally drained by her husband, she wanted a divorce and he refused to leave the home. She booked herself in for a termination.

Soon after, during a mental health appointment Linda disclosed her issues with Graham and the practitioner did refer her to the Women’s Trust, a local domestic abuse organisation. However, they were unable to get in touch and their policy states they do not let services know the outcome. Several attempts were made but they were unable to contact.

On the 30<sup>th</sup> July 2019 Graham attended the GP again saying his stress around debt continued and had now escalated to him having suicidal thoughts. He said Linda was 31 weeks pregnant. By this point she had changed her mind about the termination after hearing the baby’s heartbeat. Financial difficulties were mentioned by Graham and Linda in mid 2019.

Felix was born in September 2019.

On the 11<sup>th</sup> October 2019 Linda reported Graham had left the address and threatened to take an overdose of tablets. She explained she had caught him cheating on her and told him to leave. In response, Graham went to the kitchen, poured 14 Ramipril tablets - high blood pressure medication - into a drink and said 'I'm going to drink this'. He then walked out. Linda told officers she thought he had said it for effect as he had done similar previously. She did not think he would follow through with it. Graham returned as officers were leaving. He confirmed he had not taken the overdose. Police reported both

Graham and Linda as being civil to each other and Graham agreed to leave the address for the night.

Contact was had between Linda and the Perinatal Mental Health Service (PPIMHS). She told them about the police incidents and how she felt emotionally blackmailed by him. He had threatened to kill himself after she had found messages to other women and couldn't accept the relationship was over. She said his own family were no longer supporting him and she felt let down by her in-laws. Linda said she had fleeting thoughts of suicide. The midwifery team told PPMISH how Felix had fallen from Linda's arms and hit their head on the floor.

After these incidents the Health Visitor received an email from the Community Solutions Relationship (Early Help) manager who said they had advised Linda of actions she should follow to address her ongoing housing issues and that it would not open to their service. It appeared it was being seen as a housing issue only. This clearly was not the case and is a significant missed opportunity. This decision was correctly challenged by the health visiting team and escalated to a team leader. Within the LBB Social Care record there is no mention of domestic abuse and it appears this was not being seen through the lens of domestic abuse, despite the previous interactions LBB Social Care had had with the family.

The Covid 19 global pandemic arrived in the UK in March 2020. Services across the country adapted to these uncertain times, changing their contact methods to predominantly online and phone contact to reduce the risk of spreading infection.

In August 2020 Graham attended the GP. He disclosed not feeling as though he was in the right body which was contributing to him feeling 'depressed' and leading to him having thoughts of self-harm. Graham was advised to contact the IAPT and signposted. This DHR has not been able to explore in any depth the potential link between this and Graham's behaviour towards Linda.

There was minimal contact with Linda through 2020 with the Perinatal Parent Infant Mental Health Service closing 1 year as per their protocol. The Health Visitor attempted to visit in November 2020 but Linda responded - "How dare you come to my home". She said her children were in a high-risk category and she did not wish to see anybody during a pandemic. She did not understand why they needed to be seen after a long period of not being seen.

On the 30th January 2021 police received a call to attend Linda and Graham's address. Linda told police there was no legal child contact arrangement regarding their two children but they'd agreed between them for Graham to see the children once a week, or take them to his mother's address. Linda said she would occasionally allow Graham to sleep on the sofa so he could put the children to bed and be there for them in the morning.

On this occasion Graham had turned up with the intention of taking their youngest child Felix in his car, driving around and then falling asleep in the car. Linda felt this was

unacceptable so refused. Graham then refused to leave, which she said he had done several times before. She said he had previously searched drawers for proof she had a new partner. Linda told police she was single and this was Graham struggling to come to terms with the separation.

Linda asked police for advice. She said she was seeking a divorce on the grounds of infidelity, but she did not have the funds to proceed. She said she had previously tried to obtain an injunction but did not follow through with it. Police offered to make a referral to the National Centre for Domestic Violence (NCDV) at the scene which Linda accepted.

A week later Graham called the police reporting his wife “had bipolar and whenever we have an argument she tells me to get out and threatens to call the police”. The police write up noted “this seems to be a verbal argument between partners with no offences. Report can now be closed.” Graham said that in the past Linda had attacked him, resulting in him being scratched and bitten.

Due to police contact and associated concern, Social Care began assessing the situation again in February 2021. The Social Worker met the couple’s eldest child Freddy who was recorded as saying: “Daddy got arrested, he was strangling mummy, I did not see him do it. Mummy told me that he wanted to strangle mummy because they argue sometimes when they are together. They always argue, I shout stop arguing, they say they’re just having a discussion.”

Linda told the Social Worker Graham was visiting the home but refusing to leave. She said he would bring his washing to the home for Linda to do. She felt he behaved like they were still in a relationship. She alleged he would constantly message other women and would meet them online. She said he’d been unfaithful from the start of their marriage. He would often make out Linda was 'crazy.' He would call her mentally unstable. She described controlling behaviour, such as him tracking if she had been online. She said he would change her email address and password for Facebook.

In April 2021 the Social Worker assessment noted that despite Graham and Linda being separated there continued to be a high level of manipulation and coercion where Graham was “constantly invading Linda’s space under the guise of only wanting to see the children in the family home.” Additionally, Linda admitted she normalised the conflict and 'just got on with it.' Regarding Linda’s mental health, Linda said she did attend counselling but due to being constantly questioned about her sessions by Graham she eventually stopped attending. He would want to know if she spoke about him during the sessions.

As a result of this assessment a Child In Need (CIN) plan was recommended and the Social Worker was directed to refer to MARAC which never happened, in fact no agency ever referred to MARAC. There was an action for Refuge to assist Linda in obtaining a “legal order and housing move”. This is the only time consideration is given to orders such as an occupation order or child arrangement order.

It is noted how Graham resisted engagement with the Social Worker and did not see himself as someone with a domestic abuse issue. He did not accept he had caused harm to Linda.

As part of this DHR, Refuge reflected upon their engagement and felt Social Services had been quite insistent Refuge work with Linda and they felt there was pressure on her to do so. Linda moved to a refuge space with her two children in mid-April. Graham contacted the police saying he felt she had moved to a refuge space out of malice.

Five weeks after moving into the refuge Linda was evicted for aggression towards staff. There was also a concern Graham had been picking the children up from the address for contact. Safer Accommodation Hertsmere and Women's Refuge (SAHWR) were unable to access any records due to losing all data on their systems. Staff were interviewed and stated Linda was asked to clean the refuge, along with other residents, due to the "mess caused by all residents". She then "became volatile, threatening violence and abuse towards a member of staff". A voice note left by Linda to her friends was listened to as part of this review. In it Linda states she was asked to clear up mice droppings and there were ants. She refused and was given a warning. She felt staff were patronising towards her. Soon after this was told she would need to leave the accommodation with 2 hours' notice.

On the 4<sup>th</sup> June 2021, a multiagency safeguarding hub (MASH) referral was received from SAHWR informing them Linda and the children had been evicted and placed in temporary accommodation in the St. Albans area. This triggered a Social Care assessment to see if the parents required additional support to meet the needs of the children. Assessments of this nature include considerations for the emotional needs of children.

Linda told Social Services in Hertfordshire she had split with Graham a year previously due to "constant arguments" and that he was on the same tenancy. He had refused to leave the tenancy. She said the Social Worker in Dagenham had spoken to Freddy who had disclosed seeing his father strangle his mother. As a result of this, Linda was told by Social Services in Barking and Dagenham she would have to leave the home address. She disclosed "a few years of domestic violence" and said Graham had been manipulative.

A mental health assessment in Hertfordshire concluded Linda could not be offered a service until she registered with a GP. Once she did this the GP could refer her back in for support or she could refer herself. This was one of a number of occasions when Linda was denied a service or signposted to alternative provision. The Adult Mental Health team advised the review this was not in line with policy and have since sent the following advice to staff: *when considering referrals where a request for social care assessment or adult safeguarding as prescribed by the Care Act 2014 is indicated, acceptance of the referral should be based on the adult's place of ordinary residence, regardless of whether or not the person has a registered GP in that area. This differs to our health functions as an organisation, but is necessary for us to execute our delegated functions from the County Council.*

It is unknown how impactful this decision was on the presence of the AMHT at the Social Care strategy meeting which was held in early July but they were not present. A Child and Family Assessment concluded with a recommendation for Intensive Family Support Team (IFST) involvement which is consent based. They recommended the following:

- *Domestic abuse work to be completed work with the parents*
- *Emotional support for Linda*
- *Support around boundaries for Linda as she can struggle with Freddy's behaviour at times*
- *Financial support for Linda if needed*
- *To support parents to get Felix a preschool place*
- *To signpost/encourage Linda to attend activity sessions so she is not as isolated in the new area*
- *To support Linda to liaise with housing around her homeless application”*

Soon after this decision the parents disengaged from support despite several attempts by the IFST to engage. There was no challenge from partner agencies such as the Health Visitor around this decision and consequently, 4 months after moving to Hertfordshire, Linda was only in contact with the school and some brief interactions with housing as she looked to move from her temporary accommodation.

Linda did register with a GP in early 2022. She had two appointments with them. One was due to Felix having a cough whilst at the same time she asked for details of the sexual health clinic. She stated this was because of the breakdown of her relationship with ‘partners’. It is believed Linda had begun a new relationship at this time and it is likely, from information received he had moved into the house around Feb / March 2022.

Linda contacted the surgery again in April 2022 to discuss her mental health medication. She informed the GP she had been a victim of domestic abuse previously. It was noted her current medication as being sufficient. She was reportedly taking 150 mg venlafaxine. A note on file said this was “efficient”.

There is a significant lack of information about Linda’s new partner but her friends gave the following information: Linda began a new relationship with a man she met on TikTok who was described as narcissistic and controlling. He potentially had a cocaine issue and Linda began asking her friends for money which was uncharacteristic. He was critical of her and her appearance and displayed similar controlling traits to that displayed by Graham.

On a day in May 2022 at approximately 7:30pm Hertfordshire Police received a call from the East of England Ambulance Service reporting Linda had been found hanging at her home address. Graham had called the ambulance after returning to Linda’s home address with the children following child contact and found her.

During the police investigation Linda’s new partner was spoken to. He said on the weekend in question Linda had upset his friend’s daughter by making some comments

which made the daughter uncomfortable. This had led to the daughter saying she did not want to see Linda anymore. As a result, Linda wasn't invited to a BBQ that happened on the day she took her life.

Linda's thought book was later found. In that entry she referenced the incident at the BBQ and her belief that her boyfriend's family "NOW HATE ME". She also referenced having "NOTHING GOING FOR ME" and "NO ACTUAL CAREER". She appeared to believe she had spoiled the chance of her children being part of a new, extended family, "KIDS WERE ALL I HAD. RUINING IT FOR THEM IS ENOUGH".

The last lines of the entry made mention of "GET LETTERS DONE BY SUNDAY" along with a list of names which included her current boyfriend, Graham, her mother and her children. The final lines read as follows: "WHOEVER READS THIS I AM SORRY. THIS IS MY THOUGHT BOOK AND AS YOU CAN SEE I'M BEYOND HELP".

Linda died in hospital four days after she had been found by Graham.

Social care assessed the situation post Linda's death and concluded there was no requirement for further input. They made the following recommendations:

- *A referral to the Family centre has been made for emotional support for Graham and the children*
- *The Health Visitor and school nurse to consider what emotional support/advice around bereavement for children can be provided to the family.*
- *School to liaise with Graham around emotional support for Freddy and any support which can be offered in school if he is struggling.*
- *Graham to speak with his GP around support for his own emotional needs and for therapeutic support to be considered for him.*
- *A Families First Assessment to be considered so all agencies including school, health and Family Centre can work together to support the family.*
- *A letter to housing will be provided by Children's Services prior to closure to advise that it is in the children's best interest to remain in their home.*

### **3. Parallel reviews**

The Coroner's Inquest concluded death by suicide in June 2022.

Police enquiries did not lead to any investigations of Graham, his historic abuse of Linda nor his involvement in her death. The Police are categorical that Graham had no part in Linda's death.

#### 4. Domestic Homicide Review Panel

The following agencies and individuals were on the DHR panel:

<b>Name</b>	<b>Organisation</b>	<b>Job title</b>
Christian Brazier	Independent	Independent Chair and Author
Ildiko Cseri	Hertfordshire County Council, Strategic Partnership team	Commissioning and Monitoring Officer
Carol Harwood	Hertfordshire County Council, Strategic Partnership team	Business Support Officer
Carol Gayle	Herts Community NHS Trust	Safeguarding Children Nurse Manager
Catherine Mcarevey	Herts and West Essex ICB	Professional Nurse Advocate Lead and Specialist Safeguarding Practitioner
Katherine Johnson	Safeguarding Lead, HPFT	Professional Lead for Safeguarding Adults (MARAC lead)
Neil Kieran	Community Protection, St Albans Council	Principal Emergency Planning and Community Safety Officer
Kingsline Savarier	Children's Social Services, Hertfordshire County Council	Service Manager, Family Safeguarding West
Viran Wiltshire	Metropolitan Police	Detective Sergeant, Review Officer, Specialist Crime
Liz Perry	Safer Accommodation Hertsmere and Women's Refuge (SAHWR)	Manager
Louise Bayston	Refuge	Senior Operations Manager
Terri Heredia	Hertfordshire Police	Lead Officer for Hertfordshire Police Joint Child Protection Investigation Team and the Safeguarding Hub
Frank McSheffrey	London Borough of Barking and Dagenham Children's Social Care	Safeguarding and Quality Assurance, LBBD

Toni Pankhurst	North East London Foundation Trust	Specialist Safeguarding Children's Advisor, Barking & Dagenham and Havering, NELFT Corporate Services
Therese Drummond	Hertfordshire Partnership University NHS Foundation Trust (HPFT) <sup>10</sup>	Specialist Safeguarding Practitioner.

Many of the agencies were contacted separately via e-mail to clarify points or had separate video call meetings to talk through pertinent issues. None of the representatives at the panel, nor authors of the IMRs, had any direct involvement with the family.

## 5. Independence

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

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

## 6. Terms of Reference and Scope

During the initial panel meeting on 22nd September 2023 it was agreed for the scoping period to begin from November 2013, the date of the first police contact, to October 2022. The latter date is five months after Linda's death. It was agreed this was an opportunity to look at the care and support offered to families, specifically children where a parent has taken their own life and domestic abuse has been known.

Key Lines of Enquiry were as follows:

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<sup>10</sup> Hertfordshire Partnership University NHS Foundation Trust (HPFT) - provide mental health and learning disabilities inpatient care and treatment in the community for young people, adults and older people in Hertfordshire. Within Hertfordshire, HPFT also deliver Social Care and Safeguarding under the Care Act 2014 to Adults and Older Adults with functional mental health conditions.

These were points identified as being particularly pertinent to explore:

- What is known about the six months prior to Linda's death where contact with professionals reduces and Linda reportedly enters a new relationship?
- Police contacts with Linda and Graham between 2013 and 2022, in particular but not solely the contacts between January and April 2021.
- Linda's time at the refuge and how concerns regarding Graham's contact with her was risk assessed and managed.
- The decision to evict Linda and her children from the refuge and what plans were put in place by services to address isolation, ongoing domestic abuse, financial independence and any other issue related to fleeing an abusive relationship.
- How Linda's mental health needs were addressed and understood within the context of an abusive relationship.
- Whether opportunities were available to discuss domestic abuse perpetration intervention with Graham.

## **7. Confidentiality and dissemination**

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

To protect the identity of the deceased and her family, a pseudonym of Linda was chosen by her friends. Further pseudonyms were chosen the chair.

## **8. Methodology**

8.1 The agencies listed below submitted an Individual Management Review:

### **Barking and Dagenham**

- Metropolitan Police
- Children's Social Care
- NELFT
- GP

### **Fleeing to refuge**

- Refuge (short Report)
- SAHWR

### **Hertfordshire**

- Health visiting
- Children's Social Care

Summary of engagements / contributions were requested and gained from:

- The children's school in Hertfordshire
- Women's Outreach (Barking and Dagenham)
- Family Centre in Hertfordshire
- Hertfordshire Police
- Victim Support – Barking and Dagenham (nothing known)
- Women's Outreach – Barking and Dagenham
- Citizens Advice Bureau (nothing known)

This report is an anthology of information and facts gathered from:

- The Individual Management Reviews (IMRs) and short reports
- The Police Senior Investigating Officer
- DHR Panel discussions
- Information from friends.

Hertfordshire Community Safety Partnership and the London Borough of Barking and Dagenham are responsible for monitoring the implementation of the action plan.

### **Involvement of family and friends**

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

Linda's mother Mary (pseudonym) was contacted in September 2023. During a brief call with the DHR chair, the DHR process was explained, and Mary gave it her blessing. A letter was also sent. After this, no further phone calls were responded to. The chair contacted Mary via e-mail to give her monthly updates. On one of these e-mails Mary responded and said she would be happy for an AAFDA (Advocacy After Fatal Domestic Abuse) referral. AAFDA attempted to contact but were unable to gain any engagement with Mary.

During the course of the review LBBDD Mental Health Services attended the panel meetings and identified Mary was open to them. As a result, the chair met with Mary's mental health key worker and manager to explain the DHR process and ask that Mary's engagement be revisited. It was made clear engagement is entirely voluntary. Mary asked for time to re-consider but no further progress was made.

Additionally, LBBD Mental Health Service identified from one of their notes that Linda had described having a friend as a birthing partner. Attempts were made to identify this friend via the midwifery team at Newham Hospital but this proved unsuccessful.

It was also noted Linda had a friend who was a police officer. Discussions were had with the Metropolitan Police to try and identify this friend but due to the historical nature of the case note it was felt unlikely to reveal any new contacts.

The panel discussed the importance of engaging with the paternal side of the family, especially given how heavily they feature during the course of the review. However, it was clear early on that Graham currently has sole custody of the two children and therefore speaking to him in the context of a DHR needed to be managed carefully and sensitively. The DHR's purpose could be easily misconstrued and with his mental health situation currently unknown the panel felt they lacked the necessary information to make a clear judgement. Upon speaking to the children's school they said there were no agencies working with the family and they had found engagement with Graham difficult. They had previously sought advice from children's services but their concerns had not met the threshold for further referrals. This was addressed once more during the panel meeting and the social services representative had a direct conversation with the school. This did not change the outcome and social services confirmed their concerns did not meet the threshold for non-consent based support. They discussed with the chair how Graham had declined any support from the school and they had no power to intervene further. Therefore, no contact was made with Graham and he is unaware of this DHR.

Linda was reported to have begun a new relationship 3 / 4 months prior to her death. A statement had been taken from this man just after Linda died. The police reported he had been difficult to engage and had not wanted to give any further information including his contact details.

Towards the end of the review period two further friends of Linda's were identified. They were contacted and were keen to give their insight to the review panel. This has proved immensely valuable and is below:

Contact with Linda's friends Brenda and Patricia (pseudonyms chosen by the friends)

### **Friend's Contribution**

Brenda and Patricia knew Linda since Year 7 of secondary school when they were 11 years old. They affectionately described her as a weirdo and strange but in a loving and humorous sense. The friend's shared an edgy sense of humour which was often used as a coping mechanism in relation to traumatic experiences. Over the years they formed a

close and tightknit bond with their shared sense of humour and regular communication even when life, work and children got in the way.

They described Linda as broken in reference to the trauma she experienced as a child. Despite this she tried to make those around her happy. She was an excellent mother and always wanted to be a mum as long as her friends could remember. Linda gave her children the creative and imaginative freedom to go and express themselves, something that will always be a part of them due to Linda. She had hopes of becoming a midwife but was also talented with regards to hair and makeup. Linda wanted to make sure nobody went through what she went through.

Despite the use of humour within the group Linda would always be open with her feelings to her friends. She would often state she felt like a burden. Brenda recalled first seeing Linda self harm in a class at school at the age of 11. Linda had on / off struggles with self harm up until she died and her friends feel this was to cope with the trauma and neglect she experienced in her childhood as well as complex troubling thoughts. They were well aware Linda spent time in foster care and had many abusive and difficult experiences with her family situation. They felt that at times she needed to externalise and see her pain through self-harming.

An ex-partner of one of the friends described being a witness at Linda and Graham's wedding in 2014. They regretted doing this as they had already witnessed abusive behaviour but felt obliged to.

The friends felt the couple relied on each other in an unhealthy way. They summarised this by saying, "if no one has ever loved you, you don't know how to love back". Abusive behaviour was apparent very early on. They used the term trauma bond and explained how Linda was bonded to Graham in this way, how if this is all you know, you are more likely to go back. They felt Graham could not help but insert himself into her life at any opportunity and would not leave her alone. He was critical of her parenting and would blame any and all issues on her mental health.

They spoke of Graham messaging Linda and threatening to take her to court and take the children away if Linda ever left him. He made her think she wasn't a good mum and her mental health was the root of all issues. They felt Graham could be very full on and would make everything about him. The abuse, especially the emotional aspect, culminated in Linda feeling she had no choice but to flee the area she grew up in. However, even then Graham could not let her be as he continued to be a factor in her life. They felt the word suffocating summed his behaviour up. They reported how Graham did not like socialising with them and took a particular dislike to Brenda.

The friends queried why Linda had to move so far away. They said, if she had moved to Essex she would have been a short train ride away and the friends could have found it easier to support each other. They felt she had nobody in her new area and this was significant for her.

Linda spoke to her friends about going to refuge. They described Linda as a clean freak and detailed idiosyncrasies such as Linda not liking the TV volume on an uneven number. So, when Linda mentioned mice and ants in the refuge they felt this would have a significant impact on her. Linda spoke to them about being evicted stating she'd had a warning for refusing to tidy up and received another warning soon after which lead to her eviction. They felt this type of accommodation was not appropriate for her and Linda reported feeling patronised by staff.

This review has found very little information in regards to the second relationship Linda became involved with in Hertfordshire shortly before her death. Her friends believe she met this man on TikTok and described him as unhinged, someone who used cocaine and was a narcissist. They described similar behaviour as Linda had experienced with Graham. If Linda made an effort to look nice her new partner would call her a slag, he would call her ugly, he contacted other girls and when Linda questioned him he would call her crazy and put her down. In March 2022 Linda had what the friends described as a breakdown. They said she contacted Samaritans but found them to be unhelpful. They reported she also had contact with MIND. Not long after this they felt her behaviour started to change. She began asking for money, £30 at a time which was unusual for Linda. The friends were concerned this was to fund her new partner's drug habit.

With regards to the support Linda was offered over the years the friends felt she was mainly offered medication with very little additional support. They felt there was an over reliance on medication generally. They felt this was unhelpful as Linda had experienced so much trauma in childhood she needed long term therapeutic input.

Brenda and Patricia have bought a star and named it after Linda. They hope one day to be able to give this to Linda's children. Their contact with the children has not been facilitated since Linda died.

## 9. Equality and diversity

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

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

Those considered relevant to this review are:

**Sex** - In considering the above characteristics the panel felt sex was a significant factor. Domestic abuse and domestic homicide are crimes that disproportionately affect

women. Women make up the majority of victims and with the majority of perpetrators being male. For the year ending March 2023, the Crime Survey for England and Wales (CSEW) estimated that 1.4 million women and 751,000 men aged 16 years and over experienced domestic abuse in the last year. This is a prevalence rate of approximately 6 in 100 women and 3 in 100 men. <sup>11</sup>This fact does not diminish the importance of addressing same sex domestic abuse, familial abuse or any other form of domestic abuse but is important to consider and is relevant to this review. Sex can and does impact severity and type of abuse with women much more likely to be seriously hurt or killed. (Walby and Towers, 2018; Walby and Allen, 2004)

Furthermore, in a review of the 32 published Domestic Homicide Reviews (DHRs) where a victim had taken their own life, 25 of the 32 victims were female. <sup>12</sup>

**Pregnancy and maternity** – During the scoping period Linda twice became pregnant and gave birth. Graham placed pressure on Linda not to have contraception and this resulted in him upsetting her at the doctor's surgery which was recorded on the GP records.

**Disability** - On one self-assessment form Linda considered herself to have a disability due to her mental health. To the knowledge of this review Linda did not have official diagnosis of bipolar which she and Graham stated she had. However, she asked for help and support on numerous occasions due to her struggles with mental health and Graham often blamed their issues on this. It was clearly a significant area for Linda and one which required a domestic abuse and trauma informed Lense to truly understand.

**Marriage and Civil Partnership** – From at least 2017 Linda stated she no longer wished to be married or in a relationship with Graham. Aswell as the housing situation being a barrier to separation both Graham and Linda had very different views on divorce with Graham not wishing to have one but Linda voicing a want to be separated. She articulated this to agencies who signposted for advice. She reported not being able to afford a divorce

Additional consideration:

**Identity** – Although slightly out of the scope of these protected characteristics it is worth noting that Graham mentioned to the GP he felt as though he was in the wrong body. Signposting occurred but little else is known with no evidence of longer term intervention. This may well have had an impact on Graham's self-identity and how comfortable he felt with who he was. This may have relevance for how he functioned in relationships. Although we will not be able to gain further insight it is a nuance to consider.

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<sup>11</sup> [Domestic abuse victim characteristics, England and Wales - Office for National Statistics \(ons.gov.uk\)](https://ons.gov.uk/domestic-abuse/victim-characteristics)

<sup>12</sup> [999368 Law Domestic Violence MAIN Research Report Final FINAL PRE-PRINT.pdf \(aafda.org.uk\)](#)

## **10. Conclusions**

- 10.1 Overall, Linda, Graham and their children did not receive the appropriate domestic abuse response from the multi agency networks around them. There are pockets of good practice in isolation with the mental health service in NELFT referring Linda to a domestic abuse service and the Police regularly completing domestic abuse risk assessments.
- 10.2 The array of abusive behaviours from Graham towards Linda were not identified and fully appreciated by the multi agency network. Throughout the scoping period Linda alleged financial control (2013 re electricity ownership, accruing significant debts), physical abuse (non fatal strangulation, punch to head, pulled hair), jealous and controlling behaviours (demands for passwords, tracking online, going through draws to find evidence of infidelity), harassment (turning up at the house and refusing to leave) and threats to kill (threat to crash car / threat to slit throat). This is not an exhaustive list. Opportunities were missed to thoroughly explore domestic abuse by multiple services on multiple occasions. Due to the volume of these opportunities, they have been noted within the full chronology within the overview report.
- 10.3 It appears from this review that mental health / mood assessments are embedded in practice within health visiting and mental health services. There are regular mentions of Linda being assessed as low or medium risk of self harm / suicide by the NELFT. The tact taken to embed these assessments in practice needs to be mirrored with domestic abuse assessment. It is these frontline services who are often able to identify domestic abuse at an early stage and refer to specialist services. The Police were the predominant users of domestic abuse risk assessments either assessing risk of serious harm as standard or medium over the ten year period. Whilst this is good practice it is important for the wider multiagency network to recognise the limitations of relying solely on a police domestic abuse assessment. There can often be fear from victims about getting the perpetrator into trouble. There might also be a worry about abusive repercussions from the partner or consequences from services – such as Social Care intervention. When the police are called there may be a current crisis, heightened emotions and the response officers may never be seen again by the individual. This means rapport and trust has to be built quickly, in the moment by the police. It is often a less than ideal time to complete an assessment. Mental health practitioners, family workers, GPs and health visitors are ideally placed to build a relationship with an individual and allay any concerns about completing an assessment such as a DASH.
- 10.4 There has been reflection as to whether Linda was provided inappropriate housing in refuge for her mental health needs. It is felt she would have functioned better in self-contained accommodation. However, prior to this move happening, had Graham's

behaviour and housing circumstance been a focal point it may not have been necessary to place Linda in refuge accommodation at all. The Housing department play a key role in the decision making process where domestic abuse is present and there is a joint tenancy. As the cost of living crisis shows no sign of abating, it is increasingly difficult for an individual to leave and afford their own accommodation whilst contributing to the family home finances. This is especially true in London. This is a practical reality that can be used by someone using harm as a reason for not leaving a property. It is crucial therefore to support an alleged perpetrator of abuse in finding alternative accommodation where possible and creating a plan around this. The Homes and Money Hub (HMH) had several contacts with Graham prior to Linda fleeing the area. They were aware of Social Services involvement. Social Care were acutely aware of the housing need. Had these services liaised with each other and focussed on the perpetrators housing situation, there may well have been an alternative pathway to consider (please see analysis in overview report for further information). In April 2021 the Domestic Abuse Housing Alliance published a discussion paper exploring the benefits of identifying accommodation for perpetrators of domestic abuse.<sup>13</sup>

- 10.5 Linda clearly felt trapped over many years. She said repeatedly to a variety of professionals how she no longer wished to be in a relationship with Graham. When services became more intensely involved there was not enough practical support or advice to help the couple separate safely and conclusively. Linda was signposted to several agencies but there is no evidence she had contact with Victim Support, Women's Outreach or the Homes and Money Hub.
- 10.6 Bipolar being mentioned within the coroner's report reflects the fact services never truly got a handle on Linda's mental health needs. There is no evidence this was ever diagnosed. This is not to say she didn't have bipolar and as Linda reported herself there were significant mental health issues with her mother and grandmother before her. The longest period of therapy known to the panel was in 2015 and consisted of six attended sessions. There are certainly missed appointments from Linda but there are also periods of engagement and disclosures of personal information and trauma. The number of Linda's adverse childhood experiences she had would have significantly impacted on her and the longer term trauma informed support required was not reflected in the support given. Whilst some services did show flexibility in keeping Linda open, despite several missed appointments, there did not appear to be a longer term therapeutic plan which addressed past trauma and recognised the domestic abuse situation she was in with medication heavily relied upon.

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<sup>13</sup> [accommodation-for-perpetrators-of-domestic-abuse-discussion-paper-apr-21.pdf](https://dahalliance.org.uk/accommodation-for-perpetrators-of-domestic-abuse-discussion-paper-apr-21.pdf)  
([dahalliance.org.uk](https://dahalliance.org.uk))

- 10.7 In the end, the longer term physical separation came from a refuge placement which moved Linda and the children away from Freddy's education and Linda's support networks. Linda was in refuge for 5 weeks before she was evicted after a verbal altercation with a member of staff but also due to continued concerns about Graham being in contact with her and knowing the location of the refuge. Linda declined further support from the refuge placement post eviction. This will always be likely when someone feels aggrieved at being evicted.
- 10.8 Services in Hertfordshire appeared to have assessed continued contact between the parents as safe. This review is about learning and as we now know the outcome we can reflect as to whether there were alternative courses of actions which could be considered in future situations similar to this. The decision to remove Linda from the area she had known her entire life may well have provided her with a new start but perhaps underestimated the significant impact the loss of close connections and services would have. Linda seemed keen on this idea but there were no other ideas forthcoming, such as removing Graham from the tenancy.
- 10.9 Linda did register with a GP but not until March 2022, six months after Social Care and IFST in Hertfordshire had exited. She disclosed previous domestic abuse to the GP and her mental health was known about as she had a medication review. She was assessed as managing on the medication she was given. This was an opportunity to fully explore her needs and past experiences. Had the GP known about Linda's complex circumstances and adverse childhood experiences, this could have been an opportunity to proactively engage her in longer term therapeutic support going forward.
- 10.10 If Graham's disclosure to the police is taken at face value, that days before her death Linda had questioned why nobody loved her, it gives insight into her low view of herself and her perceived value. This is suggested by Linda herself in some of her final words "Kids were all I had, ruining it for them is enough". Linda's friends said she often felt like a burden. She said to a mental health practitioner in 2019 her kids might be better off without her. Her low view of herself was enduring and entrenched. Living with someone who criticises your parenting, your mental health and your looks, to name but a few, would have exacerbated these feelings substantially.
- 10.11 Domestic abuse can strip someone of their identity, their value and their hope. Services can and do play a significant role in supporting someone to recover. When Linda arrived in Hertfordshire she was not just battling the loss of her relationship nor the cumulative impact of the abuse over the previous decade. She had also experienced parental ill mental health since childhood, sexual abuse, financial precarity and undiagnosed mental health issues. She also had an extensive history of sporadic engagement with services. To describe the latter as persistent non-engagement would do a disservice to

the complexity of her situation, especially when considering she disclosed childhood sexual abuse to services on at least two occasions with no long-term therapeutic support offered. In fact, Linda did disclose extremely distressing topics to professionals on more than one occasion. Her sporadic engagement was also a flag for services. Hertfordshire Social Care had assessed the family as not requiring statutory safeguarding and as such consent was needed for longer term support. Had the history been fully taken into account it may well have been identified how likely disengagement from services would have been when Social Care stepped down to IFST.

- 10.12 Given her experiences with Social Care throughout her lifetime Linda would likely have seen Social Care as punitive. The wording of their final letter to her did nothing to dispel this perception. Although IFST made attempts to engage Linda, they too did not fully understand her history. A full understanding of IFST's involvement has been hindered by a lack of recording. There have been no TAF (Team Around the Family) minutes available to this review. The Health Visiting service incorrectly assessed the family as being suitable for universal services. Therefore, 5 months after being evicted from refuge Linda was in a new area without mental health support, not registered with a GP, having not engaged in any work to understand the impact of the domestic abuse and some distance from her friends and family. This review has identified the need to offer an alternative to Social Care and associated services when someone leaves refuge. As her friends reported, Linda reportedly reached out to MIND in Hertfordshire. Had there been a contact connected to her over the 12 months post refuge she may have reached out to them to build a relationship and gain the adequate support. This is further considered within the Lessons Learned and Recommendations section.
- 10.13 Services do attempt to support the family, either as individuals or together, on several occasions over the years. But these attempts do not acknowledge the entrenched nature of the issues or explore the past in the necessary depth. They too often do not risk assess domestic abuse nor do they focus on Graham's use of abuse. They do not name behaviours such as harassment or stalking as a consideration or risk assess its presence. The multi agency collaboration is often over within a matter of weeks rather than an extended period of time. In the records seen there are a lack of SMART goals to address access to the necessary services e.g mental health, domestic abuse. It is imperative services consider Linda's story to help prevent future deaths.

## **11. Key findings and lessons to be learned**

### **Lesson 1**

#### **Narrative**

The decision to move Linda to the county of Hertfordshire perplexed her friends. They felt, had she been moved to the neighbouring county of Essex, the transport links would have allowed them to continue to support Linda more effectively and frequently. Subsequently, their presence in their friend's life diminished as Graham continued to be a significant feature, evidenced by him having a spare key to the property Linda moved to upon her death.

#### **Lesson to be learned**

Fleeing domestic abuse to a refuge is a decision never made lightly and should be a last resort where there is a significant risk of serious harm / death. Where it is deemed necessary, consideration of the transport links, so friends and family have easier access to support their loved one, should be considered. This can be easily assessed via the variety of travel and transport apps available online.

### **Lesson 2**

#### **Narrative**

LBBB Children's Social Services were directed, during an internal supervision, to refer to MARAC at the same time a refuge space was being sought. This did not happen. When Linda moved to refuge and was evicted five weeks later, in part as Graham knew the location and was a continued presence in her life, another opportunity to refer to MARAC was missed. St. Albans housing have also recognised this as an omission on their part. In fact, all services had an opportunity to refer to MARAC but did not. This forum would have highlighted the domestic abuse risk and safety planning would have been discussed.

#### **Lesson to be learned**

Where someone is evicted from a refuge space and there is knowledge of the primary perpetrator's continued presence in the life of the victim, MARAC should be referred to.

### **Lesson 3**

#### **Narrative**

When Linda had contact with a MASH Social Worker in Hertfordshire, the MASH Toolkit was used to better understand the domestic abuse risk. Within this toolkit there are no mentions of DASH, MARAC or MARAC referral processes. The terms stalking and harassment were not used or considered in any assessments or agency meetings.

The warning signs known to Social Care were:

- There had been a non-fatal strangulation 6 months earlier,
- Linda had recently fled to refuge
- She had since been evicted
- Graham was still a significant factor in her life.

The length of their relationship, the challenge of the separation, the controlling nature of many of Graham's actions and its impact on Linda's mental health were not adequately considered and the tools available to MASH staff were inadequate to fully assess this.

### **Lesson to be learned**

Services should utilise tools such as the Safelives DASH to assess risk and consider MARAC and embed these within their toolkits. In this case, professional judgement could have been used to refer to MARAC but there was no mention of this option within the services toolkit.

### **Lesson 4**

#### **Narrative**

The Homes and Money Hub appears to be a positive and helpful initiative in LBB. It supports those who may be particularly vulnerable to navigate often complex systems regarding finances, benefits and housing rights.

In Feb / March 2021 this team attempted to contact Linda but only managed direct contact with Graham. They provided him with two options, one of which was moving back in with Linda. As has been made clear, she had vocalised wanting to separate from Graham since 2017. This team came close to being complicit in Graham's attempts to return to the property. They were aware of Social Care input but neither team communicated with each other. The case worker correctly took this case to supervision seeking advice but there was no check to see whether other agencies were involved.

### **Lesson to be learned**

It's vital a service such as the HMH considers DA within their screening tools. Just as important is to ensure they are linked in with Children's Social Care where cases are open to them.

### **Lesson 5**

#### **Narrative**

An individual moving to refuge, only to be evicted 5 weeks later in part due to the continued presence of the perpetrator, should be seen as the flag it is. When Linda moved to Hertfordshire the exploration of the domestic abuse throughout her relationship was not thorough nor detailed enough. A DASH was not considered, nor was a referral to MARAC. Graham clearly vocalised to Children's Social Care still being in love with Linda and wanting the relationship to continue. This indicated he was

finding the separation difficult and as there were already concerns about DA - this was a warning sign. Whilst the author acknowledges this is a victim suicide, not a homicide, and there is no evidence which suggests Graham nor Linda's new partner were directly responsible, acknowledging the length of time she had lived with controlling behaviour would enable practitioners to focus on their lived experience and the support required. Graham's strength and depth of feeling would be highly unlikely to dissipate within the 8 weeks the family were open for assessment. Likewise, Laura had experienced abusive behaviours all her life and would have required support to understand their impact.

### **Lesson to be learned**

It is important for services to acknowledge the potential for harassment and stalking and name it. Within the whole review period stalking was mentioned only once by Refuge. Had this been named and considered it may well have given more focus to the dynamic that existed and the measures / support required to educate both parents and safeguard the children.

### **Lesson 6**

#### **Narrative**

Once Linda moved to temporary accommodation Social Care assessed and exited deciding safeguarding thresholds were not met for statutory input. Although IFST were referred to, Linda may well have associated them with Social Care and been reluctant to engage based on previous experiences. Within 4 months of coming to Hertfordshire services had closed, Linda had no mental health input and was not registered with a GP. Whilst she was encouraged to engage with services at the Family Centre, a longer term plan was required.

When considering the duration of the controlling behaviour Linda had experienced and her childhood trauma, she could have benefitted from a longer term approach from the voluntary sector. Linda was willing to engage with mental health teams as she completed an assessment only to be told this could not be progressed until she registered with a GP.

### **Lesson to be learned**

The panel have recognised that those fleeing domestic abuse may often have multiple complex needs and could benefit from being open to non-statutory services for at least a 12 month period. This would enable relationships to be built and to ensure victim / survivors can settle in the area. This also gives greater to timeframes to ensure a thorough hand over of information. In this case services exited without Linda being registered with a GP, engaged in mental health support, accessing domestic abuse input nor Graham being engaged with his own domestic abuse support.

### **Lesson 7**

#### **Narrative**

When Linda did register with a GP it was 6 months after agencies had closed, with the exception of Health Visiting and Education. This was an opportunity to fully explore Linda's needs and past experiences.

### **Lesson to be learned**

Where an individual / family relocate due to domestic abuse, the GP in the new area should offer an extended in-person appointment to ensure all needs have been discussed and appropriate local services have been offered.

## **12. Panel Recommendations**

### **Recommendation 1 (Refuge)**

During their assessment, Refuge to consider the individuals access to their support networks to enable friends and family to stay connected.

### **Recommendation 2 (Safer Accommodation)**

Safer accommodation will refer to MARAC where an eviction takes place / someone leaves their accommodation and the perpetrator remains in their lives.

### **Recommendation 3 (Herts Children's Social Care)**

Hertfordshire Social Care will review the practitioner domestic abuse advice within their MASH toolkit. To use learning from this review to consider inclusion of MARAC, DASH with particular reference to using professional judgement, Stalking / Harassment, long term impact of living with DA. This is not an exhaustive list.

### **Recommendation 4**

MARAC must consider hearing cases where an individual has been evicted from refuge and the primary perpetrator continues to contact them. Harassment and stalking must be considered as a potential continued risk.

### **Recommendation 5**

For the risk management sub-group to collate and monitor the number of cases that are referred to MARAC but not accepted. This will enable HCC to identify any themes.

### **Recommendation 6**

For more detailed data around refuge evictions to be collated e.g breaches of tenancy to be broken down to identify themes and learning. This to include data by district.

### **Recommendation 7 (Head of MASH Improvement (LBBB), Partnerships and Emergency Duty Team)**

For the Homes and Money Hub in LBBB to be situated within the MASH and / or be able to identify cases open to Social Care via shared systems to ensure awareness of concerns such as Domestic Abuse.

**Recommendation 8 (CSC)**

Where an individual or family is evicted from refuge and the perpetrator remains in contact with the victim, a strategy meeting should be convened at the earliest opportunity to enable all available information to be shared. Within this forum consideration should be given to the long term impact of living with domestic abuse, stalking and harassment with appropriate risk assessment, risk mitigation plans and interventions considered.

**Recommendation 9**

Where an individual with or without children is evicted from safe accommodation, the provider will complete the MEAM (Make Every Adult Matter) eviction template and will ensure all reasonable steps have been taken prior to eviction, including risk management. This eviction template will be monitored by commissioners at Hertfordshire County Council to ensure suitable onward action has been taken. This process ensures an additional route to that offered via a safeguarding referral, a referral which can often be compromised by someone's previous experiences of Social Care, as is likely to have been the case with Linda.

**Single Agency Recommendations****North East London Foundation Trust (NELFT)****1. Learning Theme**

- Domestic abuse champions network to be utilised and updated with this DHR.

**Action to achieve theme**

- Ensure domestic abuse champions have been identified within Barking and Dagenham area. Clear role and responsibilities with NELFT. Raise Awareness within NELFT of domestic abuse champions

**2. Learning Theme**

- Increase awareness of suicidality in domestic abuse cases

**Action to achieve theme**

- To circulate the 7 minute learning organisation wide.

**3. Learning Theme**

- Professional curiosity training being delivered and Action to achieve theme

**Action to achieve theme**

- Audit of impact of training to be conducted.

#### **4. Learning Theme**

- Level 3 Safeguarding training updated with learning from this review included.

##### **Action to achieve theme**

- Training to be delivered to safeguarding professionals.

#### **5. Learning Theme**

- Relaunch revised protecting children, young people and adult from domestic abuse Standard Operating Procedure (SOP).

##### **Action to achieve theme**

- Through all trust electronic communications

#### **6. Learning to achieve theme**

- Launch of Domestic Abuse Workstream for NELFT 2024 (policy, practice guidance, training, and professional toolkit).

##### **Action to achieve theme**

- Head of Safeguarding and Named Professionals

#### **7. Learning to achieve theme**

- External Domestic Abuse Training is being provided through NELFT.

##### **Action to achieve theme**

- Practitioners and clinicians to engage in training.

### **London Borough of Barking and Dagenham Children's Social Care**

#### **1. Learning Theme**

- LBBD Continuum of need to be reviewed with MASH and Early Help to ascertain what would happen should a similar context as the children's and Linda's be referred now, where there are clear elements of coercive control.

- Early Help will have necessary training and practitioner/manager knowledge and expertise to address risk effectively around DA.

#### **Actions to achieve theme**

- MASH and EH (Early Help) managers and (where relevant) staff will meet to discuss this IMR as part of a learning/good practice workshop, with reference to the new continuum of need document. They will consider processes and knowledge required to address similar contexts- what would be different and how would this look? Also, to identify if there still any gaps in working knowledge or referral/step across processes and related procedures which govern work with DA and coercive control? How will these be resolved?

### **2. Learning Theme**

- A focus and review of current policies and pathways which seek to understand the nature of declined mental health within the context of DA/coercive control; what are the agency pathways to address this currently within LBBB, do practitioners know how to recognise the links and analyse impact?

#### **Actions to achieve theme**

- PSW and DA Lead to include reference to relevant processes, knowledge, procedures, and policies/legislation involving addressing mental health within the context of DA, in their learning review for managers. This learning to be disseminated to CSC staff by line managers within team meetings with relevant resources communicated.
- IMR / DHR to go to One panel (or other relevant partner forum such as SP learning group), whereby the multi-agency response to addressing mental health within the context of DA and coercive control will be discussed, with highlight of multi-agency/disciplinary response and any gaps present.

### **3. Learning Theme**

- Work is already ongoing around child sexual abuse. LBBB will explore the impact of Linda's previous sexual abuse and the vulnerabilities which this opened up with reference to DA and coercive control and try and utilise Linda's story for learning purposes.

#### **Action to achieve theme**

- Consideration as to the links between DA and previous significant trauma. We will look at how many referrals for children to the CSA hub have ongoing DA occurring and how we make sense of this, also how we work with survivors to help them understand trauma and so minimise future traumatic relationships.

#### 4. Learning Theme

- A focus on the use of professional curiosity for MASH and EH practitioners; what does this look like, how is it recorded and what are the safeguards to challenge, and quality assure this?

##### **Action to achieve theme**

- Within the context of service meetings, EH and MASH need to have the uses of professional curiosity as a regular agenda item, developing ways to measure this as part of management oversight- defining how does QA of this look? What are the agreed items which can be used to measure and evidence this? How do managers lead on this and what support do they need?
- Along with inclusion of professional curiosity in the assessment processes for both MASH and EH (i.e., the collation of information for the MASH inquiry from partners and the EH assessment completed by the EH worker), the MASH inquiry record and analysis work, including subsequent management decision completed by SW's/managers must evidence how professional curiosity is being used, what is the language of this and what are the potential obstacles-how are these recorded and analysed as gaps regarding risk? What decisions are then being made?

#### 5. Learning Theme

- LBBD Assessment service to indicate which risk assessment tools they are actively using to assess DA, when these are started and how they inform further planning, and the role of referring to MARAC, if this is understood and the positioning of MARAC in conjunction to CSC.

##### **Action to achieve theme**

- Assessment managers need to indicate which tools they currently use, and at which agreed points in the assessment process, how these are included in management oversight and are then analysed for decision making regarding risk. How are practitioners trained to use these and what is the role of managers in holding oversight?

#### 6. Learning Theme

- Assessment managers need to indicate which tools they currently use, and at which agreed points in the assessment process, how these are included in management oversight and are then analysed for decision making regarding risk.

How are practitioners trained to use these and what is the role of managers in holding oversight?

**Action to achieve theme**

- Furthermore, a comprehensive overview of how MARAC currently features in the assessment process, when the need for escalating risk is noted. What are the processes for involving MARAC, do practitioners have the appropriate knowledge of MARAC to know when to refer and what this means? How are managers reviewing this during their supervision. Numbers of current MARAC referrals and the context of these referrals would be a useful statistic here.

**7. Learning Theme**

- LBBB Assessment to separately review and respond to this IMR within the context of how chronologies consider EH involvement when completing a comprehensive assessment of need; to also comment on the use of two systems, EHM and LCS, whether this is problematic.

**Action to achieve theme**

- Assessment staff need to improve the quality of chronologies on the child's file, to know best practice about how these are formatted and updated. They need to attend regular training and chiefly include all EH and other external prior involvement in the chronology. The lack of this professional curiosity means assessments remain incomplete with inaccurate risk assessment.
- Assessment managers to provide a review of the strengths and obstacles in obtaining accurate EH information and including this in a timely manner in the child's assessment. What are the solutions to any obstacles they see?

**8. Learning Theme**

- The need for some clear protocols about how family strengths are used within contexts of DA and complex risk and what the role of FGC's could be especially at an EH stage.

**Action to achieve theme**

- Family's need the earliest possible intervention where DA is identified, specifically evidence of coercive controlling behaviours. Children need to know that there is family support identified to help increase parental capacity and reduce risks, so permanency can be stabilised. This needs to be seen within a strengths-based approach to working preventatively.

**9. Learning Theme**

- In the presence of “drip-fed” police information, critical for piecing together increased patterns of DA and coercive control, a review of how police information is regularly fed back to services, other than when checks are made/contacts happen.

#### **Action to achieve theme**

- Police information is vital in correctly informing ongoing cumulative risk assessment for the child. The lack of chronologising this information is problematic and implies gaps in our assessment. Staff need to regularly access this information using an approach which builds on patterns of harm, adding this to the child’s chronology-this needs to be reviewed by the manager during supervision.

### **10. Learning Theme**

- A learning review of Linda and the children’s context to be led by LBBD DA Lead Angela D’Urso and PSW Russ Bellenie, using this IMR to look at current policies and pathways aimed at providing protection for women like Linda and children like Freddy and Felix

#### **Action to achieve theme**

- Staff across CSC need to know how Linda and the children’s context can be used to promote learning in the areas of DA and coercive control. They need to know the areas of improvement in these areas and what their role is in addressing and successfully analysing these elements in ongoing planning. This could be as part of a One panel implemented review.

## **Hertfordshire Health Visiting Service**

### **1. Learning Theme**

- Awareness raising to further highlight DA risk assessment including, concerns regarding information received from another county/ area around DA. To include awareness around the impact of parental ACE’s on current risk.

#### **Actions to achieve theme**

- Embed learning around DA risk assessment in Safeguarding Children training.
- For HCT practitioners to use the DASH risk assessment tool more consistently as part of understanding wider risk around DA.
- Circulate reminder widely through our electronic communications systems to all in HCT.
- Cascade to Senior Managers within PHN for cascade down
- Shared at Safeguarding Children Forum as formal safeguarding governance and assurance mechanism.
- DA Champions use training opportunities within PHN teams to reinforce
- Circulated in Safeguarding Children newsletter

## 8. Learning Theme

- Awareness raising to ensure that professional curiosity and challenge continues to be embedded in practice within HCT especially in respect of previous DA history to support robust risk assessment and SMART action planning. This is supported by the Assessing Risk and vulnerability training.

### Actions to achieve theme

- To reiterate the importance of Professional curiosity and challenge in the Safeguarding newsletter.
- The Safeguarding Children lead to review Assessing Risk and vulnerability training.
- To continue to encourage all HCT practitioners who have contact with children to attend Assessing risk and vulnerability training.
- To promote the importance of communication and information sharing with professional networks, including the GP and other health services and partner agencies.

## 9. Learning Theme

- To remind staff of the importance of bringing vulnerable and complex cases to scheduled safeguarding supervision sessions and accessing ad hoc supervision from Safeguarding Duty nurse.

### Actions to achieve theme

- To embed learning in Safeguarding Children training.
- To circulate a reminder widely through our electronic communications systems to all in HCT.
- Cascade learning to Senior Managers within PHN for cascade.
- Shared at SGC Forum as formal safeguarding governance and assurance mechanism.
- Supervisors reinforce at safeguarding supervision sessions and actively enquire regarding cases which may not reach statutory threshold.

## 10. Learning Theme

- To ensure all records are maintained contemporaneously and in line with HCT Record Keeping Policy and Guidance, including updating groups and relationships, PR of other care givers and insertion of the DA and vulnerable child icon.

### Actions to achieve theme

- Continue to embed in Level 3 Safeguarding training.
- Continue to embed in DA and record keeping policies.
- Circulated reminder widely through our electronic communications systems to all in HCT.

- Cascade learning to Senior Managers within PHN for cascade.
- Shared at SGC Forum as formal safeguarding governance and assurance mechanism.

### **11. Learning theme**

- To ensure that the voice of the child (VOC) is recorded and understood in the context of living in a household whereby domestic abuse has been a significant feature.

#### **Actions to achieve theme**

- To embed VOC within all record keeping and documentation and within training.
- Circulate reminder of importance of capturing VOC widely through all electronic communications platforms.
- To ensure records from out of area/County are received and reviewed as per the Movement in process SOP and flow chart.
- To circulate a reminder widely through our electronic communications systems to all in HCT.
- Senior Managers within PHN for cascade down
- Shared at SGC Forum as formal safeguarding governance and assurance mechanism.
- DA Champions use training opportunities within PHN teams to reinforce.

### **12. Learning Theme**

- To ensure that all HCT practitioners continue to work in line with DA policy and Refuge SOP to support victims of domestic abuse.

#### **Actions to achieve theme**

- DA audit to continue to monitor compliance to DA policy.
- DA champions to use training opportunities to cascade any updates to DA policy and learnings from audit.

### **13. Learning Theme**

- Awareness raising around the escalation and challenge process when there is professional disagreement around case progression.

#### **Actions to achieve theme**

- HCT practitioners to work in line with HSCP Escalation policy and challenge any decisions made whereby there may be professional disagreement supported by Safeguarding Children Team.
- Circulate reminder widely through all electronic communications platforms.

## **Mental Health – Hertfordshire**

### 1. Learning Theme

- HPFT Domestic Abuse Resource Pack to include learning from this DHR

#### **Action to achieve theme**

- Resource pack to be developed and shared across all HPFT staff

### 2. Learning Theme

- Routine Enquiry to be used more consistently.

#### **Action to achieve theme**

- Routine Enquiry training to be developed and rolled out trust wide

### 3. Learning Theme

- Staff seek supervision/ escalation when appropriate, especially in domestic abuse context.

#### **Action to achieve theme**

- Basic Safeguarding adults and children training to include information on supervision/ escalation

### 4. Learning Theme

- Completion of DASH Risk Assessment and referral to MARAC

#### **Action to achieve them**

- All HPFT Domestic Abuse training to include info on DASH/ MARAC
- Hertfordshire MARAC guidance to be circulated to teams re: MARAC referral process

### 5. Learning Theme

- Domestic Abuse training to be developed with learning from this review incorporated.

#### **Action to achieve theme**

- HPFT Domestic Abuse training programme to include standalone sessions on coercive control, strangulation and suicide
- All Domestic Abuse webinars to include information on Coercion and Control, Strangulation and Suicide