Domestic Homicide Review

St. Albans Community Safety Partnership

Linda

Born: July 1993

Died: May 2022

Chair and Author: Christian Brazier

Date of completion: 14th June 2024

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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 he 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 xoxo

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 their friend shone through during the review process.

Section One

Summary of Circumstances leading to the review:

1.1.1 On a day in May 2022, Linda was found unconscious in the bathroom of her home address in Hertfordshire by her ex-partner Graham and their 6 year old son Freddy. She was transported via ambulance to hospital where she died 4 days later. A police investigation concluded Linda had ended her life via hanging.

1.1.2 Linda and Graham had been in a relationship since at least 2013 when Linda was 20 years of age and Graham 21 and were later married. They had two children together. Police information highlighted 11 police contacts due to reports of domestic abuse and welfare checks from November 2013 – April 2021. Alleged domestic abuse related calls concerned Graham using controlling and jealous behavior, threats to kill, strangulation on two occasions and potential economic abuse towards Linda. Police welfare checks related to concerns about each other's mental health.

1.1.3 Linda and Graham lived in the Barking and Dagenham area for the majority of their lives until Linda fled to refuge in Hertfordshire with their two young children in April 2021. She was evicted five weeks later due to reported aggressive behavior towards staff and continued contact with Graham. She then moved into temporary accommodation, also within Hertfordshire.

1.1.4 Summary of engagement forms from agencies highlighted both Graham and Linda as having mental health services input during their time in the London Borough of Barking and Dagenham (LBBD). It also highlighted Children's Social Care involvement in both LBBD and Hertfordshire.

1.1.5 In addition to agency involvement the review will examine the past to identify any relevant background information prior to Linda ending her life, whether support was accessed within the community and whether there were any barriers to accessing support. By taking a holistic approach the review seeks to identify appropriate solutions to make the future safer.

1.1.6 The panel decided to explore agency involvement with Linda and Graham between November 2013 which was the first recorded police involvement with them, to October 2022. This is five months after Linda's passing. The panel felt it was an opportunity to review the support given to children after a parent's suicide.

1.1.7 The key purpose for undertaking Domestic Homicide Reviews is to enable lessons to be learned. In order for these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each homicide /

victim suicide, and most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future.

Reasons for Conducting the Review

1.2.1 This Domestic Homicide Review is carried out in accordance with the statutory requirement set out in Section 9 of the Domestic Violence, Crime and Victims Act 2004.

1.2.2 The review must, according to the Act, be a review 'of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by:

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

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

"Where a victim took their own life (suicide) and the circumstances give rise to concern, for example it emerges that there was coercive controlling behaviour in the relationship, a review should be undertaken, even if a suspect is not charged with an offence or they are tried and acquitted. Reviews are not about who is culpable." [1]

Due to the knowledge Linda had fled Barking and Dagenham due to domestic abuse, it was deemed appropriate to commence a review to learn valuable lessons.

1.2.4 The purpose of the DHR is to:

- Establish what lessons are to be learned from the Domestic Homicide / Victim Suicide regarding the way 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 those lessons to service responses including changes to policies and procedures as appropriate

[1] DHR-Statutory-Guidance-161206.pdf (publishing.service.gov.uk)

- Prevent domestic violence homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working.

- Contribute to a better understanding of the nature of domestic abuse.

- Highlight good practice.

Timescales

1.3.1 Hertfordshire Community Safety Partnership were notified of the death of Linda by the Hertfordshire Health Visiting Service on 19th August 2022.

1.3.2 On the 23rd August 2022 the Community Safety Partnership decided the criteria had been met to conduct a Domestic Homicide Review.

1.3.3 The Home Office were notified of this decision on 25th August 2022.

1.3.4 On the 26th August 2022, requests for Summaries of Engagements (SoEs) were sent to all agencies who may or may not have had contact with Linda, Graham or their children.

1.3.5 There was then a significant delay in appointing a chair as explained below:

There was a significant increase in DHR referrals in 2021 and 2022 (six and five referrals respectively). Before 2021, the average number of DHRs per annum in Hertfordshire was 2.6.

A rapid increase in the number of DHRs needing to be conducted has been observed nationally, as well as locally. Most Chairs on Hertfordshire's Approved List do not work exclusively in Hertfordshire, and due to the increase in domestic homicides nationally, few were available to conduct new reviews.

To increase the number of Chairs available in Hertfordshire, the Strategic Partnerships Team commissioned AAFDA (Advocacy After Fatal Domestic Abuse) to provide Home Office accredited DHR Chair training. Expressions of interest for this training were sought from those working in the domestic abuse sector, and those with the most suitable experience were offered the opportunity. This training took place in early 2023 and eight candidates were successfully trained.

Following this training, the newly qualified DHR Chairs requested that the contract for Hertfordshire's Approved List be modified, to reflect changes in national legislation (namely the Domestic Abuse Act and UK GDPR). This caused further delay.

1.3.6 An Independent Chair and Author was appointed in September 2023. It was acknowledged Linda had only been in Hertfordshire for 11 months and therefore much

pertinent information would be held by the London Borough of Barking and Dagenham (LBBD).

1.3.7 After the initial panel meeting further services were identified as being significant to the review. These were primarily Barking and Dagenham Services. It proved challenging to identify the correct contacts. The IMR for Children's Social Care in LBBD was received in March 2024 but proved highly valuable to the panel.

1.3.8 Meetings were held via Microsoft Teams on:

Initial Panel Meeting	-	22nd September 2023
Panel Meeting 2	-	19th January 2024
Panel Meeting 3	-	1st March 2024
Panel Meeting 4	-	16th April 2024
Panel Meeting 5	-	7th June 2024

Individual meetings were held with services separately as appropriate .

Confidentiality

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

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

Methodology

1.5.1 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 but it was agreed that this is 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.

1.5.2 The following agencies confirmed that they had had relevant contact with either Linda or Graham, and therefore were asked to undertake an Independent Management Review (IMR). This is an internal deep dive into the agencies records to identify what was known to that organisation. Those writing the reviews were independent and had no direct involvement with family members. These were:

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 Domestic Abuse Service (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)

Terms of Reference

1.6.1 The panel, as well as those completing IMRs, were asked to consider the following:

- To review current roles, responsibilities, policies, and practices in relation to victims of domestic abuse with specific consideration of coercive control – to build up a picture of what should have happened.
- To review this against what happened to draw out the strengths and areas for improvement.
- To review national best practice in respect of protecting adults and children from domestic abuse.
- To draw out conclusions about how organisations and partnerships can improve their working in the future to support victims of domestic abuse.

1.6.2 A full terms of reference forms the analysis in Section Four.

1.6.3 If any information of relevance prior to the scoping period became apparent, agencies were asked to share it so more context could be gained and lessons learned.

Key lines of enquiry

1.7.1 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.

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

1.8.1 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.

1.8.2 During the course of the review LBBD 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.

1.8.3 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.

1.8.4 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.

1.8.5 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.

1.8.6 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.

1.8.7 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:

1.8.8 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 aswell 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. Unfortunately, their contact with the children has not been facilitated since Linda died.

Contributors to the Review

1.9.1 Those contributing to the review do so under Section 2 (4) of the statutory guidance for the conduct of DHRs, and it is the duty of any person or body participating in the review to have regard for the guidance.

1.9.2 All individuals interviewed by the Chair were made aware of the aims of the DHR and referenced the statutory guidance.

1.9.3 The following agencies contributed to the review and were on the panel:

Name	Organisation	Job title
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)[2]	Specialist Safeguarding Practitioner.

[2] 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.

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

The Author of the Overview Review Report

1.10 This report is chaired and authored by Christian Brazier. He is independent of all statutory and non-statutory services of Hertfordshire County Council and has never had contact with the family nor any persons associated with them prior to the DHR.

Christian worked in frontline practice within the Police, Family Intervention and Domestic Abuse sectors for nearly 15 years. In 2016, he specialised in domestic abuse perpetrator interventions working within medium and high risk domestic abuse perpetrator projects as a Skills Enhancer and Deputy Manager. Following this he worked for the national domestic abuse organisation Respect as a Drive Practice Advisor - high risk domestic abuse intervention, and later as a Make A Change practice lead - an early intervention domestic abuse intervention. Here he created tools and workshops for friends, family and colleagues who might be concerned about people using harmful behaviour towards their loved ones. He is an associate trainer for the national domestic abuse charity Safelives facilitating their high harm perpetrators and MARAC sessions as well as their Engaging Those Who Use Harm training. Christian attended the Advocacy After Fatal Domestic Abuse Chair's Training in January 2023 and the Home Office Chair's Training in September 2024. He qualified as a journalist in 2013.

Parallel Reviews

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

1.11.2 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.

Equality and Diversity

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

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

Those considered relevant to this review are:

1.12.2 **Sex** - In considering the above characteristics the panel felt sex was a significant factor. Domestic abuse and domestic homicide are crimes that disproportionately affect women. Women make up the majority of victims and with the majority of perpetrators being male. For the year ending March 2023, the Crime Survey for England and Wales (CSEW) estimated that 1.4 million women and 751,000 men aged 16 years and over experienced domestic abuse in the last year. This is a prevalence rate of approximately 6 in 100 women and 3 in 100 men. [3]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. [4] Whilst this is a small sample it represents a significant proportion of victims.

1.12.3 **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.

1.12.4 **Disability** - On one self-assessment form Linda considered herself to have a disability due to her mental health although she was never officially registered as having a disability. To the knowledge of this review Linda did not have an 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.

1.12.5 **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:

[3] Domestic abuse victim characteristics, England and Wale s - Office for National Statistics (ons.gov.uk)
[4] 999368 Law_Domestic Violence MAIN Research Report Final FINAL PRE-PRINT.pdf (aafda.org.uk)

1.12.6 **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 the answer to this question it is a nuance to consider.

Dissemination List

The following will receive copies of the review report:

- Linda's friends and her mother.
- Review Panel members
- The Home Office
- The Domestic Abuse Commissioner
- Police and Crime Commissioner

Additionally, Hertfordshire conduct a "DHR briefing" for every case that has been published sent to panel members to disseminate at their future meetings and learning events. Briefings are finalised once a review has been quality assured and approved for publication by the Home Office.

Section Two

Background Information

2.1 The focus of this review is Linda and her pseudonym was chosen by her friends. All other pseudonyms have been chosen by the chair. The children have been provided names to encourage connection with their experiences. Their 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 died in May 2022 after ending her life via hanging. She was initially found unconscious by her ex-partner Graham and their eldest son at the Hertfordshire home she lived in with their two children Freddy and Felix before dying in hospital four days later. Graham had been 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 after moving to a 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.

Prior to Scoping Period

2.2 Linda grew up with her mother who had severe and enduring mental health issues. In one mental health appointment Linda recalled being pulled out of 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 an alcohol problem. She had an older half-sister who left when Linda was 13 to live with her biological father. Linda spent a significant amount of time in foster care.

2.3 Given this, it is unsurprising Linda 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.

2.4 From available information it is believed Linda and Graham were in a relationship from 2009 when Linda would have been 16 and Graham 17. It is believed Linda studied Health and Beauty locally.

2.5 Graham was seen by Improving Access Psychological Therapies (IAPT)[5] in August 2012 citing issues with anger when he was 20 years old. 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, based on all available information, the panel believes 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.

[5] NHS England (2021) published the Improving Access Psychological Therapies (IAPT) manual which the National Institute for Health and Care Excellence (NICE) recommends psychological therapies as first choice interventions for depression and anxiety disorders. The service began in 2008 and offered two pathways – the first is usually a single session offering assessment, normalisation, simple advice and, if appropriate, signposting elsewhere. The second is multi sessions offering psychological therapy.

Section Three

Chronology

3.1 On 24th June 2013 both the GP and local Emergency Department (ED) recorded that Linda, aged 20, was harming herself via cutting. Linda said an argument with her partner had triggered this. It is not known what the argument looked like. She was discharged from Barking and Dagenham psychological therapy services (BDPS) on 27th November 2013 due to not attending an appointment on 9th October 2013.

3.2 On 4th November 2013, the police received two calls, one from the concierge of Linda and Graham's accommodation and one from a friend of Linda's, to attend their flat in Barking due to reports of a disturbance. Police attended with only Linda present. She 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.

3.3 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 had grabbed Linda with both hands around the shoulders and neck. He again demanded her password and threatened to cut her throat if she did not hand it over.

3.4 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.

3.5 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".

3.6 The police recorded a crime of common assault and conducted a Domestic Abuse Stalking and Harassment Risk Assessment (DASH)[6] with Linda which was assessed as medium.

3.7 Graham voluntarily handed himself into the police station later that night where he was arrested for common assault.

3.8 During interview Graham said both he and Linda got on really well and he 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

[6] https://library.college.police.uk/docs/college-of-policing/Risk-led-policing-2-2016.pdf

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. Linda was updated and records state she was "happy" with the outcome. A Social Worker at the accommodation was also informed of the outcome.

3.9 On the 19th December 2013, Barking and Dagenham Access and Assessment Team (BDAAT) received a referral from Linda's GP requesting an urgent review. She had told her GP she wanted support as she was experiencing a deterioration in her mental health and had not heard from BDAAT. Checks showed Linda had been discharged from the service in September 2013. She was offered a new appointment on 27th December 2013 but did not attend. There is no reference to domestic abuse within these records.

3.10 Further attempts were made to engage Linda via telephone and two letters. This resulted in a telephone consultation on 10th February 2014. Linda reported being bullied at work (McDonalds) which had resulted in panic attacks over the last three months, poor sleep, her boyfriend commenting on weight gain and fear of ghosts in her current flat. Her wishes were documented as being a medication review, counselling, and a diagnosis.

3.11 Linda attended a face-to-face consultation with BDAAT on 4th March 2014, accompanied by Graham's mother. She told the service she was Linda's next of kin. Linda described increased anxiety and agitation from July 2013. She mentioned sometimes having panic attacks and detailed obsessive cleaning of the current property with bleach, which she reported moving into around August 2013 with her partner Graham.

3.12 She gave BDAAT background to her childhood experiences mentioning emotional abuse from her mother which continued into adulthood. This strained relationship impacted on her family's attendance at her recent wedding. It is unknown whether Linda was seen alone during the appointment.

3.13 The North East London Foundation Trust (NELFT) provide a range of integrated community and mental health services for people living in Barking & Dagenham. During their reflections they queried whether Linda's description of emotional abuse from her mother was considered as a risk or impacting on her mental health and felt further exploration could have taken place regarding Linda's lived experience. This consultation led to a clinical decision meeting within BDAAT services the next day with therapy recommended.

3.14 Linda attended a further appointment on 2nd May 2014 with Barking and Dagenham Psychological Therapy Service (BDPS). She was accompanied by Graham and his mother and stated she was now married to Graham. She was seen on her own during the second half of the consultation. The result of this was for her to be placed on a waiting list for individual integrative psychotherapy.

3.15 Just over a month later, on 12th June 2014 Graham called BDAAT and said Linda was feeling low and her medication wasn't working. Linda was spoken to by BDAAT and said

she felt sleepy and had low mood. She said she'd been medicated since July 2013 but felt nothing was working. She said she was on her way to the GP that day. There is no record of this appointment within the GP report.

3.16 Barking and Dagenham Access and Assessment Team (BDAAT)[7] received a call from Graham's mother in July 2014. She reported a concern for Linda's mental health and said she'd been self-harming. She said Linda was currently staying with her. Within this conversation she mentioned Graham was out of work and there was uncertainty about their accommodation; although she also reported they had a property secured for one year. She was advised Linda needed to see her GP. There is evidence of BDAAT communicating with the GP around this time and mention of Linda being prescribed sertraline – which is often used to treat mental health concerns such depression panic attacks, obsessive compulsive disorder and post traumatic stress disorder [8] and lorazepam which is used to treat anxiety and sleep problems. [9] She was also offered a gym prescription.[10] Within the space of a month both Graham and his mother had deemed it necessary to become directly involved in Linda's mental health care. This is an early indicator of close family potentially framing issues as centred solely on Linda's mental health.

3.17 Linda spoke to the Barking and Dagenham Psychological Therapy Service (BDPS)[11] on 30th October 2014 over the phone, four months after the referral to their service. She explained she had moved into a hostel the previous month. She declined introductory sessions with the therapy service. She spoke about financial difficulties and housing issues as being the main causes of concern at that time.

3.18 BDAAT received another referral from Linda's GP on the 24th December 2014 due to her continuous low mood. She reported difficulties in her relationship with her mother-in-law following their return from her honeymoon although no further information was given. The GP prescribed her Fluoxetine[12], a medication used to primarily treat depression, following this appointment. Linda continued to remain on a waiting list for therapy and therefore BDAAT recorded they would not offer her a service.

3.19 On the 12th March 2015, Linda called the Metropolitan Police saying she wanted to ask a question. She asked, "If I want to leave the house and my husband tells me I'm not allowed, am I allowed to leave?" She explained her husband was standing in the way of the door and not letting her leave the house. She said they'd had a verbal argument but had since resolved their issues. She said she did not wish to see Police as everything was back to normal and she regretted making the call in haste. Police recorded this as a Non-Crime Domestic (NCD), meaning it was a domestic incident, but no crime would be recorded. A DASH risk assessment was completed over the phone and graded as

[7] BDAAT was a secondary service offered at the time, however due to the organisational transformation of adult mental health services, Linda would receive a different service if referred to services today.
[8] About sertraline - NHS (www.nhs.uk)
[9] Lorazepam: a medicine to treat anxiety and sleeping problems - NHS (www.nhs.uk)
[10] The National Institute for Health and Care Excellence (NICE) recommends as a form of treatment NHS services should prescribe exercise for mild to moderate depression.
[11] BDPS is a Secondary service which is accessible through referrals by professionals only for psychological sessions.
[12] About fluoxetine - NHS (www.nhs.uk)

standard. No visit was made to the property which is now standard Metropolitan Police procedure in domestic abuse related calls.

3.20 On 19th March 2015, ten months after her initial assessment, Linda attended her first therapy session with BDPS. During this appointment she disclosed an argument with her mother which impacted on her sleep. There may well have been offending behaviour within this argument as it's documented that Linda did not wish to have police involvement due to her younger sister being in the care of her mother. There are no further details recorded.

3.21 She said she'd planned an overdose but managed to de-escalate those thoughts after speaking to Samaritans. It was noted Linda engaged well in sessions, "despite the impact her personal relationships had on her mental health". There was no further expansion on this point within records.

3.22 Notes indicated a reluctance to involve other agencies. It is theorised this may be due to adverse childhood experiences such as witnessing the detention of her mother under the mental health act and spending time in care. Within this appointment she said she'd helped raise her sibling who was 4 at that time due to her mother's mental health.

3.23 On the same day Linda visited the GP citing issues with her sleep and said "a lot has happened". No further details are recorded and Linda was prescribed zopiclone which is used to address sleep issues [13]

3.24 Linda attended her second session with BDPS the following week saying issues with her mother continued and she was unable to see her younger sister. She described trust issues stemming from childhood but said she was not ready to speak further on this subject.

3.25 In between sessions with BDPS, the Perinatal Parent Infant Mental Health Service (PPIMHS) received a referral from the midwifery team advising of Linda's first pregnancy. However, this referral was declined. It is reported that the PPIMHS required a "severe" mental health diagnosis to accept a referral and there was no record of Linda having such diagnosis, despite her referencing several during her interactions with agencies.

3.26 It is now widely accepted from research that maternal stress can impact on unborn baby's brain development. Had the same situation arisen today the NELFT report Linda would have been offered a service under PPIMHS.

3.27 It is worth noting the entirety of the Barking and Dagenham Psychological Therapy Service (BDPS) intervention with Linda and the content of their support. This is the first and only sustained period of adult therapeutic intervention Linda received to the knowledge of this review.

[13] Zopiclone: medicine used for sleeping problems (insomnia) - NHS (www.nhs.uk)

3.28

Date	Session	Content
19/03/2015	Session 1	Please see chronology above
26/03/2015	Session 2	Please see chronology above
31/03/2015	Cancelled (by service)	
17/04/2015	Missed	Attempts to call Linda were unsuccessful, message left offering appointment on 21/04/2015
21/04/2015	Missed	Linda did not attend this appointment. Phone call attempted. Appointment planned for 07/05/2015
07/05/2015	Session 3	Linda attended session and reported to be pregnant and in high risk category due to blood pressure. All medication stopped. Explored breathing and mindful techniques.
28/05/2015	Missed	Telephone call to Linda who reported illness and could not attend session. She said she continued to use techniques of breathing and mindfulness.
04/06/2015	Cancelled (by Linda)	Linda called BDPS advising she was unable to attend appointment as hospital appointment at same time.
11/06/2015	Session 4	Linda attended this session. BDPS explored not attending sessions. Linda reported she wanted to be in therapy but had antenatal appointments to attend. Reported to have ongoing issues with in-laws and no longer in contact with her mother and younger sibling.
18/06/2015	Session 5	Linda attended the session - reported she'd had a difficult week due to relationship with mother in law. Discussed laughter as a mechanism to cope. She reported mother-in-law and her husband had called her selfish.
02/07/2015	Session 6	Linda attended session - reported to be worried about recent London shootings and losing husband. Linda believed that her husband was the only one who would put up with her.
09/07/2015	Cancelled (by Linda)	Linda reported to be experiencing mild contractions and advised to stay at home.

16/07/2015	Telephone appointment	Telephone appointment as unable to attend clinic. Started to discuss coming to end of therapy.
30/07/2015	Missed	Linda did not attend her appointment.
06/08/2015	Missed	Linda did not attend her appointment. Letter was latterly sent on 25/09/2015 to her stating her therapy sessions had ended and now discharged.

3.29 It is clear Linda had a traumatic childhood. Within these six attended sessions it is highly unlikely these adverse childhood experiences, the impact on her self-esteem and her functioning in relationships could have been explored in the necessary depth. When considering the backdrop of Linda being pregnant for the first time, it would have been additionally challenging for her to focus on her mental health needs. It is also of note how one week Linda said Graham and his mother had described her as selfish and the next felt Graham was the only one who would "put up with her". This potentially gives insight into her own self view aswell as how critical these relationships could be.

3.30 Freddy was born towards the end of 2015 and Linda and Graham were visited by a health visitor a month after the birth.

3.31 Linda and Freddy were placed under a universal plus caseload due to maternal mental health after a vulnerability assessment. During this time Linda completed a diversity monitoring form and viewed herself as having a disability due to her mental health. This provided professionals with insight as to how she viewed herself, but no further discussion was documented to have taken place. Her mother-in-law was recorded as being present at this visit. On 4th December 2015 an alert was added to Freddy's records to indicate Linda's depression although it was documented she was not medicated at the time.

3.32 Linda attended the GP on 7th January 2016 for a postnatal review with her mother-in-law. Here it was noted she was "becoming manic on a background of bipolar", was spending money and becoming more agitated. This is the first mention of bipolar within the records received to this review. As a result, the GP referred to the Barking and Dagenham Access and Assessment Brief Intervention Team (BDAABIT)[14]. On the referral an entry stated, "No Domestic Violence". It is unknown how this had been concluded.

3.33 BDAAT attempted to contact Linda on the 7th January 2016. The call was answered by Graham who requested further information as Linda was out. He was advised they were required to speak with Linda initially. A letter was sent to her requesting contact. Whilst the NELFT state it was good practice not to share information, records were not reviewed at this time. These may have lead to questions around best ways to engage

[14] Barking and Dagenham Access and Assessment Brief Intervention Team (BDAABIT). This was a secondary service requiring referral from professionals. A different service is received by service users today.

her and ensure her safety – i.e, querying whether she had access to her own phone or whether letters were opened by her husband.

3.34 The Health Visitor returned to see Linda on the 12th January 2016 via a home visit and Linda's biological mother was present. Several weeks earlier she had reported no contact with the maternal side of her family so there appeared to have been a change although no reasons were explored for this. Linda reported having been to the GP with low mood and referred to therapy services. She said she was coping well as her husband and mother were supportive. It appeared Linda's reporting of relationships was different depending on who was present with her.

3.35 A telephone consultation took place with Linda on 19th February 2016 with BDAABIT after several missed calls. It was documented she engaged well over the telephone but it was unknown if anybody else was present. She said she had been told in the past she had bipolar and was adamant about this diagnosis and asked for medication. She was offered an assessment, and her requests were discussed with the medical team. After a review of her records medication was offered but Linda declined asking for a different brand. The NELFT felt previous suicidal ideations and references to overdose should have been considered. This could have prompted an assessment of risk and appropriate safety planning.

3.36 Linda attended a face-to-face assessment on 23rd March 2016 with BDAABIT. This is a significant appointment as she shared a lot of information. She described her childhood as "awful" due to being in and out of care and maternal mental health which resulted in her mother's detention under the Mental Health Act. She reported being a registered carer for her mother but it is likely she meant she was a young carer. Her grandmother was also noted as having a mental health diagnosis. She said her father was 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 lived. She signed consent for information to be shared. This was the first and only time known to the NELFT Linda disclosed sexual abuse in childhood. She was not offered support or a referral to relevant sexual abuse / support service. Her use of cannabis and it's impact on her mental and physical health, especially considering its potential use alongside prescribed medication was not explored further.[15]

3.37 Following these disclosures Linda did not attend her next two scheduled appointments. She also cancelled an echocardiogram (ECG) but it is unknown why one was requested. One reason given was childcare issues. Additionally, she did not attend a consultant led appointment. The referral remained open for Linda when typical practice at the time would have lead to it being closed which evidences good practice. Therefore, there is acknowledgment of the need to offer some flexibility.[16]

[15] The NELFT approved an Exploitation Policy in July 2023 and practitioners can now refer to a section called 'Managing a disclosure of non-recent sexual abuse for adults and children'.

[16] NELFT now have a procedure in place for practitioners to follow after missed appointments titled: "Procedure for Managing Missed Appointment / Non-Attendance / Was Not Brought for Adults and Childrens Health Appointments"

3.38 On the 17th June 2016 Linda attended her GP asking for Lorazepam. This request was declined for an undocumented reason. She was reminded of the number for BDAAT. During this appointment it was noted she had a "supportive husband" but whether or not he was present is unknown.

3.39 On the 11th August 2016 Linda again attended the GP. She said she had missed another BDAAT appointment and said her panic attacks were getting worse. She was tearful during this appointment. It was noted there were no concerns about her ability to look after her baby. Linda was given her next BDAAT appointment on the 14th September 2016.

3.40 Linda was next seen by a health visitor in clinic for Freddy's one year health review. Her mother-in-law was present at this visit. The Health Visitor recorded being "a little worried" about Linda having a lot to say and so contacted the mental health team who booked an appointment to see her on 28th December 2016. An alert was added to Freddy's records to highlight maternal vulnerability, namely a "bipolar diagnosis and being medicated" which is believed to have been self-reported by Linda. No concerns were noted around Freddy's health and development. NELFT have reflected that a professional / team around the child (TAC) meeting should have been held to confirm Linda's mental health diagnosis. Within this forum, risk and concerns for the family could have been explored further. The NELFT note there was a lack of bringing Freddy's voice and experience into the picture and a primary focus was on Linda's mental health.

3.41 Linda attended her appointment on 28th December 2016 with BDAABIT. It was documented she had a reoccurring depressive disorder and Emotionally Unstable Personality Disorder (EUPD) traits. She attended this appointment alone. She disclosed difficulties in the relationship with her husband. She said he was receiving text messages from other women which she was suspicious of.

She discussed her childhood, saying her mother had boyfriends come and go from the house. She said she did not want her child to go through what she experienced in childhood. She was risk assessed as low with regards to suicide risk.[17]
The doctor conducting this appointment attempted to contact Social Care to gain further details about Linda's childhood experiences such as being in care and living with other relatives. This is good practice but there are no notes to confirm whether they were successful or not.

This encourages professional curiosity to better understand barriers for engagement and to promote improved attendance.

[17] This method of assessing suicide risk is in the process of changing within the NELFT who state they are "currently moving from the current risk management model of risk stratification to the more person-centred Risk Formulation model." This means they are moving away from a low, medium or high-risk categorisation and towards a model that recognises risk is specific to a person and changes dependent on a person's life experiences.
Domestic abuse was not assessed.

3.42 Linda also mentioned she was living in temporary accommodation, had received threats from neighbours and had concerns about neighbour's drug use. The nature of these threats were not recorded. She reflected on her own childhood experiences and similarities in her mental health and marital relationship which she did not want to impact on her child. She did not attend her next appointment in January and later said she had not received her appointment letter. This is the second time Linda discloses information about traumatic experiences and then does not attend the next appointment.

3.43 On 23rd February 2017 BDAABIT referred Linda to anger management and an emotional control programme. It is unknown why this decision was made and documentation referred to her previous appointment on 23rd March 2016, over 11 months previously.

3.44 Linda was next seen on 18th March 2017 by BDAABIT. She continued to reference issues in her relationship with her husband and said he could be controlling and use her mental health to blame her. She described a past event which involved her wanting to jump from a 6th floor balcony, damage to property and police involvement. She mentioned concerns with neighbours and described banging on her flat door and cannabis use. During this appointment Linda said she had no support network.

3.45 Due to these concerns the practitioner discussed Children's Social Care input with Linda. She said she was fearful her child would be removed from her care due to her own experiences as a child. The practitioner told Linda her situation would be discussed with the team Social Worker to identify any relevant support. There was mention of couple's therapy being explored as a potential intervention. An e-mail was then sent to the Social Worker in relation to these concerns. However, there was no evidence of any further action at this point.

3.46 The NELFT have reflected how further exploration would have been beneficial at this point. This could have helped understand the impact of Graham's controlling behaviours on Linda and on Freddy as well as enabling services to risk assess. There is no evidence a domestic abuse risk assessment was completed, nor of any further actions from this appointment. There is a current policy of protecting adults and children at risk of Domestic Abuse where staff would be advised to complete a DASH risk assessment which may not have been common practice in 2017.

3.47 On the 20th March 2017 Linda attended the GP. She said she had been "mucking about with her partner and suddenly fell". She said she had hurt the right side of her back and shoulder but the GP noted she was no longer feeling any pain. There are no further explorations of this incident recorded in the GP notes and this was a missed opportunity to explore domestic abuse.

3.48 Just over a week later Linda attended her GP surgery to see the nurse 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. As a result of these disclosures Linda was advised to call talking therapies. This is clearly a missed opportunity to consider domestic abuse, risk assess and safeguard appropriately.

3.49 Graham attended the GP on the 22nd July 2017 for low mood. He said he was struggling for motivation, was unemployed and self-harmed two months prior. The nature of this self harm is unknown. He made mention of previously having anger management sessions. As a result of this appointment, he was prescribed Sertraline and referred to IAPT - Improving Access to Psychological Therapies, also known as Talking Therapies.

3.50 On the 2nd August 2017 Linda again attended her GP due to "deliberate self harm". She told the GP her home life was "poor". She described wanting a divorce but her partner didn't want one. She said she was not sleeping well and her appetite was being impacted. She was advised to contact the mental health crisis team. It does not appear the child's experience of having two parents who had both self-harmed within the past month were considered.

3.51 Between August and December 2017 Linda was not seen by 0 -19 services nor BDAABIT and was discharged from the latter's service on 30th October 2017. It appears this is due to this service being unable to engage Linda.

3.52 Linda was called by the Health Visitor on 1st December 2017 requesting she bring Freddy in to be weighed. During the call she said her mental health had stabilised which she put down to medication. She said she no longer required support from mental health services. Contrary to the appointment in March 2017, Linda reported she was being supported by her mother-in-law. She said she was only living with her husband as his name was on the tenancy. She was supporting her biological mother following an operation. A maternal mood assessment was completed which was documented as being "satisfactory". No concerns were raised around Linda no longer engaging with BDAABIT. Nor is there any documented evidence of Linda being signposted to support for her housing needs. Linda brought Freddy in to be weighed 3 days later.

3.53 On the 21st February 2018 the Health Visitor called Linda who told them Freddy was with his grandparents due to concerns about the air quality at their flat and to support with nursery attendance. The NELFT have reflected that had safeguarding supervision been utilised at this juncture it may have allowed the practitioner to consider:

- patterns of missed appointments by Linda,
- an over-focus on Linda's mental health rather than impacts on Freddy, and
- Linda often stating she had not received letters or did not return calls.

Protected time for the Health Visitor to review records may well have been beneficial.

3.54 On the morning of 3rd March 2018 Graham contacted the service Mental Health Direct, a free 24 / 7 service which can put people in touch with the relevant mental health professionals. He 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. He said Freddy was with paternal grandmother.

3.55 Linda attended the Emergency Department (ED) later that afternoon and was seen by the mental health crisis team. Graham was with her. It is not documented whether she was seen alone during her consultation at any point but Linda was described as being angry at mental health services for not listening to her. She was provided with a prescription and referred to therapeutic services. She was assessed as medium risk with regards to suicidality. This is not the first time Graham had been directly involved in Linda’s mental health needs.

3.56 Linda attended an appointment with BDAABIT on 27th March 2018. She said following her Emergency Department attendance a few weeks earlier she had “smashed up the property” and the police were involved. There is no record of police involvement around this time. She said her husband and mother-in-law had commented that she cannot look after her child which triggered her behaviour. She described irrational thoughts, although no further details were given. She again referred to housing issues saying their property was overcrowded as they lived in a one bedroomed flat. She was assessed as low risk of harm to herself.

3.57 Following this appointment Linda’s situation was taken to a multi-disciplinary team meeting by BDAABIT for discussion. Subsequently her lead practitioner contacted her via phone on 11th April 2018 and offered her a change of medication. She asked to think it over. Anxiety management was also offered but it was noted Linda declined this. A referral for therapy was also completed.

3.58 The NELFT reported contact with Linda was challenging between 23rd April and 6th June 2018. Both BDAABIT and BDPS services said there were issues with not attending appointments and / or missed phone calls.

3.59 During a phone call on 6th June 2018 from BDAABIT, Linda refused to speak with the practitioner and a discussion took place through Graham. Linda subsequently attended a medical appointment with a doctor and reported a recent outburst and police involvement (no record found). She discussed her history of difficulties within relationships and friendships although no further details were noted. She reported impulsive buying which lead to arrears in electric and water bills. She mentioned binge drinking every few weeks and said her child would be with the paternal grandparents on these weekends. She also mentioned her mother lived across the road from their flat.

3.60 Following this appointment BDAABIT and BDPS discussed Linda’s situation. Attempts to send appointments by email were unsuccessful. There was no documentation to evidence this was followed up, therefore Linda was not offered a service with BDPS.

3.61 The police received a call from Graham on the 30th July 2018. He said he was unable to gain access to his home address as Linda had put the front door on a chain and refused him entry. He referenced Linda’s history of self-harm and said he was fearful she would

hurt herself. Officers attended and Linda showed officers her wrists. They noted there was no indication she had attempted to self-harm and she was not under the influence of drunk or drugs. Linda told them she just wanted to end the relationship and requested Graham stay away for a few days. There were no offences disclosed and subsequently police recorded this as a non-crime domestic. A DASH risk assessment was completed and graded as standard.

3.62 Just over a week later, on 7th August 2018, Linda called the police and said she'd been a passenger in a car which Graham was driving. An argument began and he'd threatened to "crash the car into a wall". He drove them both home at which point Linda called the police. Police attended, Graham denied making this comment but accepted they'd had an argument. He told officers they were still living together but didn't wish to any longer. Advice was given to both parties to contact the local housing department or Citizen's Advice Bureau. Police noted tensions still seemed high between them and they were still visibly annoyed by the argument. As a result, Graham was asked to leave the area. Police recorded this as a 'non-crime domestic' and a DASH risk assessment was conducted with Linda and graded as standard risk. It was noted Freddy did witness the argument and was therefore in the car. This is something that would today have relevance for the DA Act 2021[18] where children are viewed as victims of DA, not witnesses.

3.63 Police informed LBBD Social Services of this incident. They called Linda who 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. She confirmed she was receiving mental health input. When Graham was spoken to, he blamed the situation on Linda's "unstable mental health" and said he wanted her to have support with this.

3.64 The outcome of social services early consideration of the case was for Linda to have direct work with regards to "relationship issues with her husband".

3.65 The actions agreed were as follows and are quoted:

- *Refer Linda to Victim Support to get legal advice in relation to have her husband removed from the tenancy. (Police request feedback is not sent to them due to work volumes.)*
- *Signpost the family to other relevant services and consider young carers for the child as he lives with a parent suffering from mental health problems.*
- *Also signpost father to appropriate support in relation to "living with a wife with mental health problems."*

3.66 The Social Worker decided not to undertake a statutory assessment which, given the traits of coercion, was a missed opportunity. There was a lack of curiosity within the recommendations, and this reinforced stigma. The phrase "would not accept the end of the relationship" required further exploration and domestic abuse needed to be considered. This outcome and practice would have likely confirmed to Linda the

[18] Domestic Abuse Act 2021 (legislation.gov.uk)

family's issues stemmed from her mental health which did nothing to address the threat from Graham to crash the car into the wall.

3.67 On the 29th August 2018 Social Services conducted a home visit to see Linda. She said she had suffered from depression since she was 12 years old. She had suffered physical and sexual abuse and was now afraid to trust people. She reported trouble sleeping and said she was taking medication. She said Graham was using their child to manipulate her whenever she asked him to leave the house or told him she didn't want to be with him anymore. It was decided a CAF (Common Assessment Framework) would be completed by an Early Help Worker and a meeting would be set up with Graham. This was another missed opportunity to refer Linda for support around past sexual abuse.

3.68 Graham was met a day later and reported how Linda cared for him and supported him but it was unclear in what context he required care. He said he knew her mental health condition before marrying her which was not a problem for him, but thought it was temporary. He reported she blamed him for anything negative that happened and gave an example if something was out of place in the house or dirty he would be blamed because he was the person closest. He said she did it because of her OCD (obsessive compulsive disorder). He asked for marriage counselling because "he needed advice on how to deal with his wife's mental health problems", how to help her and support her. He said that he loved her and didn't want to give up of the marriage. There is a continued picture of Graham creating a narrative of Linda's mental health issues being the prevailing issue.

3.69 On the 9th October 2018 Linda reported to Social Care that Graham was threatening her saying if she left him he would take their child away from her. There is an additional note on the Social Care record saying Graham reported he saw an "anger management therapist" four years previously through his GP and was discharged after completing the sessions. There is an action to refer to Relate after a referral to the Family Group Conference was declined by that service. It has been documented in previous DHRs how referrals to Relate are often inappropriate[19] within a context such as Linda and Graham's.

3.70 LBBD (London Borough of Barking and Dagenham) systems show the Early Help Assessment was completed on the same day. Within this there was no mention of any professional domestic abuse intervention being sought nor any risk assessment tools being used. This is a clear omission. There were many warning signs which indicated domestic abuse was present and needed to be addressed.

3.71 Police were called again on the 10th October 2018, this time by Graham. He stated he was concerned for Linda's state of mind and was worried about her. He said she'd walked out and appeared to be distressed. Police visited and by the time they did Linda had returned home. She told them she'd walked out because their marriage had broken down and she no longer wished to be with her husband. Additionally, she said she

[19] Domestic Homicide Review - In respect of the death of Elizabeth (homicide-review.homeoffice.gov.uk)

could no longer afford medication, and it was not being covered by health services. She declined a referral to Victim Support and she was assessed as being of sound mind to make that decision. A Merlin (safeguarding) report was submitted by police. A multi-agency safeguarding hub (MASH) supervision entry noted that it did not meet threshold for submission to other agencies and there were "no concerns for Linda's welfare". This is the third police contact within four months. A Multi Agency Risk Assessment Conference (MARAC) referral could have been considered. [20]

3.72 On 16th October 2018 the NELFT noted a 'Family Intervention Officer' had called the talking therapy service requesting an update on a referral made for Graham. They were advised there was no such referral on the system and that he could self-refer. Details of this were forwarded onto the Family Intervention Officer. This appears to contradict the information provided by the GP of Graham being referred on 22nd July 2017, albeit over 12 months previously. This query indicates Graham was continuing to have concerns about his mental health but there is no further exploration of this.

3.73 BDAABIT next saw Linda on the 25th October 2018. She attended on her own, and said she was looking after her mother who was mentally unwell. She told the practitioner her husband was not supportive. She said he was self-employed but often did not look for work and would stay at home for long periods playing on his computer. She said one of the reasons she felt depressed was due to being "under a microscope" by him. 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.

3.74 She mentioned her husband had previously attempted to strangle her infront of a friend years ago before the birth of their child. She said there had been police involvement and her husband was arrested. She described him as being mentally manipulative and dependant on her. She said they had no intimacy and she wanted a divorce but he would not agree to one.

3.75 Linda once again raised housing as an issue and said their tenancy was in joint names which lead to her feeling stuck and unable to move their situation forward. She reported having suicidal thoughts and it had crossed her mind to take an overdose. Despite these disclosures she was risk assessed as low risk of harm to herself. Linda clearly discussed a domestically abusive relationship at this appointment but there appears to be no consideration of conducting a domestic abuse risk assessment or linking her in with domestic abuse services nor any safeguarding referrals.

3.76 Linda next contacted BDAABIT on the 8th November 2018 saying she was having a breakdown and didn't want to be here anymore. She received a call back approximately two and a half hours later. She said she had spoken to a friend in the interim and felt better. She once again voiced difficulties in her relationship and said Graham had made derogatory remarks towards her. The exact nature of what was said by Graham was not documented.

[20] Marac referral criteria and form - SafeLives

3.77 On the 3rd December 2018 a Team Around the Family Meeting was held. The police incident was discussed where Graham reported Linda going missing. Linda said she had not gone missing but went for a walk to relieve stress. Both Graham and Linda requested to end their involvement with Children's Social Care. Due to Early Help plans being consent based, their case was closed. It is recorded how educations services reported no concerns with Freddy. It is unknown who attended this meeting, nor what information was shared.

3.78 The Health Visitor contacted Linda on 7th December 2018 via phone after an unsuccessful home visit. Linda said everything was "ok" with her mental health and she didn't feel they needed to see Freddy. Linda appeared to be preventing a home visit and it was unclear why. There was no recorded follow up action.

3.79 On the 31st January 2019 Linda attended her GP and said she was pregnant which she had mixed feelings about. She told the GP she was unhappy in her relationship with her husband and had recently had Social Services involvement, which had since ended. She said she felt emotionally drained by her husband, she wanted a divorce and he refused to leave the home. She said she had been going to the Citizens Advice Bureau about this. The GP noted there was no physical or sexual abuse present which evidences some consideration of some aspects of domestic abuse but once again, no risk assessments were conducted and there was no acknowledgment of coercive control. Despite Linda saying she was emotionally drained there were no notes to evidence exploration of this or to offer specific support.

3.80 On the 8th February 2019 Linda attended her planned appointment with BDAABIT at the Enhanced Primary Interface Care clinic (EPIC).[21] She continued to report 'relationship difficulties with husband' although the details of said difficulties were not detailed in BDAABIT notes. Linda informed the practitioner she was pregnant, but she had booked a termination through her GP.

3.81 Linda told her practitioner she had reported her concerns around housing and her relationship to several agencies including social care but had been unable to get support. A discussion to refer her to the Women's Trust domestic abuse service took place which Linda agreed to and provided consent for. The practitioner referred her to the Women's Trust the same day. This is an appropriate action but it is of note how often Linda had mentioned similar issues to multiple professionals without consideration of such a referral up to this point.

3.82 The practitioner also discussed medication with Linda. They considered her overly reliant on medication to change her behaviour and mental health. The NELFT have reflected that further exploration of the impact homelife and domestic abuse was having on her emotional, physical, and mental wellbeing at the time would have been beneficial. This is the first known acknowledgement by a professional of an over reliance on medication.

[21] This was a pilot service to meet with service users and review medication treatment and to conclude a plan before transferring back to primary care. This service has since been discontinued.

3.83 The BDAABIT practitioner spoke to the Women's Trust directly. The referral was accepted for group support in another 2 weeks' time. It was confirmed Linda would be contacted by someone from the Women's Trust. The practitioner expressed Linda's preferred choice of one-to-one support. They were informed that if Linda contacted the service on the 1st March 2019, she could enrol for counselling support. There was no further documentation received to know whether Linda engaged with the Women's Trust.

3.84 During the course of this review the Women's Trust were contacted who said they'd had no direct contact with Linda. They stated she was booked into an assessment appointment for support groups on 13th March 2019 which was cancelled.

3.85 Two further attempts were made to contact Linda on 7th May 2019 and 29th May 2019 to which there was no response. Attempts were made via calls and text messages. Upon the last attempt, Linda was given a deadline of 12th June 2019 to contact the service to which she did not respond. The Women's Trust finally closed her file on 28th Aug 2019. Their policy is that once a client is referred to the service, they do not advise of their referral status.

3.86 On the 15th February 2019 Linda returned to the GP surgery to say she had changed her mind about the pregnancy. There are no records which indicate further exploration. She was referred to antenatal services and separately BDAAT for a review of her medication.

3.87 On the 15th March 2019, the Perinatal Parent Infant Mental Health Service (PPIMHS) service received a referral for Linda. The referral form said Linda had a good friend network but poor support from partner. The mental health diagnosis on the referral form differed from those on the NELFT electronic records. It stated she had bipolar which continued the confusion around her mental health diagnoses.

3.88 An appointment was made for Linda on the 10th May 2019 with the PPIMHS which she did not attend. Contact was eventually made on the 2nd July 2019 via telephone. She reported having no contact with maternal family and told the practitioner she did have a close friend but they had recently moved away. She told them she lived with her husband who was "unsupportive".

3.89 Separately, Graham attended the GP on the 16th July 2019 due to feelings of stress and low mood. He said he felt anxious, in part due to debt and that he felt useless. He was subsequently referred to IAPT. No further information has been identified in relation to this.

3.90 An antenatal form was completed on the 22nd July 2019. The reviewer for NELFT has been unable to gain clarity on the completion of this form but it's believed it was completed with Linda in the antenatal clinic whilst she was with Graham. It did not incorporate risks or concerns for Linda or their unborn. The panel representative for the NELFT reflected there is no free text information on this form so Linda's feelings about pregnancy were discussed but what her feelings may have been were not documented.

3.91 A text message was received by the PPIMHS (Perinatal Parent Infant Mental Health Service) from Linda on 26th July 2019 who said she was unable to afford public transport to attend their meeting. PPIMHS telephoned her. Linda said her husband was sorting out rent, but it had not been paid for some time. She said the Homes and Money Hub were assisting them with their debt. It was believed Graham was in the flat at time of the call and Linda denied any abuse from him when asked. A home visit was offered to Linda when she was child free so they could discuss her wellbeing and her mental health in more depth.

3.92 On the 30th 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. The GP assessed there to be no safeguarding issues. Graham was referred for therapeutic support and prescribed sertraline.

3.93 The BDAABIT received a referral from the GP for Graham on the 2nd August 2019. He was accepted by Improving Access Psychological Therapies (IAPT) and an opt in letter was sent. Records indicate Graham did not reply and he was therefore discharged back to his GP on 5th September 2019. No risks, concerns or links to the think family approach were noted in the review of Graham's records.

3.94 A home visit took place on 8th August 2019 from the PPIMHS. Linda explained her reasons for not going ahead with the termination saying she had seen the baby's heart beat in a scan and changed her mind. They discussed her childhood and how she had witnessed physical abuse of her own mother by mothers' partners. They discussed her current mental health and the doctor felt she did not have traits of EUPD which had previously been indicated. Notes indicated Linda was being treated for mixed anxiety and depression. They had a conversation about medication and its potential effects the unborn. It was the practitioner's assessment Linda was bonding with her unborn.

3.95 Linda said they were having financial difficulties. She said she used to control family finances and manage well. Her husband had recently taken over and she felt this was a reason for them having fallen behind with payments of rent and other bills. It is unknown why there was a change to how they organised the finances. She said their telephone had been cut off and they were using a food bank. During this visit she also disclosed Graham's parents had recently split up which may have some relevance for Graham's mental health and Linda as Graham's mother was on/off support.

3.96 It is documented domestic abuse was disclosed. An action from this meeting was for a clinic letter to be shared with the professional network working with Linda. During this review a copy of this letter could not be found. It is therefore unclear what information was shared or if this was actioned.

3.97 On the 3rd September 2019 the midwifery service sent an email to PPIMHS due to being concerned Linda was not bonding with her unborn contrary to the PPIMHS observation. They were also concerned she had not been attending midwifery appointments.

3.98 The PPIMHS contacted Linda on the same day the email was received. She said Graham had returned to work the previous day after a year out of employment. She said her birthing partner was on holiday indicating Linda was maintaining at least one friendship. The practitioner stayed in contact with Linda and a face to face visit was planned for after the birth.

3.99 Felix was born around September 2019.

3.100 The 0-19 service visited on the 27th September 2019. The health visitor reported cramped living conditions and completed a pre-CAF (common assessment framework) referral. This referral requests additional support from the local authority for families with multiple needs. The focus of the referral was housing conditions and overcrowding.

3.101 A discussion around the couple's relationship was not able to happen in any great depth. Graham was present in the next room. Linda went as far as saying he could be cold and unsupportive but denied any abuse.

3.102 It is noted that Graham was generally not included in these visits and there appeared to be an over focus on Linda's mental health. Linda scored 22 on the Edinburgh Postnatal Depression Score. A score of more than 10 on this scale indicates depression may be present.

3.103 A home visit was conducted by the PPIMHS on the 3rd October 2019 where the practitioner discussed parental conflict and the impact it can have on children. No further information is available. The practitioner completed a mental health risk assessment which was graded as medium risk.

3.104 The Health Visitor met with Linda, Felix and Freddy on the 11th October 2019 and no concerns were noted. However, later that day police were called by Linda. She 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. A safeguarding report for Graham was completed by the police and rated as amber, the highest rating of concern being a red, due to concerns regarding his mental health and wellbeing.

3.105 A further home visit was carried out by the PPIMHS the day after on the 12th of October 2019 and a slight improvement in home conditions was noted. Linda told the practitioner Graham had been sending messages of a sexual nature to other women. She said her mother was supportive and they could stay with her if necessary. No police call is mentioned in this entry and it is unknown whether the PPIMHS were aware.

3.106 On the 15th October the ACORN Midwifery team telephoned PPIMHS to report concerns regarding Linda and Graham's relationship and the mental health of Freddy. They reported the baby had slipped from Linda's arms and hit their head on the floor. They had advised Linda to seek medical opinion. Linda reported she had called 111 but they advised no further action was necessary. The PPIMHS practitioner queried whether the midwifery service had referred to Children's Social Care based on this information, and it was agreed they would follow up on this prior to discharging Felix from their service. This information was also shared with the Health Visitor which shows good multi agency working. However, it is unknown whether a Social Care referral was submitted.

3.107 PPIMHS phoned Linda on 17th October 2019. She declined a home visit. She said difficulties continued with her husband and his mental health. She mentioned the police involvement on 11th October 2019 and said Graham had now returned to the family home. She said 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.

3.108 There is no recorded consideration of the impact of mental health and domestic abuse on the two children and no signposting or referrals to domestic abuse services or children's social care were made.

3.109 A day later 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 housing issue 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 is explored further within the analysis. This decision was correctly challenged by the health visiting team and escalated to a team leader. Within the LBBD Social Care record there is no mention of domestic abuse and it appears this was not being seen through the lense of domestic abuse, despite the previous interactions LBBD social care had had with the family.

3.110 The NELFT have interrogated their records in relation to their challenge of the Social Care decision and how it was conducted. From their review it could not be ascertained whether 0 – 19 services reviewed their records or liaised back with PPIMHS. The concerns known to the health visiting service at this stage were:

- a recent police incident,
- the baby being dropped on their head,
- emotional abuse from Graham to Linda and
- mental health of both parents including suicidal thoughts.

3.111 The NELFT have considered how they challenge decisions such as these during the course of this review. They felt challenge could have been strengthened using the local authority threshold document.

3.112 On the 21st October 2019 Social Care received an e-mail from LBBD Housing department stating the family would not secure rehousing as they had significant arrears which

LBBD would commence action over. LBBD Housing have been contacted as part of this review. They state they were only made aware of domestic abuse in 2021 when Linda fled the area. They have informed the review how Linda and Graham were working with the Homes and Money hub to address their financial and housing concerns. There is clearly a disconnect with what is recorded on the two services systems.

3.113 Home visits by PPIMHS were declined by Linda over the following days but there is evidence of continued care and concern by this service who text and called Linda regularly. On the 24th October 2019 Linda picked up and reported to be staying with her mother and unable to talk.

3.114 On the 31st October 2019 Linda said she was back living with her husband but communication was limited. She said she was exhausted and had dropped the baby off the side of the bed. It is possible this is another occasion where Linda dropped Felix with potentially a second head injury. The NELFT state this should have lead to signposting for medical opinion but there is no evidence to indicate this happened.

3.115 The following day the health visitor conducted a home visit and completed a 6–8 week review which noted Graham was sleeping on the sofa.

3.116 On 18th November 2019 the PPIMHS visited Linda at home. She said Graham had been asked to leave the family home tomorrow and would not be returning. She said she had been receiving messages from other women regarding his “infidelities and lies”.

3.117 Between the 18th November 2019 and 29th January 2020 there were seven attempts to meet with Linda by the PPMIHS and 0 – 19 service, all of which were declined by Linda. Reasons provided were she had family over, her youngest child was in hospital or she simply did not attend.

3.118 On 29th January 2020 the PPMIHS sent a discharge letter to Linda which informed her she would be closed to their service. This detailed what she could do if her mental health declined and that she could self-refer back into them until Felix was 1 year old. Today PPIMHS offer a completely different service. Whilst at the time it was felt no further actions could have been taken to re-engage Linda, since the recommissioning of PPIMHS Linda would be offered different plan of care.

3.119 The health visiting service called Linda on the 12th February 2020. On this occasion Graham answered the phone and they requested Linda call them back. This never happened and it is unknown if she was passed the message.

3.120 The Covid 19 global pandemic arrived in the UK in Mach 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.

3.121 There is no information available to this review between March 2020 and August 2020

3.122 On the 14th 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 meaningful depth the potential link between this and Graham's behaviour towards Linda.

3.123 The health visiting service contacted the family virtually to complete Felix's one year review on 12th August 2020. A student health visitor conducted the online meeting and noted Graham to be "unhelpful". The NELFT consider this visit to be in line with the 0-19 service business continuity plan at the time.

3.124 There are several attempts to contact Linda over the phone throughout October 2020. On one occasion Linda replied to a text to say her phone was not working. Further messages were not responded to and so the Health Visitor contacted Graham to try and establish contact. He told the Health Visitor he was out working and it should be fine to visit the property. The Health Visitor attended but gained no response and left a message for Linda. Later on the 12th November 2020, Linda messaged saying "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. Linda requested a different practitioner.

3.125 There was liaison between the Health Visitor, school, multi-agency safeguarding hub (MASH) and GP after this appointment flagging a lack of contact with Linda. The practitioner also took the case to safeguarding supervision to discuss. This is good practice.

3.126 The final contact from LBBD 0 – 19 service was on the 15th December 2020 when a team leader contacted Linda to explain the changes in practice due to Covid 19. The call cut off twice and they were unable to re-establish contact with her.

3.127 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.

3.128 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.

3.129 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.

3.130 Police recorded the incident as a Non-Crime Domestic (NCD). They completed a DASH risk assessment which was graded as standard and on which Linda scored 2. An Adult Come to Notice (ACN) safeguarding report was completed for Linda also. This interaction triggered Social Care involvement for the second time. Subsequently they opened an assessment.

3.131 On 4th February 2021 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. Police recorded this as Actual Bodily Harm (ABH) on a crime report. They completed a DASH with Graham which was graded as medium. Graham was named as victim and Linda as the suspect. Graham then attended Dagenham Police Station to report in person but could not stay as he stated he needed to get back to his children. Police records noted he was due to re-attend on 6th February 2021 but did not. A message was created on the police to check on the welfare of the children, however, this was closed on 5th February 2021. A supervisor noted that they did not believe there was any information to suggest the children were at risk, that it was a verbal argument between partners with no offences. Graham's home address was recorded as different to the joint tenancy they shared. The report was closed.

3.132 Police have reflected how the documented minimum 5 year checks did not correctly record all police incidents. There was no child safeguarding referral (MERLIN) created for the children which was not compliant with policies. There was no investigation completed in relation to the assault alleged by Graham and the report incorrectly noted that this was verbal argument with no offences. The report was not sent to the Community Safety Unit (CSU).[22]

3.133 Due to the recent police contact and associated concern, Social Care began assessing the situation in February 2021. On the 23rd February 2021, during a social care supervision session, the Social Worker mentioned how Freddy talked about the recent police attendance at the home. *"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."* During this interactions Freddy used lego to build a prison and showed the Social Worker. Freddy reportedly said it was a prison to put "daddy in it because daddy got arrested."

[22] Additionally, to the Met's policy: "*Complete MERLIN (safeguarding) report in all cases where children are included in the relationship, whether present or not and including unborn children*." MPS direction during COVID was that positive action should still be taken in all domestic abuse cases; *arrests should still be affected when allegations are made.*

3.134 During another Social Worker visit Linda reported that Graham was visiting the property daily and that his name was on the tenancy. She said he had been staying with his father in Dagenham. He had lost his job as an electrician due to lateness and taking time off, so they let him go. Linda said she was a hairdresser and the main provider but Graham had landed them in debt. She received around £800 in benefits. Graham had not been paying the council tax so they were in arrears. Linda mentioned how she had an ambition of becoming an embalmer and to do the hair and make up of the deceased.

3.135 Additionally, Linda continued to report Graham visiting the home but refusing to leave. Graham would bring his washing to the home for Linda to do. She felt he behaved like they were still in a relationship. Graham 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.

3.136 Also, towards the end of February 2021, the Homes and Money Hub within LBBD attempted to make contact with Linda via phone to begin an assessment. The Homes and Money Hub (HMH) is a partnership launched in 2018 in LBBD to support residents to sustain tenancies, address debt and "support and help our most vulnerable residents to giving them the security and confidence to improve their lives" [23]. It allocates residents a caseworker who has links to the relevant teams e.g DWP, rent etc to provide a holistic response to financial and housing concerns.

3.137 After several attempts via text and calls, on the 2nd March 2021 the HMH got through to Graham on the number provided, not Linda. He said he was the one who had originally called the council for assistance "since his wife had mental health problems (bipolar and PTSD)". Graham said she was on various strong medications for these conditions.

3.138 Graham told the caseworker that last year he had been advised by a debt agency to go from a joint Universal Credit (UC) claim to a separate claim and that "he had to do this to get a top up on his UC". He also said at that time his relationship with his wife was on the verge of breaking down and he was staying temporarily at his dad's.

3.139 He said that from Aug 2020 to Jan 2021 he was not working due to Covid but was furloughed. He said that his company closed down on 3rd February 2021 and he was now getting Universal Credit. He complained that the rents team had not sent any letters to inform them the account was going into arrears, otherwise they would have realised sooner there was a problem. The caseworker arranged a follow up call to complete an income and expenditure form on 4th March.

3.140 On the 3rd March 2021 Refuge received an e-mail referral from the LBBD referral and assessment team detailing abuse Linda was subjected to by Graham. She was allocated an Independent Gender Violence Advocate (IGVA) to make contact to offer their service.

[23] Homes and Money Hub | One Borough Voice (lbbd.gov.uk)

3.141 Refuge attempted to contact Linda several times over the next week but were unsuccessful.

3.142 On the 5th March 2021, during a Social Care supervision session, it was queried whether Linda could go and stay with her mother for a while. Freddy was described as 'throwing things angrily' and could be starting to experience emotional harm from witnessing domestic abuse. The social worker discussed the safety plan she had devised with Linda which included direction to call the police in the event of any domestic abuse incidents. If it was not possible for her to call police, the Hollie Guard[24] App and 55 discreet call system had been discussed. It was commented within the supervision notes how this plan did not seem robust nor effective enough and there was direction for the Social Worker to review. Additionally, they were directed to complete the CAADA DASH and refer Linda to MARAC (Multi Agency Risk Assessment Conference) within 1 week.

3.143 On the 11th March 2021, the Allocated IGVA let the Social Worker know they had not been able to speak to Linda yet as they'd had no response. The referrer suggested calling at school drop off and pick up times (08:50am or 2:50pm) due to phone signal issues Linda had at the home address. They provided a safe email address for her. The allocated IGVA provided the Social Worker with her contact details to pass onto Linda.

3.144 After several cancelled appointments by Graham, the Homes and Money Hub were able to speak to him again on the 15th March 2021 to continue their assessment. This evidenced a good level of perseverance from this team. The caseworker had sought advice from seniors about Graham and Linda's situation. Due to both individuals being on the tenancy, universal credit (UC) could only be paid to Linda for her half of the rent costs. They noted there were already arrears prior to the lockdown, approximately £2500. After the couple went on to separate claims for UC in July 2020 it appeared they did not update their housing costs, something disputed by Graham. Therefore, there were no housing costs from UC in payment from July 2020.

The two options outlined by the HMH caseworker were:

1. If Graham decided to relinquish the tenancy and take his name off then Linda could apply for full housing costs to be reinstated from July 2020 on the basis of an untidy tenancy (i.e. a tenancy for which two tenants are registered but one is in the process of being removed).

2. If the couple went back to a joint universal credit (UC) claim and Graham was spending more time at the home address than at his dad's then the full UC housing costs would be paid. The case manager calculated a joint UC claim based on them both not working would pay £1953.75 per month, inclusive of council tax support.

[24] Hollie Guard – Personal Safety App

3.145 The case manager called Graham to go through these options. He did not want to give up his tenancy in case he was found intentionally homeless. He asked the HMH case manager if he would get any help from the Housing Options Team if he were to do this who said they would speak with a team leader about this.

3.146 This internal discussion occurred, and the team leader advised Graham had the same rights to the tenancy as his wife so would not be considered homeless. If the couple decided to split up they would have to apply to the courts for a decision on who should remain at the property and who should leave. If he were told to leave the council would then not have a duty to rehouse him if he was not deemed in 'priority need' and at his age he would only be entitled to shared room rate of local housing allowance. The team leader asked whether the couple had been to mediation or marriage counselling. The case manager called Graham back to discuss. Their notes state Graham recalled the Social Worker telling them they would need to pay for mediation. Regardless, he said, Linda would not want it as she blamed him for everything. He did not want to give up his tenancy as his dad was selling up and he could not stay long term. He said his only viable option was going back on to a joint claim. He asked the case manager whether they would explain this to Linda.

3.147 On the 29th March 2021 the HMH case manager recorded they had been unsuccessful in making contact with Linda. Graham called and informed them Linda had agreed to go over to a joint universal credit claim and he just had some questions about the process. After answering these questions the case manager made an appointment to assist them to apply for Council Tax Support, check their UC records to ensure details were accurate and to assist them to apply for discretionary housing payment to try to clear some of the arrears.

3.148 As noted, the HMH were aware of Social Care involvement due to the mention from Graham of there being a social worker. This interaction highlights the importance of multiagency working to see the complete picture and reduce the risk of being manipulated. Graham had cited Linda's mental health difficulties as the reason he had contacted the HMH initially. He then requested the HMH case manager explain the requirement for them to go back to a joint claim to Linda. There is disparity here and it is possibly an example of Graham using agencies to manipulate a situation. It is fortunate HMH did not get through to Linda as they would have unwittingly been complicit in helping Graham go back into the property. This point has been unpicked in depth within the analysis.

3.149 There were further attempts by the IGVA (Independent Gender Violence Advocate) to contact Linda over the next few weeks but with no success. On the 30th March 2021 the IGVA emailed the Social Worker to let her know she would be closing the case as she had not heard from Linda. The IGVA encouraged the Social Worker to give Linda her contact details. It is assumed this prompted the Social Worker to contact Linda as later that day they responded to Refuge letting them know she would be calling them at 3pm the following day. This contact did not occur but a day later at 10:33am Linda did contact Refuge. She disclosed that Graham attended the property at all times. The IGVA went through options including occupation orders, sanctuary schemes (home

security safety measures) and refuge provision. This is the only known time these options were discussed. Linda asked to be referred to a refuge and the IGVA asked her about disabilities. She disclosed she suffered from bi-polar and anxiety but her medication controlled the conditions. There were no refuges available that day, but the IGVA agreed to keep looking and provided Linda with the national domestic abuse helpline number. The IGVA went over some basic safety advice with her.

3.150 On the 13th April 2021 the Social Work 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. It is unclear which counselling Linda was referring to and the only known therapeutic input to this review is that stated within the chronology.

3.151 The assessment continued and described how Graham would use Linda's mental health difficulties against her and would refer to her as 'crazy' and criticise her parenting. Linda stated she had borderline personality disorder, bi polar, manic depression and anxiety. She said she was not currently on any medication which is contrary to her call to Refuge two weeks earlier. She said Graham would openly contact women online and made no secret of his interest in other women. Linda recalled being hit in the face by Graham when she was about 18. The abuse had been physical as well as mental and emotional she said.

3.152 As a result of this assessment a Child In Need (CIN) plan was recommended. There was an action for Refuge to assist Linda in obtaining a "legal order and housing move". 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.

3.153 Between the 6th and 19th April 2021 there were several contacts between the IGVA and Linda attempting to gain her a refuge place. This was delayed somewhat by a lack of available refuge spaces and Linda's worry that her children may have had Covid. After tests, it was confirmed they just had a cough. Linda requested a self-contained space due to one of her children having asthma.

3.154 Refuge interviewed one of their members of staff as part of this review. Within it they queried why a domestic abuse risk assessment had not been completed with Linda. The IGVA explained they'd felt the Social Worker had been quite insistent Refuge work with Linda and they felt there was pressure on her to do so. The IGVA said in the first call Linda had the children with her and so the IGVA was telling her what they could offer but she wasn't saying what she wanted. During the second call the IGVA didn't feel it was the right time to do a risk assessment as she was prioritising finding a refuge space, Linda again had both the children with her as they were both ill and so it was not appropriate to complete the risk assessment. Refuge's policy on risk assessment is

clear; *it is not appropriate to complete a risk assessment in the presence of other people including the survivors' children*.

3.155 On the 19th April 2021 Linda left the LBBD and moved to a refuge placement in Hertfordshire. On the same day, Graham contacted the Social Worker. He said he felt Linda going to refuge was an act of malice and now she had total control. He made counter allegations saying she had been making threats towards him about stopping him from seeing the children. He said he wanted to go to Court to apply for joint custody, wanted to know where he stood regarding housing, was upset he could no longer see the children on a daily basis, wanted to get rid all of Linda's possessions and said he had suggested mediation but Linda refused.

3.156 He said Linda had told him the flat was his and she was getting another flat. This indicated continued contact. Graham was advised to seek legal advice in respect of child contact.

3.157 Linda was later spoken to by social care and reported feeling very happy to be away in a refuge. She felt she could "cry thinking about being free from Graham". It was noted she would be supported by her keyworker in refuge with the Triple R programme (Recognition, Recovery, Resilience) to raise her awareness about the risks of domestic abuse to herself and children and how to maintain safe decision making. It was noted how the Health Visitor had also made contact with Linda and would be offering ongoing support to the family in the new area. Due to Linda moving out of area the case was closed to Social Care.

3.158 Linda sent a text to the Health Visitor on 20th April 2021 saying she no longer lived in the local area. The Health Visitor called Linda who would only share she had gone to a refuge before ending the call.

3.159 On the 27th April 2021 the Social Worker spoke to Linda who said the children had contact with Graham over the weekend. She described it as emotional for both him and the children. They met at a neutral place, he took the children and returned as planned.

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3.160 As part of the health visiting "transfer in assessment", the Hertfordshire health visitor conducted a first visit to Linda and the children on the 27th April 2021. They had requested previous health visiting records from Barking and Dagenham. Had they been received this would have allowed a further review of maternal and children's history especially regarding maternal mental health and domestic abuse history alongside the children's experience of witnessing domestic abuse. During this contact Linda said she was not happy in refuge and was considering leaving. The Health Visitor completed an anxiety assessment called a GAD 7 and a depression questionnaire called a PHQ9. Linda scored 0 on both, which was assessed as being within normal limits. Despite these scores Linda said she was having a 'bad day'. There was no recorded exploration of why Linda scored 0 on these assessments but additional undocumented exploration may well have taken place as the Health Visitor referred her to the mental wellbeing

team. There was no further discussion around Linda's vulnerabilities or coping strategies which the NHS Community Trust consider to be a missed opportunity.

3.161 A day later, on the 28th April 2021, a Duty Health Visitor received a verbal handover from a Health Visitor in Barking and Dagenham. Hertfordshire were informed Linda and her children had been receiving the Universal Partnership Health Visiting service due to her mental health. There is no further documentation describing the nature of the mental health concerns. Therefore, no real understanding of her mental health and previous experiences could be gained. A "history of non-engagement" had lead the previous Health Visitor to take the case to safeguarding supervision. There was no further exploration of this from Hertfordshire Health Visiting and therefore no understanding of what the Barking and Dagenham health visitors were recommending from their safeguarding supervision.

3.162 The Hertfordshire Health Visiting service did refer into the single point of access (SPA) in Hertfordshire on the 28th April 2021. The SPA is a one front door hub meaning referrals for a variety of concerns, from child safeguarding to mental health support, can be received and disseminated to the appropriate agencies. This referral requested the wellbeing service within the mental health team support Linda. The Health Visitor had been concerned Linda appeared stressed and anxious. The referral detailed diagnoses of Bi-polar Disorder, Personality Disorder, Obsessive Compulsive Disorder and Post Traumatic Stress Disorder after "being raped as a young child by her mother's partner". Linda reported that she had not been ready to engage in mental health services previously but now felt ready. This referral was returned due to a lack of information around her current mental state. It was queried whether a SAFA (Safeguarding Adults From Harm) had been submitted. This acronym was not widely used at the time and has since changed. There was some confusion about what this meant. Learning from this review is a reminder for agencies to avoid using acronyms, especially between agencies who may not have an awareness of their meaning.

3.163 The referral was re-submitted the day after with a decision not to be taken on by the wellbeing team due to Linda having a personality disorder diagnosis. The panel have clarified that the only mental health diagnosis Linda had at this point was a "Mixed Anxiety and Depressive Disorder".

3.164 On 29th April 2021 Linda and her children were transferred out from the Barking and Dagenham Health Visiting Service. An alert - do not divulge address - was added to records, which highlights good practice as mother and children were reported to be in Refuge.

3.165 On the 4th May 2021 the SPA (Single Point of Access) attempted to contact Linda several times before eventually getting through via phone. She would not disclose her address as she said she was in a refuge and wanted to stick to the protocol. She said she had tested positive for Covid. The caller could hear her youngest child crying in the background. They asked Linda if she would like to tend to them, which she did.

3.166 The SPA spoke to Linda the following day. She said she had been sexually abused when 5 years old by mother's ex-partner. Her mother only knew about this some years later. She disclosed her experience of domestic abuse and said her husband had given her a black eye and tried to strangle her previously. She said her eldest child, 5 at the time, had disclosed this to the Social Worker. Her husband had been asked to leave the home but would not and this is the reason she had to flee to refuge. She said she had reported domestic abuse to the Police and the case was closed because she was in refuge. She reported feeling down about her current living arrangement in shared accommodation. She said she was having issues with sleep and weight gain due to her medication and reported a poor appetite. She said her mother was aware of what she was going through and was very helpful. She said her best friend lived in Barking but she couldn't discuss those issues with them. This was not explored further by the practitioner and remains unknown. Linda requested to be seen by a psychiatrist.

3.167 The following actions were noted by the SPA following this contact:

- Linda to continue to engage with Health Visiting Service.
- Linda to engage with a case worker at refuge and attend her group support.
- Linda to contact Sunflower Domestic Abuse Services.
- Linda advised to use Mental Health Helpline.
- SPA triage to discuss Linda at Multi-Disciplinary Team and liaise with Health Visitor.
- Linda prescribed promethazine to help her sleep.

3.168 Linda was scheduled in for a brief assessment the following day. She was uncontactable. The SPA had assessed Linda as not being a risk to herself or others. A call was scheduled for the following day to try and complete the assessment.

3.169 On the 7th May 2021 the Community Psychiatric Nurse contacted Linda via phone to complete a brief assessment. Linda reported not feeling well with tonsilitis and asked to be called back the following week.

3.170 Calls were attempted on 10th May 2021 but with no response.

3.171 On the 11th May 2021 a text message was sent to Linda inviting her to a mental health assessment on 27th May 2021 at 2:30. She was given advice to be somewhere where she would not be interrupted.

3.172 Linda telephoned the school nursing team on the 11th May 2021 and shared concerns that Freddy may have attention deficit disorder (ADHD). She advised he was waiting for a school place. The school nursing team advised Linda to call back once Freddy had a place at school as they were not commissioned to offer a service to children who weren't currently attending school. This action did not appear to take into account the family's vulnerability and specifically Freddy perhaps having an increased vulnerability due to possible attention deficit disorder (ADHD). Therefore there was no support in place for Linda to manage his behaviours.

3.173 On the 27th May 2021 Linda spoke to a duty social worker within the mental health team and explained she was being evicted from her refuge placement. This was a brief phone call where Linda said she could not talk due to the eviction. The mental health team gained Linda's new address in St. Albans and shared this with the local mental health service so they could offer an initial assessment.

3.174 During the course of this review the accommodation Linda fled to - St Albans and Hertsmere Woman's Refuge (SAHWR) were liaised with and formed part of the panel. Unfortunately, all records pertaining to her time at the refuge have been lost due to a change in their internal recording system. This is a significant gap. As part of their internal review they interviewed two keyworkers who were present when Linda was a resident. They recalled how, on the 27th May 2021, 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.

3.175 As a result of Linda's behaviour towards staff, coupled with a concern she had disclosed the location of the refuge to Graham, SAHWR asked Linda to leave the refuge with immediate effect. Contact was made with St Albans Council where she had applied for housing to find emergency alternative accommodation, which was provided. There was no consideration of MARAC from SAHWR. It is a recommendation for any refuge space, where a perpetrator is still in contact with the victim, to refer to MARAC regardless of whether an eviction happens or not.

3.176 The accommodation recalled how Linda was collected directly from the refuge by Graham and were later shown a video sent to another resident of Graham and Linda at the accommodation with the children. As a result of this the staff at this accommodation submitted a safeguarding referral into Hertfordshire Children's Service.

3.177 On the 1st June 2021 an e-mail exchange took place between the homeless housing officer and SAWHR asking if a "MARAC" form had been completed, meaning a DASH risk assessment. SAWHR replied the form had not been completed. The Homelessness Officer (HO) also asked for details on "declared" violence. SAHWR replied that details came from Linda herself and that they were also informed that one of the children had said to Social Worker about "daddy hurting mummy". A DASH was not completed by the HO either which was not in line with the local housing procedures at the time.

3.178 A housing needs assessment form was later completed which highlighted physical and mental health issues as being present in the household. Conditions mentioned were bi polar, asthma, high blood pressure, borderline personality disorder, anxiety and PTSD. The housing needs form concluded how medium/low support needs were evidenced with monthly support checks required.

3.179 A week later, on the 4th 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. Concerns were raised by the refuge for the welfare of the children and it was made clear the family had experienced domestic abuse and the perpetrator of the abuse was still in their lives. His presence was described as one of the reasons for the eviction.

3.180 A multiagency safeguarding hub (MASH) assessment was conducted on the 7th June 2021. Linda was spoken to and explained her ex-partner Graham had been picking the children up from her refuge address every weekend for the past four weeks. She said she had no concerns for the welfare of the children in their father's care. She confirmed she had been evicted from the refuge.

3.181 She gave some more details about the history of her relationship saying they had split up 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 she would have to leave the home address. She disclosed "a few years of domestic violence" and said Graham had been manipulative. She felt that things had improved since the move but that she knew nobody in the local area and her family were in Kent, Barking and Ireland. She said she wanted a divorce. She reported to Social Care that conditions in the refuge were poor and her children were blamed for some of the mess. She said there had been mice and ant infestations and she didn't feel it was fair for her to be asked to do a deep clean. As a result of this request she said she raised her voice to refuge staff. She said she had been told to leave and given 2 hours notice. She said she couldn't get her belongings out in that time and called Graham to help.

3.182 The accommodation were contacted as part of the MASH assessment. They reported Graham had picked Linda up from the refuge space and she had returned twice with him to collect her belongings. Another client at the refuge had showed a member of staff some footage of Linda showing Graham around the refuge. The accommodation reported Linda had asked another client for some weed and said that she would get Graham to bring some. They said she was very aggressive in front of the children, that she took out a rolling pin to smash up a member of staff's car, but she was stopped. Linda reportedly said that she would 'rather get my face smashed in by Graham than be told what to do by you'. They reported she had lodged a complaint against the refuge.

3.183 Linda shared that despite wanting a divorce, the children's father wanted to get back together. She said not all domestic abuse incidents had been reported. She shared reports of Graham pulling her hair, locking her in the bathroom and being strangled in January of that year. She said she was not financially dependant on him. She also discussed her mental health needs but no further details of this are recorded.

3.184 The MASH completed a Domestic Abuse toolkit on their call with Linda. This toolkit has been viewed during this review. Within it, it states:

- *If information as part of the MASH episode identifies the incident to be 3rd or more significant DA incident in a rolling 12 month period, please discuss with manager for consideration regarding case progression.*
- *The MASH episode must identify a parent acting protectively and engaging in relevant support via IDVA/Sunflower centre, and how the contact between Children and Perpetrator will be managed.*

3.185 Within this, there is no mention of MARAC or referring to MARAC on professional judgement as per the Safelives guidelines [25]. Neither is there mention of completing a DASH to assess the risk of further harm. It is a recommendation for Hertfordshire Social Care to review their MASH Toolkit advice, to incorporate Safelives guidance and to consider using Linda's experience to highlight the need for longer term support for those leaving refuge. On the 7th June 2021 the MASH were aware Linda had fled LBBD due to domestic abuse and had just been evicted from the refuge in part due to continued contact from the perpetrator. Stalking and / or harassment possibilities were not considered. This could have lead to a referral to MARAC on professional judgement. This will be detailed further within the analysis.

3.186 MASH attempted to contact Graham on one occasion with no answer. They requested information from Barking and Dagenham Children's Services. Health information was received and informed them Linda had significant mental health issues. Diagnosis of bi polar, multiple personality disorder, OCD and PTSD from traumatic childhood experience with sexual abuse mentioned. As had been identified by this review, this was inaccurate. Linda had reported concerns with Freddy's behaviour, and he was not attending school. It was noted that previous Children's Service involvement was in part due to domestic abuse from Graham.

3.187 The MASH health view was that the referral was very concerning. It appeared to them Linda was back in contact with her abuser and "not safeguarding the children". Linda had a significant mental health history and there appeared to be "minimal protective factors for the children".

3.188 On the 9th June 2021 the Health Visitor gave a verbal handover to a duty Health Visitor in the family's new area where they had gone to temporary accommodation. This was swift and timely handover and an example of good practice. A history of domestic abuse between parents was disclosed as was continued contact between the parents. The Health Visitor raised concerns around the children being potentially at risk of continued exposure to domestic abuse. The duty Health Visitor advised they would add

[25] https://safelives.org.uk/sites/default/files/resources/Marac%20Referral%20Criteria%20-%20Definitions_.doc#:~:text=Visible%20High%20Risk&text=SafeLives%20recommends%20that%2014%20'yes,the%20overall%20assessment%20of%20risk.

the family to the team allocations list and Linda would be contacted so that a "movement in" visit could be arranged. A new Health Visitor was allocated but there is no documentation on the health visiting system of their action plan.

3.189 The Mental Health Team then contacted Linda on the 9th June 2021 where she was offered an initial assessment on 22nd June 2021. A voice message was left. Linda confirmed this appointment a day later and agreed to it being virtual.

3.190 On the 11th June 2021, due to concerns about ongoing contact between the parents, a decision was made by Social Services to complete a Child & Family Assessment.

3.191 On the 17th June 2021 the newly allocated Health Visitor completed a transfer in home visit at Linda's temporary accommodation. Linda reported Graham to be having contact with the family which she had no concerns about. Mood assessments were completed once again. The Health Visitor documented an intention to refer the family to the Family Centre for additional support and to liaise with refuge staff to gain further information.

3.192 The refuge staff were liaised with by the Health Visitor who explained concerns about Linda's aggressive behaviour towards them and her continued contact with Graham whilst in the refuge. Review of Health Visiting records showed no further risk assessments, analysis, or action plans to mitigate or manage any risk around maternal mental health or any ongoing domestic abuse; which would have included a DASH risk assessment. There was also a further missed opportunity to generate the vulnerability icon[26] on the children's records.

3.193 The mental health team conducted an initial assessment with Linda on the 22nd June 2021. This was completed by a student social worker and occupational therapist via the phone. It is unknown why this was not virtual as had been agreed.

3.194 Later that day Linda was discussed at a post assessment meeting. It was decided that she should be discharged until she registered with a GP. Once she did this the GP could refer her back in for support or she could refer herself. The student social worker contacted Social Services in Barking and Dagenham requesting Linda's history. They were told this information could not be shared without Linda's consent. This is another example of Linda being told a service could not be offered since her move to Hertfordshire. Discharging her did not adequately reflect her vulnerability, complexity of needs or acknowledge the level of support she could have benefitted from. The refusal

[26] This icon is used when any health professional has concerns that the child's health or development is likely to be impaired without additional services. This may include children with significant unmet health needs or those whose parents are unable to fully meet their needs because of their own issues e.g. mental health issues, learning/other disability, substance misuse. It should be completed whenever there are concerns about a child, even if no other agencies are involved.

to share information from LBBD Social Care did not consider there was an ongoing child and family assessment where assessing parental health plays a significant part in accurately assessing risk. This needed to be challenged.

3.195 Linda was informed of this outcome later that day by the occupational therapist. Children's Social Care were discussed and Linda confirmed she was already allocated to them. She was asked if she wanted to report the historical sexual abuse but she became tearful and said she did not wish to discuss this infront of the children. She was provided with helpline numbers. This is the first recorded occasion she had been offered specific support for the childhood sexual abuse.

3.196 The mental health team received the requested medical history from the GP on 24th June 2021. The occupational therapist from mental health contacted the local IDVA (Independent Domestic Violence Advisor) service on the 25th June 2021 to see if Linda was known to them. She was not so a referral form was given to the mental health team to complete. It is clear from their notes the mental health team were concerned Graham was still present and wanted her to have support.

3.197 On what was to become the last contact between the mental health team and Linda, accepting support from an IDVA was discussed. Linda would not give consent for this but took the details incase she needed them later. It is unknown why she would not consent. The childhood sexual abuse she experienced was discussed again. She said she was trying to ascertain the man's name as her mother had not been in a relationship with him for some time. However, her mother was friends with him on facebook and she was concerned about her little sister who still lived with her mother. Linda was reminded by the occupational therapist about the risk that could be posed to others by him and she was given advice on speaking to the ACMHS (Adult Community Mental Health Service) at a later date to discuss reporting the abuse. This is another example of Linda being advised to do something. This teams safeguarding duty to Linda's sister was discharged to Linda via this action. The panel identified this during the course of this review and as a result referred Linda's disclosure to the local authority in Barking and Dagenham for safeguarding actions to be commenced.

3.198 Linda was advised to register with a GP so she could be referred for psychology. However, it was suggested psychology might be more appropriate when she was more settled as she could feel a little worse before she felt better.

3.199 On 30th June 2021 it was agreed a strategy discussion was required after liaison between the Social Worker and Team Manager. The length of time between being evicted from refuge - 27th May 2021 - and a strategy discussion being held – 8th July 2021 – has been discussed at length as part of this review. Both LBBD and Hertfordshire Social Care do not consider this to have been a significant delay, nor do they consider it to have

hindered the work to Linda in any way. However, by the time the strategy meeting happened, the mental health team had exited and were not present at this meeting. They therefore did not give their agency's view / information at this meeting nor could they be challenged about closing Linda's file until she was registered with a GP.

3.200 On the 7th July 2021 the Social Worker visited the school to complete wishes and feelings work with Freddy.

3.201 During this session Freddy drew a picture of the family which included Felix, mum, dad and their cat. Freddy described not living with dad Graham anymore and mentioned missing the cat who remained with Graham. Significantly, Freddy mentioned Graham would sleep at their house on the sofa as he was there when Freddy woke up that morning. Freddy said things were better in the new house as Linda and Graham did not argue as they had done before.

3.202 The head teacher said Freddy had settled in very well and was described as a lovely child. They reported Graham had been to the school and seemed to be very involved with the children. The school were aware that Linda had been to a refuge. The school were spoken to as part of the review and reported being very concerned about receiving a Section 47 child welfare report when Freddy first attended school. They didn't know whether they were able to let Freddy leave school with Graham. They were so concerned they called the police to seek clarity, the first time the headteacher had done this in his career. This confusion typifies the mixed picture at the time. There are professionals with significant concerns based on Linda fleeing refuge due to domestic abuse, being evicted and Graham still being present. Conversely, there are no MARAC referrals, DASH assessments or apparent concern harassment and stalking may be present.

3.203 During the social work visit to school, Freddy spent most of the time playing with Graham, going to him for cuddles and playing cars with him. Freddy was very active during the visit and seen to throw toys around several times. The parents advised they would look at pre-school for Felix but could not afford this and would not get funding until January 2022.

3.204 On the 8th July 2021 a section 47 strategy discussion was held. It was attended by Children's services, Housing, Police, Health Visitor, School Nurse and School, all from Hertfordshire.

3.205 During this meeting, the Social Worker shared that during a home visit, when they'd asked the couple about their relationship Linda had clearly stated it was definitely over and they would not be getting back together. Graham had commented he still loved her and would resume the relationship if possible. The couple were seen to be "very

comfortable with each other and were getting on well". Graham said he didn't stay the night at the flat but came around very early that morning. The Social Worker explained how Linda had had a mental health assessment who suggested therapeutic support but she would need to be in a stable environment before it could proceed.

3.206 Housing reported that on 2nd June 2021 they visited the temporary accommodation. Linda said she was not dressed, so they could not enter and were concerned that Graham was at the address. They reported Linda as having £5000 rent arrears on her previous property.

3.207 The police information disclosed went back to 2018 which was a missed opportunity to disclose the full picture which, as the review has established, dated back to at least 2013 when there was the first incident of strangling.

3.208 The result of this strategy discussion was as follows: *"For a child and family assessment to be completed and to look at the safety of the children. Worker to consider whether the risk factors are sufficient to warrant whether the case meets the criteria for a child in need plan or whether the case should step down to IFST (Intensive Family Support Team), as there are issues in regards to domestic violence, mother having cannabis cookies and the rent arrears."*

3.209 On the 15th July 2021 the Child and Family assessment was finalised. This has been viewed by the review chair. Within it states:

Linda has spoken about how she fled to the refuge due to an incident of domestic abuse and being told by Barking and Dagenham Children's Services that the couple were not able to live together due to this. Linda spoke about how they would have lots of arguments, even though their relationship had ended, and that Graham would continue to come to the flat when she asked him not to. Graham has denied any domestic abuse and states that he doesn't know why Linda fled to the refuge, but that towards the end of their relationship there were lots of arguments. Although the parents are stating that they are not in a relationship, Graham is spending a lot of time at the family home and he has stated that he still loves Linda. Both parents have spoken about how they understand that their arguments were having an impact on the children and their plan long term is to be able to co-parent the children amicably, whether they resume their relationship or not.

The admission from Graham, that he still loved Linda, needed to be considered alongside the history and in a domestic abuse context. When considering Linda's friend's testimony, that he inserted himself into Linda's life where he could, and the available evidence such as Linda fleeing from him yet him still being a significant fixture in her life, there were warning signs which suggested Graham's behaviour might not

simply abate. There is strong evidence which suggests abuse continues and often increases on separation.[27] This does not seem to be considered. Furthermore, this could be viewed as an indicator that Graham required support to come to terms with the end of his intimate relationship with Linda. This was an opportunity to encourage his engagement in support services such as the Men and Masculinities group in Barking and Dagenham. [28]

3.210 The assessment concludes – *Both parents have stated that they are willing to engage with any support ongoing and have agreed to work with the Intensive Family Support Team.*

3.211 A letter was sent to Linda on the 26th July 2021 with the outcome of the child and family assessment and is written below. This has been written below for reflection upon tone which is further discussed in the analysis:

"I write further to Children's Services receiving a referral on 1.6.21 as you had been evicted from a refuge and there were concerns that you were in contact with Graham (husband and father to your children) despite previous domestic abuse. It is Hertfordshire County Council's policy to follow up any information we receive involving the welfare of children. Children's Services need to have assurance that the basic needs of children are being met.

A Child and Family Assessment has been completed by Children's Services on 15.7.21 whereby agency checks have been completed, the children have been seen in your care and Freddy has been seen in school. You have spoken about how there were previous arguments in the home but that you are now able to communicate with Graham around the children with no ongoing arguments.

The Assessment Team Manager has reviewed the referral information and assessment and has advised that Children's Services will not be pursuing the matter further at this point in time. It is Children's Services recommendation that you engage with the Intensive Families Support Team who will offer ongoing support as follows:

- *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"*

[27] Post-separation abuse: A literature review connecting tactics to harm - PMC (nih.gov)
[28] Men & Masculinities - Cranstoun

3.212 It was commented within the closure record how Graham had denied domestic abuse but both parents agreed there were arguments between them when their relationship broke down which the children witnessed. “Parents now speak, Graham has regular contact with the children but they are not in a relationship. No concerns have been raised around the care of the children, the oldest child has started school and settled extremely well. They have been observed to have a positive relationship with both parents. Mum has previously had poor mental health but this is currently stable.”

3.213 The Intensive Family Support Team (IFST) attempted to make contact with Linda on 28th July 2021 but gained no response. On the same day, the Family Centre, who had been referred to by the Health Visitor, visited Linda at home and she agreed to support for herself and the children. However, from that point on Linda cancelled contacts due to concerns about the children being unwell or a worry about Covid. There were five attempts in total until the referral was officially closed on 7th October 2021 with the Health Visitor notified of this outcome.

3.214 A home visit was cancelled by Linda on the 2nd August 2021 but she did meet with the IFST worker the following day. The records state “Consent Withdrawn” as she felt she didn’t need IFST support. She was invited to an IFST funday and IFST park day meet. It was noted how the family appeared to be settled and the “only safeguarding concern was the history of domestic abuse from father”. The practitioner noted: *“I believe the children and mum to be comfortable and getting on well. The home is in good condition, children are dressed appropriately, and mum is attentive and caring. There are no financial concerns either.”*

3.215 On the 3rd August 2021 the Health Visitor noted receipt of a closure letter from Children’s services, saying a referral to Early Help had been completed requesting support with positive parenting and financial support for Linda. The Health Visitor appeared to accept Children Services decision to close the case and as a result closed the vulnerable child icon on the internal records without a further risk assessment. Linda and the children were then seen as per Universal health visiting service. There is no evidence that the Health Visitor reached out to their safeguarding supervisor for support which was a missed opportunity. If the family had been brought to supervision it would have offered the practitioner the opportunity to reflect on the situation and consider the assessments available to gain professional oversight into the lived experience of Linda and her children. There is no evidence of any challenge to Children Services around this decision.

3.216 On the 14th August 2021 Linda sent an e-mail to the housing team asking for a property with a garden if possible. Within this she thanked staff for a new life and home. She said she had been in a horrible situation for years and the house had changed her family’s lives forever. She said she couldn’t thank them enough and that she had been treated with kindness and respect.

3.217 Despite the lack of consent the IFST worker continued to try and engage Linda over the next two months which was good practice. Voice messages were left for her and an unannounced home visit was completed on 23rd August 2021 but without success.

3.218 A home visit was completed by IFST on 27th August 2021. The family worker met both children and described them engaging and happy. Freddy told them all about their toys, and Felix appeared very smiley and content. Linda was positive about the current circumstances. She said the children saw Graham at the weekends. The IFST worker stated they would help Linda settle into the area and look at activities and clubs, as well as assist with school uniform support. They commented she seemed well and was "very engaging". They agreed to catch up on the 6th September 2021. This is the last direct contact recorded by this team. On the surface, it is understandable how IFST would be assured by the presentation of the family as detailed. But this gives a snapshot of a particular day. The context of the family's arrival in Hertfordshire, the domestic abuse history, the context of Graham's continued contact, Linda's untreated and poorly understood mental health needs and her experiences of Children's Social Care throughout her life required a trauma informed approach, pause for thought and unpicking within supervision.

3.219 During an internal IFST supervision session on 10th September 2021 there was mention of a Team Around the Family (TAF) meeting being planned for the following week. There are no records about whether or not this occurred nor who attended. It was commented that home conditions were good enough and school had no concerns about the eldest child's wellbeing. There are several mentions of home conditions within the notes which in hindsight appears to be an overfocus. Actions were noted as follows:

- Complete Risk Assessment
- Complete Families First Assessment[29]
- Contact professionals involved to inform of IFST involvement
- Refer to Family Centre
- Complete Case Summary
- Complete Family Star (an assessment tool)

3.220 As can be seen, there is no mention of Linda registering with a GP, mental health input nor domestic abuse work with either parent within this supervision session. The latter was specifically mentioned within the closing letter from Children's Social Care. It would be beneficial for reflection to occur with previously agreed actions to identify whether goals have or have not been met.

3.221 During the 20th September 2021 IFST supervision it was commented how the children continued to have contact with their father at paternal grandmother's home fortnightly. It was again commented a TAF had been arranged for the following week but no further details about who had been invited.

[29] Families First (hertfordshire.gov.uk)

3.222 No further contact was had with Linda despite attempts. The IFST practitioner contacted school who had no concerns about Freddys wellbeing. The family were closed to their service on the 13th October 2021.

3.223 On the 29th September 2021 Linda updated her housing needs assessment form. She stated she had been under the care of the crisis team and also mentioned episodes of self-harm from 2 years previously.

3.224 Linda's email contact with housing continued in October 2021 where she messaged saying they could not live above anybody due to Felix's "severe anaphylaxis" and the impact of cooking fumes. She was provided with permanent accommodation on 22nd November 2021 at which point housing ended their monthly calls with her.

3.225 On the 10th February 2022 a third party call was made to the Metropolitan Police by a friend of Graham's due to concerns about his welfare. Graham had left a group chat saying he was going to say goodbye to his kids that night. Police spoke to Graham who said he'd found out his ex-partner had a new partner who had already met his kids. Graham told officers he "felt shit" but was not feeling suicidal.

3.226 The health visiting team attempted to contact Linda four times between 9th March 2022 and the 19th April 2022 to arrange a developmental review for Freddy. However, it was deemed further attempts were not required in line the Standard Operating Procedures (SOP). This could be considered another missed opportunity to seek the family's lived experience.

3.227 Linda registered with a new GP in March 2022. She made an appointment for Felix due to a "productive cough". Whilst there she asked for details of the sexual health clinic. She stated this was because of the breakdown of her relationship with 'partners'. It is unknown if this was with reference to Graham or her new partner. This was the first of two contacts with the GP. The second and final one came two weeks later in April 2022 when Linda contacted the surgery 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". This was the totality of this call. There was no further exploration of Linda's circumstances or history. Linda gives an indication of previous domestic abuse to the GP. Given she was a new patient at this surgery it could have been explored in more depth. Had the GP been aware Linda had fled to the area from refuge, an extended in-person appointment would have given the GP an opportunity to better grasp Linda's mental health background and enquire about prior domestic abuse support. This was the last time the GP had contact with Linda. As Linda's friends have detailed, she was going through a "breakdown" around about the same time.

3.228 Other than Linda's friend's description, there is a significant lack of information about all aspects of family life in 2022. Despite it being a key line of enquiry, the panel have been unable to shed any further light on Linda's experiences at that time. There are no significant concerns reported by education. As the friend's detailed in their

contribution, 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.

3.229 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. He had been looking after the children for the weekend and on Sunday evening was bringing the boys back to her address. On the way back, they stopped for McDonalds and Graham received a phone call at about 7pm from Linda which concerned him. Although there was no mention of Linda ending her life, he felt she was talking in an odd way. She had asked him to take the children home with him and told him he was a good dad. Graham later told the police Linda had a history of self-harm which had included cutting and a prior attempt to drown herself in the bath.

3.230 Following the phone call, Graham attended the home address and used his spare key to enter the flat. Freddy entered the bathroom and saw his mum. Linda had hung herself via the shower fitting. Graham lowered Linda to the floor and attempted to revive her via CPR. Police arrived soon afterwards.

3.231 Linda was taken to hospital and placed into an induced coma. Although there was a heartbeat, she was unable to breathe without the help of a ventilator. Police were informed she had suffered brain damage and that they did not believe she would be able to breathe on her own. Some days later, following consultation with her next of kin, life support was withdrawn from Linda and she died.

Post

3.232 The police investigation into Linda's death examined her digital devices and interviewed her current partner aswell as Graham.

3.233 Her new partner said he had been in a relationship with Linda for around three and a half to four months and that he had lived with her and the children since roughly the end of February. This would mean he moved into the family home after a few weeks. He said Linda had been quite open about her mental health issues, telling him she took medication for depression and bi-polar.

3.234 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.

3.235 He recounted how everything had been "normal" that day, they got up together, had a coffee and rolled a cigarette just as they normally would. He left at around 10am and at various points throughout the day called, text and facetimed Linda.

3.236 His last messages discussed what time he would be home. Having told her 9pm, he messaged at around 6:30pm to say he had drunk a few beers and would be having a lie down. Just before 7pm Linda replied "I KNEW THIS WOULD HAPPEN. GOODBYE". He did not see that message until around 7:15pm, replying immediately. Linda never opened those messages and by the time he got to the flat, police were there and Linda was on her way to hospital. He did not want to give further details and would not provide his contact details to the police.

3.237 Police also spoke to Graham as part of their investigation. He said there had been a marked change in Linda when she began her relationship. In his eyes, "she stopped going out, stopped seeing people and had closed herself off from others". He reported tearful phone calls from Linda asking why nobody loved her and said that she had never been with somebody yet felt so lonely at the same time.

3.238 The police explored Linda's internet search history as part of their investigation. She had bookmarked Wikipedia pages: 'Suicide Methods', 'Noose' and 'Suicide by Hanging'. In terms of her internet searches, the following were noted:

- Searched for 'direct payday loans'. There was nothing else that indicated she had money issues.
- On the same evening Linda searched "burden I think too much but I hate it". Police believed this was in reference to a song lyric.
- Linda also searched for 'forms of self harm'. Later she searched for 'load bearing rope' and accessed the Google Shopping Pages. She also searched for 'celebrities that committed suicide'

3.239 Notable pages in Linda's recent internet usage included:

- accessing pages regarding 'what is self-harm?',
- 'suicide by hanging' and 'List of Suicides in 21st Century' (last two both on Wikipedia).
- She also accessed the Wikipedia page of Chester Bennington, an American musician who committed suicide by hanging.

3.240 Other than the above, Linda's internet usage was described as very normal, frequently accessing pages for online streaming of tv shows, grocery shopping, clothing stores and looking up information on schools and nurseries.

3.241 On the coroner's postmortem examination report, psychiatric diagnoses were noted as

- Bipolar Disorder
- Obsessive-Compulsive Disorder
- Post-Traumatic Stress Disorder
- Depression.

As has been established via this review, with the exception of depression, these were not official diagnoses.

3.242 In October 2022 Graham contacted police to say he had found a notebook hidden inside a kitchen cupboard at Linda's home address. He had been living there with the children since Linda's death. Graham said she referred to it as her "Thought Book" and she'd owned it for a year or two as he recalled seeing it previously in her temporary accommodation. He said she would sometimes use the book to write down her thoughts and feelings, in particular when she was struggling with her mental health. She would usually hide the book away so other people did not see it, which presumably is why it was hidden in the kitchen cupboard.

3.243 The entries in the book were clearly written at times when Linda was very unhappy and was having suicidal thoughts. There were any number of insults and comments written about herself, as well as numerous references to ending her life.

3.244 Linda's most recent entry was written just five days before she ended her own life. 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 spoilt the chance of her children being part of a new, extended family, "KIDS WERE ALL I HAD. RUINING IT FOR THEM IS ENOUGH".

3.245 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".

3.246 Following Linda taking her life, Children's Social Care opened a further assessment to examine the safety and wellbeing of the boys in Graham's care. They spoke with school, Graham, his parents and the children themselves. It was unclear how much they fully comprehended given their age, and Freddy especially was noted as quiet. The assessment concluded stating there was no requirement for further CSC input. They highlighted the following:

- *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.*

Section Four

Analysis

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

Domestic Abuse

4.1 **The review will explore the relationship history between Linda and Graham, what was known about any abusive behaviour and which agencies this was known to. Was the gendered nature of domestic abuse considered within this and addressed appropriately?**

Abusive behaviors noted included consistent blaming of Linda's mental health for all issues, threats to remove the child, two incidents of non-fatal strangulation, threats to kill himself (Graham) but also a threat to crash the car with Linda and their child in and stalking behaviors. This is not exhaustive and further behaviors are listed within the conclusion. Each agency held key information. As can be seen by the chronology in this review, information was held by the GP, Mental Health Teams, Social Care, Intensive Family Support Team, Early Help, Police and Health Visiting in both areas. Had this information been collated, assessed, shared and fully understood there could have been a good understanding of the nature of the abusive behavior, its impacts and attempts could have been made to intervene appropriately. However, services rarely worked together, despite there being several occasions when multiple agencies were involved concurrently. There is evidence of good multi agency working within para 3.131 but this does not seem to be the common practice. The strategy meeting in Hertfordshire post refuge was unable to fully grasp the breadth of the abusive behavior and consider its impacts. Nor did the subsequent child and family assessment. Even towards the end of the scoping period, when Team Around the Family meetings were said to have been organized by the IFST, there are no notes of who attended nor minutes which state what was discussed. Therefore, it appears not only was the gendered nature of domestic abuse not recognized, but domestic abuse overall was barely recognized. This review, as many others have shown, highlights the importance of professionals recognizing domestic abuse and naming abuse such as harassment, stalking and coercive control.

Agencies are rarely involved with a family for the 10 year period which this review encompasses. It is therefore vital that reports are recorded and records shared. There were missed opportunities throughout the 10 year scoping period to collate the information and fully appreciate the dynamic at play. Graham was often a peripheral figure and was rarely engaged with in any meaningful way. Where he was liaised with, he denied abuse and persistently framed issues as being around Linda's mental health. The GP had the most significant meaningful contact with him which was non domestic abuse related.

The police came into contact with the couple on a number of occasions between 2013 and 2021 but never assessed the risk of domestic abuse harm as high. Within this time

there were two reports of non-fatal strangulation. The limitations in timeframes of agency checks proved significant as during the strategy meeting held in July 2021 police did not disclose the non-fatal strangulation from 2013. This was a missed opportunity to build a more complete picture. The direction for the LBBD Social Worker to refer into MARAC was not followed and subsequent professionals did not refer in either.

Social Care within LBBD have reflected how the gendered nature of domestic abuse was never considered during assessments at Early Help or Social Work stages. Since this time they report they have trained all Social Workers in Safe and Together, as well as other key members of the children's workforce. They have also rolled out Safe and Together training[30] for all people working with children and young people across Barking and Dagenham to ensure a shared understanding of domestic abuse. They state they have also commissioned 10 specifically designed courses provided by their survivor's service available to all in LBBD on domestic abuse, which includes understanding of the gender-based nature of domestic abuse.

4.2 **Whether family and friends were aware of any abusive or concerning behaviour between the perpetrator and victim (or other persons). Were there any barriers they may have experienced in reporting concerns if they knew how to and felt able to?**

As previously mentioned, involvement of friends, family and the wider community have been limited in this review. However, two friends were spoken to towards the end of the review period. They state they were aware of controlling behavior from Graham towards Linda and gave examples of him blaming her mental health and criticizing her parenting. They were also aware of his threats to leave with the children if Linda ever left him. They also had concerns about Linda's new partner although by this point Linda was living farther away and it was difficult to understand her experiences.

There are several mentions throughout the review of Linda's mother, with whom she had a complex relationship. As noted, her mother had complex mental health needs and had been detained under the Mental Health Act when Linda was a child.

Her mother-in-law sometimes attended appointments with her. These appear to be the most significant family members who encountered agencies. As noted by the NELFT, Linda appeared to disclose different information dependent on who she was in an appointment with. There are times within the review where Graham's mother appeared to collude with Graham's narrative of all the issues stemming from Linda's mental health. Linda told one agency her mother in law had said she was not a fit mother. At other times she appeared to be a support.

Within Children Social Care in LBBD there was no knowledge of friends or family although there was an early attempt to arrange an FGC (Family Group Conference), but the criteria wasn't met at the time and it's unknown why. LBBD state they have recently reviewed content on their website and have updated it to provide information, advice

[30] About the Safe & Together™ Model | Safe & Together Institute (safeandtogetherinstitute.com)

and guidance to friends and families who may be worried about a loved one and what they can do and how they can talk to professionals and experts.

4.3 **Whether any neighbours reported concerns of antisocial behaviour pertaining to Linda and Graham's relationship (e.g overheard arguments) and how these concerns were addressed.**

There is no record of neighbours contacting any service to report concerns about the family with the exception of a neighbour in 2013 contacting the police about Graham's aggression towards Linda.

LBBD Children's Social Care have reflected that since Linda's death they have updated their Antisocial Behaviour (ASB) Policy and embedded domestic abuse within it, so it is a key consideration by professionals when responding to reports of ASB.

4.4 **Communication to the general public and non-specialist services about available specialist services related to domestic abuse.**

London Borough of Barking and Dagenham

LBBD state, where DA is present, families will "always be referred to Refuge and Cranston for support and advocacy, along with MARAC for high-risk contexts." General communication about LBBD domestic abuse services appears on the external website with the link provided below:

https://www.lbbd.gov.uk/adult-health-and-social-care/health-and-wellbeing/domestic-abuse/professionals-guidance-and-advice

https://www.lbbd.gov.uk/adult-health-and-social-care/health-and-wellbeing/domestic-abuse/talk-someone-we-believe-you

https://www.lbbd.gov.uk/adult-health-and-social-care/health-and-wellbeing/domestic-abuse/how-you-can-help-someone

LBBD state they have commissioned both Refuge and Cranston to provide community outreach services – creating links across Family Hubs footprints with the community, voluntary and business sectors. This ensures promotion of the services available, earlier identification/referral/response and effective and consistent communication.

LBBD also have forums where they advertise and promote services available, as well as work with the community to codesign services and interventions, including a Domestic Abuse Forum and a Public Women's Safety Forum.

Coercive control, strangulation, stalking and economic abuse

4.5 **Were concerns of economic abuse, strangulation, stalking and coercive control – all of which appear to have been present, acknowledged, risk assessed and addressed according to current policies and procedures. Do these policies and procedures require a review?**

The LBBD Children's Social Care internal management review reflected how concerns about strangulation and Graham's resulting caution for common assault were never properly analysed by Early Help nor the Assessment team. This was not mentioned by the Social Work team. The stalking behaviours Linda mentioned weren't fully analysed. They appeared in limited form within the referral to Refuge. The Social Worker did recognise the 'manipulation and coercive control' by Graham and the impact especially given Linda's additional vulnerabilities and traumatic background, but there is no risk assessment to inform and fully evaluate these behaviours, they were simply recorded with some analysis and subsequent Refuge referral. It is assumed they were used to escalate the need for relocation for the family.

The Social Worker manager commented the assessment of risk and safety plan did not seem 'robust or effective.' They suggested strategies to manage risk such as the 'Hollie Guard app and 55 discreet calling' but these were never mentioned again. The financial difficulties Linda mentioned, being in debt due to Graham not paying the rent, him refusing to leave the home, constantly returning due to his name being on the tenancy and not being able to divorce him due to finances, were not seen in the context of economic abuse or being part of coercion. Within the SW assessment they were labelled as 'complicating factors'.

Since 2021, LBBD state they have updated their domestic abuse policies and procedures with clearer communication and protocols to safeguard. They feel this will enable them to accurately analyse and risk assess domestic abuse. They have a 'Support to Safety team' within the MASH which would now triage and robustly assess contexts such as this families. Although there have been changes since Linda lived in LBBD, considering the above discrepancies, LBBD CSC have committed to reviewing their current policies and protocols further within the context of a learning review, to ensure that these lessons are fully learned.

With LBBD's reflection in mind, Hertfordshire children's social care did not fully acknowledge, assess or address the domestic abuse concerns as listed in this ToR. Despite Linda coming to the area from refuge and Graham still very much being present in her life, there were no domestic abuse risk assessments conducted, for example. This could have been referred to MARAC on professional judgement, a high risk forum which would have enabled agencies to robustly share information and plan accordingly. In a Children's Social Care letter to Linda they stated:

> *"You have spoken about how there were previous arguments in the home but that you are now able to communicate with Graham around the children with no ongoing arguments."*

In the same letter, Social Care acknowledge concerns about domestic abuse and Graham still being present. These statements are contradictory, one acknowledging domestic abuse and one stating that communication is now managed. This does not truly acknowledge Graham's abusive behaviour, his future intentions and his difficulty in letting Linda go. It is unrealistic for an assessment to conclude that a 10 year (minimum)

relationship has ended with Linda fleeing domestic abuse to a refuge, being evicted, with the partner still present, no domestic abuse work having been completed and there to be no current risk without a thorough assessment of risk. The letter also states:

"Social Care need to have assurance that the basic needs of children are being met"

It is important to be mindful of language. This statement gives the impression social care are only there to assess whether basic needs are met. Indeed, there are several references from IFST and Social Care alluding to home conditions and children's presentation at school which do not take into account their prior trauma, nor the continued risk from Graham. It is pertinent to reiterate under the Domestic Abuse Act 2021[31] children are victims of domestic abuse which has an impact on Social Services thresholds. As set out in the Children's Social Care National Framework statutory guidance:

Children's social care exists to support children, young people and families, to protect them by intervening decisively when they are at risk of harm and to provide care for those who need it so that they grow up and thrive with safety, stability and love. [32]

This is terminology is quite different from the previous quote.

The domestic abuse toolkit, used by the MASH within Hertfordshire County Council has been viewed as part of this review. It is a recommendation to this agency to review this toolkit as soon as possible to include reference to MARAC – with specific reference to professional judgement, the DASH risk assessment and to use this DHR as a reference point. Where a survivor has fled, only for the perpetrator to still be present, there is a continued risk. Stalking and harassment need to be named and considered. Although there was limited information transferred from LBBD there were still two significant red flags:

i) Linda fleeing domestic abuse to a refuge and ii) her partner still being present.

To quote the MASH toolkit domestic abuse guidance:

"The MASH episode must identify a parent acting protectively and engaging in relevant support via IDVA/Sunflower centre, and how the contact between Children and Perpetrator will be managed."

There is no evidence of Linda engaging with said service and the managing of the child contact appears to fall at her door. Linda was acting protectively by fleeing domestic abuse but this guidance does not acknowledge the responsibility of the perpetrator to stop.

4.6 **The impact of domestic abuse, with specific consideration of coercive control on children and young people.**

[31] Domestic Abuse Act 2021 (legislation.gov.uk)
[32] Children's social care national framework (publishing.service.gov.uk)

The term coercive control is not mentioned in any assessment and when one reads the chronology it is clear there were multiple signs of coercive control being present. Consideration of the impact on the children is mostly lacking in thought throughout multiple agency reports.

There were definite traits of coercive control exhibited by Graham during LBBD's time working with him as below (not exhaustive):

- Graham's blaming narrative of Linda's mental health, minimising his own responsibility in the relationship, while influencing her seeking help e.g asking her if she spoke about him.
- His apparent manipulation of Linda using threats of self-harm, her seeing another man and him being homeless.
- His use of the children, threats to remove them and continued attendance at the home address.
- The impact the DA was having on the children.
- Linda's allegations that Graham was 'isolating her by continually calling her phone (harassment) and was very jealous' and that he stalked her online.

LBBD state there has been significant work across the domestic abuse system to ensure practitioners recognize and respond effectively to coercive control. This includes the impact upon children and young people. They feel the roll out of the DARAC (Domestic Abuse Risk Assessment for Children) tool will encourage practitioners to specifically consider the risks to children.

Housing

4.7 **Whether housing support was available and offered to Graham during his reported period of homelessness. Whether this was considered within the context of domestic abuse and the pressure often applied to victims of domestic abuse when their perpetrator / ex-partner is homeless**.

Barking and Dagenham Children Social Care's housing support often considered the parents as together and needing joint rehousing due to the home being too small for their needs. However, this contrasts with the multiple reports of Linda telling agencies she wanted to separate from Graham. Social Care have recorded how the family's significant debt prevented them from moving to more suitable accommodation and this seems to be a significant barrier focused on by professionals.

In 2018 the LBBD MASH directed Early Help to support Graham to be rehoused separately but there is no reference on their files of this happening. Social Care have reflected how it was difficult to tell the period of Graham's homelessness as when workers visited in LBBD he was always present or in the background with the family. If he was there due to harassment of Linda then opportunities were needed to talk through the housing situation with each parent individually. LBBD Social Care have reported

they liaised with housing in 2021. However, there is no evidence to suggest this was done prior to Linda fleeing the area.

The Homes and Money Hub (HMH) was launched in the London Borough of Barking and Dagenham in April 2018. This service was established to support residents to:

- Sustain and secure tenancies by making people as financially independent as possible.
- Help to reduce residents' debts and give them the support and skills to manage their finances.
- Create greater opportunities or our residents so they may realise their potential.
- Support and help our most vulnerable residents giving them the security and confidence to improve their lives. [33]

Therefore, domestic abuse situations such as the subject of this review are likely to present themselves often.

The first contact the HMH had with the family was February 2021 and was with Graham. Infact, it is Graham who has the entirety of the contact with this service. This is at the height of concerns from Social Services in LBBD whilst they are encouraging Linda to liaise with Refuge and flee Graham's domestic abuse. The HMH have reported to this review how there were *"no indicators or signs to hint at domestic abuse/any household issues when presenting to the Homes & Money Hub"* although they have also reported that Graham self-disclosed social services involvement on 15th March 2021. It appears this flag was not acknowledged.

Housing support was offered to Graham as detailed in the chronology but one of the options suggested to Graham was to stay on a joint claim with Linda. Had the HMH been aware of the domestic abuse this clearly would have been inappropriate advice. In their reflections they state, had they been aware of the domestic abuse, they would have *"considered a referral to Cranston who offer a temporary response to perpetrators where housing and domestic abuse are a feature. Cranston also offer those using harm a programme of support and intensive intervention for a period of up to 6 months whilst they address the DA and move the perpetrator onto another property appropriate for the circumstances. This would require agreement and consent from the person using harm to engage in such a programme."* It is clear Graham did not consider he had used any abusive behaviour and framed the issues as stemming from Linda's mental health. It is unlikely he would have consented to such an intervention but this was not tested either way and no work was commenced to encourage him to reflect and recognise his harmful behaviour.

The consideration of Graham leaving the property on a more permanent basis did not happen as Graham's disclosure of Social Care input was not interrogated further and

[33] Homes and Money Hub | One Borough Voice (lbbd.gov.uk)

the LBBD systems did not highlight any social care input or current concern to HMH. This was a missed opportunity and has been addressed within the recommendations.

Linda would automatically have been considered in priority need of housing under s.189(1)(e) Housing Act 1996 as inserted by s. 78 Domestic Abuse Act 2021[34]. The housing specialist attached to the panel reported, had the children been coming to stay with Graham on a consistent basis then he too would have been deemed in priority need of housing. This is not evidenced as being considered within the LBBD approach. Additionally, there is no evidence of a managed end to the tenancy being considered rather than the homeless legislation, for example the family law act, transfers, terminations and granting sole tenancies in order to manage risks.

In 2021, in response to the Covid 19 pandemic and Domestic Abuse Bill, the DA Housing Alliance published a discussion paper [35] looking at the benefit to the victim of agencies focussing on the perpetrator's housing. The then home secretary Priti Patel, on 11th April 2020, was quoted as saying *"perpetrators should be the ones who have to leave the family home, not the supposed loved ones whom they torment and abuse."* There is a place for victims to flee domestic abuse to a refuge space or alternative accommodation - when the risk is high and there is a threat of serious harm or death. However, this should be a last resort as the upheaval to victims and children can be significant.

It is clear Linda felt trapped in the relationship due to Graham's refusal to let her go for many years. The joint benefit claim and tenancy contributed to a sense she was locked into the relationship. Graham too felt trapped via the housing situation, not knowing whether he would be found intentionally homeless if he were to give up his tenancy. This was an opportunity to look at alternative housing options for him in more depth with a domestic abuse lense. This required multi agency communication and collaboration to identify the least impactful and safest way to address the risk. It is imperative for housing and children's social care to work together to understand the levels of risk and what remedies can address the housing situation.

In relation to progress taken in LBBD since Linda's passing, Children's Social Care report they now have an IDVA co-located within their homelessness service. They have also engaged with DAHA[36] (Domestic Abuse Housing Alliance) to review their responses and take the necessary action to meet the DAHA standards. Additionally, they worked with AVA (Against Violence and Abuse) as a pilot Housing and Homelessness borough, working with experts by lived experience to develop their Charter of Excellence – this work is ongoing.

It is becoming increasingly difficult for people to afford to separate and live separately. Services such as the HMH are crucial in being able to help people navigate a challenging backdrop of a cost of living crisis which is particularly impactful in London.

[34] Housing Act 1996 (legislation.gov.uk)
[35] accommodation-for-perpetrators-of-domestic-abuse-discussion-paper-apr-21.pdf (dahalliance.org.uk)
[36] Who We Are - daha - Domestic Abuse Housing Alliance (dahalliance.org.uk)

It's important for domestic abuse to be a consideration within their screening tools and assessments.

During the course of this DHR advice was sought from solicitor Dawn Konstantinou with the Citizens Advice Bureau who practises family law specialising in domestic abuse in Barking and Dagenham. She was given an understanding of the DHR circumstances at the time of V/S departure from LBBD. The advice offered is listed here for wider learning purposes:

The non-fatal strangulation reported by V/S was grounds for a non-molestation order and occupation order. This was not suggested as an option until V/S had a conversation with Refuge. At this point she was keen to leave the home imminently. The occupation order would have directed AP to stay away from the property for a specified period.

With regards to the AP's concern at being found intentionally homeless this could have been addressed. V/S could have applied to transfer the tenancy into her sole name whilst at the same time commencing divorce proceedings. The court could then order the transfer of tenancy which would mean AP would not have been intentionally homeless and would have been able to apply for housing. The ability to identify housing would still depend on available housing stock but this would have been an additional option.

Although it's clear the AP was reluctant to divorce, it is now much harder to refuse a divorce with the only defence being an invalid marriage or the marriage already having been dissolved. There is still a requirement for someone to respond to the divorce proceedings but if they don't respond and you can prove they have been notified, the court can proceed. Legal aid would cover divorce proceedings in these circumstances although evidence of DA would be required. Even if someone doesn't have this evidence there can be exceptional case funding e.g if it is going to affect their human rights not to have funding then they can be supported outside of the rules.

Domestic Abuse Risk Assessment

4.8 **Whether Linda and Graham's domestic abuse related history was considered when assessing risk. Were appropriate referrals made from these assessments?**

The short answer to this is no. There was a lack of assessment therefore appropriate referrals were lack for the majority of the 10 year scoping period. Throughout the entirety of the relationship, Police were the predominant users of the Safelives DASH. This is despite Linda fleeing to refuge and then re-settling in a new area with her ex-partner still very much in contact with her and seeing her regularly. The Access and Assessment Team at the NELFT in LBBD did refer to The Women's Trust on 8th February 2019 although they were not able to establish contact with Linda. Social Care in LBBD referred into Refuge to try and gain Linda a refuge space with her children. There were multiple mental health assessments conducted during the scoping period. None appeared to take into account the domestic abuse she was experiencing at the time.

It is noted how rich in information the LBBD Social Worker case note is. Within their case note on 3rd March 2021 they commented; *"Graham would often make out Linda was 'crazy.' He would call her mentally unstable. Linda described controlling behaviour, such as him tracking if she had been online. She said he would change her email address and password for Facebook."* This is alongside other pertinent domestic abuse information. It is clear, this information did not translate into further assessments of risk by any agency over the next few months. Based on this information alone, there are concerns of stalking, controlling behaviour and gas lighting behaviour e.g making someone feel they are mad.

A key period is March 2021 – July 2021. Within this short timeframe Linda fled LBBD, moved to a refuge space before being evicted and accommodated in temporary housing in Hertfordshire. There were many opportunities to collate the relevant information and gain a thorough understanding of the domestic abuse risk. Some are as follows:

5th March 2021 – the LBBD Social worker was directed to complete a DASH and refer to MARAC. There is no evidence this occurred.

1st April 2021 – Refuge spoke to Linda but did not feel able to complete a DASH over the phone due to perceived pressure by a Social Worker also on the call.

4th May 2021 – Contact with SPA (Single Point of Access) where Linda disclosed domestic abuse. No recognised risk assessment was completed. Linda was in a refuge placement at this point and it is a fair assumption the accommodation would have completed one and she would have been at reduced risk of harm.

26th May 2021 – Linda was evicted from SAHWR, in part, due to her ex-partner being present. Given his presence was responsible for her fleeing to refuge in the first place, this is a missed opportunity to refer to MARAC.

1st June 2021 – Linda had contact with housing via e-mail. A DASH was not completed which was not in line with housing policy.

A key opportunity was on 8th July 2021 where a strategy discussion occurred in Herts. At the strategy meeting in July 2021 the police disclosed the history back to 2018. This omitted the non-fatal strangulation from 2013. Regardless, there *was* enough concern for a social care assessment to be commenced.

The above is a snapshot of time where agencies had significant input. Prior to this there were opportunities for services such as the GP, Health Visitor or Mental Health to consider the domestic abuse history and risk assess accordingly. It is important to be mindful this review is not in relation to a homicide but Linda ending her life. Despite this, the focus on how agencies assessed risk and the actions they took is just as pertinent. The lack of risk assessment in this case hindered services ability to consider the context of domestic abuse and its impact on Linda and the children. This lead to an overfocus on Linda's mental health. In this instance Linda openly disclosed to several agencies controlling behaviour, stalking behaviours, gas lighting, physical abuse, jealous behaviours and non-fatal strangulation. She had fled LBBD due to Graham's behaviour

yet when it is clear he had been staying at the new property and remained in contact this behaviour did not appear to cause alarm. It was assessed as two parents managing the contact situation appropriately. No risk assessment was completed, nor was the domestic abuse history completely understood.

A common theme within the Hertfordshire Health Visiting Service review was how they did not explore Domestic Abuse with Linda in the necessary depth. Linda said 'she felt safe'. Having new accommodation in a new county may well have contributed to this but this is in comparison to living for years with someone she wanted to break up from. There was a lack of professional challenge and analysis in the face of Linda entering a refuge and then leaving prematurely without safety plans in place. This included lack of further liaison with Barking and Dagenham to establish the history of domestic abuse and failure to recognise escalation by the fact Linda had moved to a refuge. This applies not only to the Health Visiting Team. When there was a MASH assessment with the case being closed, there was missed opportunity to consider seeking safeguarding supervision and escalation as per the Hertfordshire Safeguarding Children Partnership Policy (HSCP).

Professionals who engaged with Linda were accepting of her decline of support and did not challenge further. The internal Health Visiting review reflected how there was a lack of professional curiosity aswell as a lack of acknowledgement and understanding of the impact of adverse childhood experiences and trauma informed practice. This lead to missed opportunities to really understand the potential rationale and motives behind Linda's refusal of support and to seek alternative ways to engage with the family meaningfully.

Safeguarding supervision was not utilised. Accessing this relies upon the practitioners involved recognising and responding to the increased risks and the impacts on victim and children. Accessing safeguarding supervision may have allowed further exploration and understanding. Current practice in supervision advocates the use of a chronology as a tool to create an overarching view of family functioning and risk which was lacking in Linda's case. This is a helpful reflection from health visiting and is one which is useful for others to consider too.

Risk assessments may have also been hindered by Linda leaving the refuge without a safety plan, and by the full records from Barking and Dagenham not being obtained. If those records had been obtained, it may have allowed a greater understanding of the history of domestic abuse and Linda's reported adverse childhood experiences.

Health Visiting reflected how Linda and family were on a universal caseload. They have posited, had Linda had been under Universal Plus [37], the Health Visiting service may have had a greater understanding of previous conversations around the relationship status, nature of the Domestic Abuse incidents, decline of support and minimisation of incidents. However, it appears no agency in Hertfordshire had a thorough understanding

[37] Overview 1: National Health Visiting Programme (publishing.service.gov.uk) p.2

of the domestic abuse history. Had they been under Universal Plus, it may have enabled Linda to build up a relationship with the health visitor and may have changed her acceptance for support.

The LBBD Children's Social Care review acknowledged Early Help included a referral to IAPTS / Talking Therapies to help Linda with her mental health, but this was not seen within the context of domestic harm.

Linda scored 2 on the initial Multi Agency Safeguarding Hub DASH RIC in LBBD. Instruction was given to the Social Worker to complete a further DASH and refer to MARAC, but there is nothing on file to say that this occurred. The assessment referred to the domestic abuse and the risk both to Linda and the children, however no specific risk assessment tool was used to assess this more in-depth. A referral was made to Refuge and a physical refuge sought ultimately for the family to relocate to.

Since this time, LBBD have made several changes to their training such as introducing, amongst others:

- A course entitled: Risk Assessment and Safety Planning, which focuses on how professionals can accurately assess the risk of survivors and what tools they can use, and what constitutes a good safety plan and the importance of it being individual to the person.
- Rolled out the DARAC (domestic abuse risk assessment for children) – with 200 staff trained so far.

Protective Measures

4.9 The following two ToRs have been combined:

Were opportunities to support Linda to apply for legal orders (e.g non-molestation orders) recognised and utilised?

Were opportunities to consider and implement Domestic Violence Prevention Notices / Orders considered by the Police?

The only mention of legal orders, aside from a police context, are those discussed by Refuge when they spoke to Linda over the phone. By this point they were exploring accommodation for her and the children and Linda was adamant she wanted to leave her accommodation in LBBD. An occupation order was discussed but declined.

On the 30th January 2021 the police referred Linda to the National Centre for Domestic Violence (NCDV) at the scene. She reported having previously tried to obtain an injunction against Graham but said did not follow through with it.

During the police call on 30th January 2021 the MPS note how the investigating officer could have considered a Domestic Violence Protection Notice (DVPN), which would have provided immediate protection for 48 hours. Officers had taken positive action and made referral to NCDV. There were risk factors present such as Graham showing

behaviour indicative of jealously. The couple had also separated. It is widely acknowledged from research and learning from previous DHRs post-separation can see an escalation of abuse - so there was clearly scope for this to have been considered.

There were 11 police reports in total, not all relating to domestic abuse. There were no DVPNs issued in this time. DVPOs were implemented across all forces in March 2014 so the initial police call in 2013 may not have been applicable.

4.10 **Were opportunities to consider the Domestic Violence Disclosure Scheme (also known as Claire's Law) considered and utilized?**

There is no evidence to suggest that Claire's law was utilized. There was mention of infidelity several times within the chronology and there could well be further concerns with regards to other partners. This remains an unknown to the panel but the prospect was never considered in any of the internal management reviews seen.

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

Prior to the commencement of this review it was unknown whether MARAC had been involved with the couple at any stage. It appears MARAC was not involved despite mention of a referral being required by Social Care LBBD in March 2021. The MARAC lead for Hertfordshire was contacted as part of this review and the circumstances of Linda fleeing LBBD relayed. The MARAC lead (police) reiterated that MARAC is a high risk forum designed to address a high risk of serious harm or death from a family member or (ex) partner. They could not say one way or another whether Linda would have been heard at the MARAC. They felt this would be reliant on the quality of the referral. The MARAC lead stated it would need to be clear that Linda was at risk of serious harm or homicide. Given Linda had fled LBBD to get away from Graham but he remained heavily involved in her life, it is likely this would have been heard at MARAC due to concerns of continued harassment / stalking. With a growing body of evidence highlighting the link between suicide and domestic abuse it may well be MARAC chairs / coordinators will be asked to consider whether high risk of suicide in a DA context meets the MARAC eligibility criteria. This is a wider question and one which will be posed to Safelives but will fall outside the timeframe of this review.

<u>Financial barriers</u>

4.12 **Any known barriers, financial or otherwise, that prevented Linda from accessing mediation services and what support could have been offered in this regard.**

Linda was referred to Relate in October 2018 for mediation by Early Help in LBBD. This was not taken up due to it being a chargeable service and the parents stating they could not afford it. As the review has indicated, it is also not an appropriate referral in cases of domestic abuse. The fact the couple could not afford Relate highlights their financial difficulties. However, had domestic abuse been identified free programmes such as

Cranstoun's Men and Masculinities[38] could have supported Graham and provision for Linda's experiences could have been sought. Linda was signposted to NCDV, Victim Support, Citizen's Advice Bureau and Women's Outreach during the scoping period. Victim Support have no record of Linda and Women's Outreach tried several times to contact Linda without success. There is a theme throughout this review of signposting Linda to services to address complex issues with no follow up or support to make these happen. This is in part due to the short timeframes many services were present for.

There were opportunities to engage Linda on her own but often Graham was present. It appears Linda's disclosures were impacted by who was present with her in appointments.

Linda did engage in talking therapies but not in the context of domestic abuse. The Early Help worker was tasked to undertake relational work with Linda to better understand her relationship with Graham but there was nothing on file to tell CSC LBBD what was discussed. There was mention in the Early Help assessment to say that two sessions occurred to address this with both parents but again no further detail. Financial barriers are a theme throughout and required assertive engagement and hands on support to assist the family.

4.13 **What is known about Linda and Graham's marital status and attempts from Linda to separate from Graham. Were there any known barriers that prevented her from doing so?**

It is now clear that Graham and Linda were married in approximately 2014. LBBD – CSC commented: "We know that Linda continually told professionals that she had ended her relationship with Graham, had asked him to leave (17/08/2018), wanted a divorce but lacked the funds (30/01/2021), contacted police when he turned up unannounced, but also struggled to sustain this due to reported normalisation of the conflict (13/04/2021). Graham allegedly made it harder for separation due to the presence of coercive, suspicious control even when found "cheating" (11/10/2018, 30/01/2018, 23/02/2021, 13/04/2021) and refusal to accept the relationship had ended (17/08/2018). Financial reasons seemed to dictate improper separation, including Graham's refusal to take his name off the tenancy (17/08/2018), while also not paying the rent (23/02/2021). Additionally, Linda's mental health and history of traumatic background may well have impacted on her struggles to separate (29/08/2018, 31/10/2018, 13/04/2021). The presence of some emotionally enmeshed co-dependence (feeling sorry for Graham) as being an obstacle to separation ('allowing him to sofa surf so he can put children to bed and get them up') is also a possibility.

Graham openly said he did not wish to divorce and this left Linda in a difficult position where she felt stuck. Once again, this required some long term support and risk assessment which was not forthcoming.

[38] Men & Masculinities - Cranstoun

Mental Health

4.14 **If known, were Linda's domestic abuse experiences considered within the mental health support she sought or was referred to?**

Linda's mental health received inconsistent attention throughout the course of the 10 year period. She had limited therapeutic input, twice disengaging after disclosing distressing incidents of historic sexual abuse. When this was disclosed, she was not given specific support around these experiences. There are mentions of various mental health conditions throughout the review including bipolar, EUPD, OCD, PTSD yet the only clear diagnosis was an anxiety and depressive disorder.

On the 8th August 2019 Linda was seen at home for a psychiatric review. This did show a flexibility and understanding from this team as Linda had previously said she could not afford the fares to get to the appointment. She described unhappiness due to relationship issues, said Graham had got them into significant debt and wasn't helpful. She said she occasionally had thoughts her children would be better off without her something which was clearly relevant as her final written thoughts evidence. Domestic abuse was not considered in this appointment.

The NELFT have commented how risk assessments were used by adult mental health and PPIMHS services from a mental health perspective and on a few occasions domestic abuse was recorded under harm from others but only once was Linda referred to domestic abuse support (Women's Trust - Oct 2019).

Linda's domestic abuse experiences were occasionally considered. More often than not there was a focus on medicating her with various medications tried over the years. There was confusion about her mental health diagnosis right up until she died with professionals occasionally referring to bi polar disorder, something she was never diagnosed with. There was too much reliance on her self disclosure rather than checking records. As her friends illuded to, there were numerous mentions of changes to medication and mood assessments and suicide risk assessments occur often. Domestic abuse in comparison is not on agency's radar despite many warning signs offered by Linda.

Policies, Procedures and Training

4.15 **An evaluation of any training or awareness raising requirements that are necessary to ensure a greater knowledge and understanding of domestic abuse processes and/or services in Hertfordshire and Barking and Dagenham**.

There have been many changes in LBBD CSC since 2019. Many of these have already been mentioned and the author of their IMR is confident Linda would receive a different service today. There are several actions they have taken as noted below:

As part of the Domestic Abuse Improvement Program a full multi agency learning and development package has been designed and delivered, including:

- Briefly and in detail domestic abuse guidance and practitioner toolkits, available on the council's intranet and internet sites, and the Safeguarding Children Partnership internet site. The toolkit is detailed and includes information related to practice improvements required as identified by the BDSCP Practice Review September 2022 e.g., intersectionality's, completing risk assessments, working with survivors etc.
- A MARAC Protocol, aimed at MARAC attendees and those who may refer to the MARAC.
- A domestic abuse learning and development lead has been commissioned – a range of courses have been agreed as outlined below (based on the findings of the Safeguarding Children Partnership's Practice Week in September 2022) and the content developed. The courses are available to the multiagency workforce. The lead also provides direct and bespoke training to agencies and services to ensure knowledge and understanding, and shared practice approaches.

LBBD have also held many DA learning events, and with a particular focus during the 16 Days of Action. These include:

- DA Lunch and Learn Drop-in Session for children's social care / early help workforce – all DA service providers were there to introduce the available services, resulting in increased understanding of service offer and increased referrals to services.
- A DA Symposium for BDSCP practitioners in LBBD, which focused on specific types of DA, impacts upon families and communities, tools available (including Safe and Together and the DARAC) and key risk factors including relationship breakdown.
- A DA Conference for Practitioners and the community to promote awareness of DA in all its forms and awareness of support services available and how to refer to or contact them.
- A SAB conference, where we raised awareness of all forms of domestic abuse and impacts, as well as available services and information, advice and guidance for professionals and communities.
- DA and intersectionality's – including improving our cultural competencies.

As previously stated, LBBD have created specific DA spaces on our intranet and internet sites, providing practitioners with multi-agency guidance to identify, respond to and reduce the risk of domestic abuse. We have ensured the workforce has the tools they need to address DA. This has also been included in the Family Hubs tools.

LBBD revised their continuum of need document and linked it to risk levels within the DASH RIC, supporting professionals to make objective judgements using recognized and embedded tools. It will also be updated to reflect the DARAC when roll out is completed.

LBBD have launched Domestic Abuse Champions across the council and partners, which aim to support practitioners with points of expertise in their service areas.

Colocations of commissioned services have increased, with colocations in universal, triage and statutory service settings – again supporting improved practice and learning.

The chair, having reviewed the MASH toolkit within Hertfordshire Social Care, recommends this is reviewed which the panel agreed with. The reasons for this are listed in the Lesson to be Learned section of this report. It is also recommended for Linda's experiences to be utilized as a learning tool to recognize the impact living with abusive behavior can have on one's self worth and mental health.

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

LBBD state their policies and procedures for working with DA have become more concrete in the last year (2023), alongside a new continuum of need protocol setting out threshold expectations. With regards to Early Help involvement, potentially the family could have progressed to statutory services for assessment in 2018 rather than voluntary EH, given the clear presence of elements of coercive control and what was known about the alleged strangulation incident in 2013. The MASH assessment lacked professional curiosity, were not properly signed off by a manager and focused on Graham learning to live with Linda's poor mental health, in fact too much emphasis on her mental health and not enough on the clear presence of DA was given. The subsequent EH intervention was, in LBBD's words "weak, lacking curiosity, with no DA risk assessment". The MASH direction to engage 'victim support to help Linda remove Graham from the property legally', was not effectively addressed and there was no referral to Refuge. It was deemed the issues were marital rather than resulting from DA.

There is no presence of an ongoing CAADA DASH risk assessment or use of the then used Barnardo's tool, which could have been a minimum standard. It is unclear if EH workers would have been trained to use these tools at the time. There is a question about correct application of criteria of need, having all the necessary information to hand to inform proper risk assessment and the skill set of the EH team to actively engage with risk around DA and its apparent complexity within the parental relationship.

Once within the statutory arena in 2021, more robust assessment of risk by MASH was available and quick escalation to relocation for the family. However, there is no MARAC referral or comprehensive risk assessment at this stage either, even though clear directions had been given. It appears the history of DA may not have been researched on internal systems.

Within Children's Social Care in Hertfordshire they have reflected that policies and procedures were followed. The guidance for DHR's states one must "go beyond the process" para 10 - DHR-Statutory-Guidance-161206.pdf (publishing.service.gov.uk) to explore what adaptions to policy, procedures or training could occur in the future. This has not been evident within this DHR.

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

The 2020 review within LBBD[39] (victim killed in 2018) raises very similar issues of strangulation, economic and financial abuse, the wider definitions of DA not being known and the evidence that this perpetrator was also described as a "philanderer." Unlike the murder victim in the 2020 review, Linda did want to leave Graham. There is a sense that, had these definitions been realised, earlier intervention would have helped properly risk assess, particularly a referral to MARAC.

Within the 2018 review (victim killed in 2014), similarities arise from, the lack of early intervention, this time from universal services, who struggled to recognise some of the core elements of DA, to offer specific expert help to the victim and alongside this offer subsequent intervention to the alleged perpetrator.

4.18 **The impact of the Covid 19 pandemic and whether this influenced or changed any decision making.**

There is nothing on file to suggest that the COVID pandemic impacted LBBD's work with the family. They were not involved with them during 2020 when the pandemic began, as EH had closed their involvement in 2018/19. The bulk of the SW assessment began in January 2021, when vaccinations had begun to be rolled out. Covid does appear to be a concern for Linda latterly as she denies entry to services stating her children are vulnerable.

Key Lines of Enquiry

4.19 **What is known about the six months prior to Linda's death where contact with professionals appears to reduce and Linda reportedly enters a new relationship?**

Linda did register with a local GP in Mach 2022 several months after all agencies has ceased working with her. She received details for the sexual health clinic as she wanted a check up. The Health Visiting service did attempt to see Linda but there attempts were not responded to. It is known Linda began a new relationship in approximately February 2022. This would have been her first experience of another relationship other than Graham. The only other attempts to engage Linda during this time were from the Health Visiting Service who attempted several times in March and April 2022. When Linda did not respond they assessed further attempts were not required which was in line with their Standard Operating Procedures (SOP).

Linda's friends have suggested her new partner was controlling (see friend's contribution) and may potentially have been involved with Class A drug use. They felt he made degrading and derogatory remarks towards Linda and displayed similar

[39] https://www.lbbd.gov.uk/adult-social-care/health-and-wellbeing/domestic-abuse-and-sexual-violence/domestic-homicide-review

controlling behaviours to those exhibited by Graham. They report Linda struggled with her mental health in March 2022 and she reached out to the Samaritans who she didn't feel were helpful.

4.20 **Police contacts with Linda and Graham between 2013 and 2022, in particular but not solely the contacts between January and April 2021.**

These have been explored throughout the chronology. All completed DASH assessments were rated either medium or standard and none resulted in a referral to MARAC. For the most part contacts were graded and attended appropriately by the Metropolitan Police. Since the initial abusive incident in 2013 there is now the offence of non-fatal strangulation. This was brought in in 2022 in recognition of the severe harm this abuse can cause.[40]

The incident on the 12th March 2015 where Linda called the police to ask them whether she was allowed to leave the house if her husband told her not was not attended by the Police. The home address should have been visited. The MPS Domestic Abuse Policy states: The initial response to domestic violence victims seeking the help of the police service is paramount to any subsequent investigation and to provide reassurance that they will be supported. We must create the opportunity at this stage to protect the victim from further harm. A timely response is key to this aim.

The Police have further reflected how they could have referred to MARAC on professional judgement after receiving calls in July, August and then September 2018.

On the 30th January 2021 the investigating officer could have considered a Domestic Violence Protection Notice (DVPN), which would have provided immediate protection for 48 hours. Officers had taken positive action and made referral to NCDV. There were risk factors present, Graham had shown behaviour indicative of jealously. The couple had also separated, post-separation can see an escalation of abuse with women reporting continued threats and intimidation when leaving their abusive partner.

4.21 **Linda's time at the refuge and how concerns regarding Graham's contact with her were risk assessed and managed.**

It has been difficult to ascertain exactly what actions were taken by SAWHR with regards to Linda having contact with Graham and how these were managed due to their data from this time being lost. Despite Linda only being in the refuge with her children for five weeks there are no records of any warnings being given to her nor any documentation evidencing her being spoken to about their concerns with regards to contact with Graham.

Following Linda's decline of resettlement support and Graham's continued presence in her life, greater exploration of the risk and referrals to other domestic abuse services would have been appropriate. It is a recommendation for SAWHR to review their

[40] Non-fatal strangulation is an important risk factor for homicide of women - PMC (nih.gov)

procedures in this regard and refer to MARAC where an alleged perpetrator remains in contact.

4.22 **Once the decision was made to evict Linda from her refuge placement whether a plan was put in place to address her needs (for example - mental health, domestic abuse experiences, finances, isolation)? If so, did that support adequately reflect the significant challenges faced by victims of domestic abuse when leaving refuge accommodation.**

Linda was described by SAWHR as "volatile", and staff described how her behaviour could be managed until she became verbally and physically threatening on the day she was evicted. This is when it was deemed she posed a risk to staff and other residents and therefore SAWHR felt their decision to evict was appropriate. Linda did not accept any post refuge support although was supported by housing to move into temporary accommodation. As will be discussed in the Learning to be Learned section, it is a recommendation for SAHWR to refer to MARAC which would have highlighted Linda's situation to professionals and shone a light on the domestic abuse risk.

Linda was evicted from the refuge 27th May 2021. A strategy discussion took place on 7th July 2021. Within this time the mental health team assessed and closed as they required Linda be registered with a GP prior to commencing longer term therapeutic intervention. The Safeguarding Adults Team have identified and addressed this process during the course of the DHR as follows:

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.

The Child and Family Assessment was agreed to and concluded on the 15th July 2021. Within this it recommended a step down to IFST with the following plan:

- 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

There is no mention of Linda needing to register with a GP to gain MH support. Within the C & F assessment there is mention of Linda self reporting with bipolar but this not aligning with services records. There is clearly uncertainty around her diagnosis and

what support is needed to support her. Whilst emotional support is identified it is not detailed in a SMART action plan or made clear what emotional support is required. This could be said for all of the actions. Domestic abuse work is also identified as needing to be done but again, it is not recorded in a SMART way. Several days after this plan was confirmed to Linda via letter, she withdrew consent for IFST intervention. Many of these points had not been progressed.

Considering the following:

- Linda's experiences of a 10 year plus controlling relationship,
- her experiences of childhood sexual abuse and domestic abuse,
- continued presence of Graham,
- recent separation,
- recent eviction from refuge,
- her move to a new county away from her support network,
- her poorly understood mental health situation,
- lack of mental health support,
- lack of GP,

The support provided was limited and overall inadequate. Linda's previous experiences with Children's Social Care would have given her mixed feelings about this service and Graham had used them as a threat previously. She may well have been concerned about them criticizing her parenting. The punitive tone of Social Care's communication would have done nothing to indicate they were aiming to support Linda and the family and help encourage long term safety and stability for the family.

4.23 **How Linda's mental health needs were addressed and understood within the context of an abusive relationship.**

The first sign LBBD had of Linda's mental health needs was content from her GP letter about her 'severe depression and attempts to commit suicide.' This was received much later and would have been helpful for earlier preventative work to evaluate and help Linda in this area. It was assessed the alleged self-harm and depression stemmed from childhood physical and sexual abuse from a family member and was not linked to domestic abuse, though would have been a factor to consider regarding her vulnerability to coercive control and resulting mental health needs while in relationship with partners. Graham's focus on Linda's "unstable" mental health- her "OCD" and blame of this for their relational difficulties is particularly poignant here.

Linda stated during the social work assessment process that Graham often called her 'crazy and mentally unstable'. During the assessment she said although she did access counselling, she was constantly being questioned about her sessions by Graham that she eventually stopped attending. He would want to know if she spoke about him during the sessions. Graham would also use Linda's mental health difficulties against her and would refer to her a 'crazy' and criticise her parenting. She stated that she had borderline personality disorder, bipolar, manic depressive and anxiety.'

The LBBD 2021 social work assessment did analyse the impact of Linda's vulnerability to self-harm, negative childhood experiences affecting her mental health, the added domestic harm and this was reflected in the Refuge referral to some degree. However, there was no domestic abuse risk assessment tool completed during LBBD CSC involvement with the family and this would have considered in much more depth the subject of her mental health in the context of an abusive relationship. Neither was there any in-depth liaison with Linda's psychologist/talking therapies about the nature of how her mental health, traumatic background and use of medication might be seen and understood/better defined within the context of harm from domestic abuse and coercive control. The initial referral to Talking Therapies by the Early Help worker in 2018 mentioned nothing about the presence of domestic abuse. Upon leaving LBBD to enter the refuge in Herts, Linda reported feeling 'very happy to be away in a refuge and felt she could cry thinking about being free from Graham'.

The NELFT commented that further exploration, particularly in 2014, around Linda's relationships and day to day lived experiences could have taken place as throughout the period of this report Linda reported issues in relationships with her mother, mother-in-law, and husband – therefore there were missed opportunities to explore what was going on for her further.

The Met Police state officers applied best practice and followed policies, showing professional judgement after a contact in 2021, by completing an adult safeguarding referral. Linda did not make reference to suicide in her conversations with police.

4.24 **Were there services available locally for those using harmful behaviour and if so, were these known about and were there opportunities to inform and direct Graham to these. Were practitioners confident in knowing how to ask these questions?**

In 2013, Graham indicated to the Met Police he was seeking support with anger management. At the time there were no domestic abuse perpetrator programmes within MPS. This was believed to be sessions with a Social Worker and there was no further information on police records. Regardless, anger management is not a DA perpetrator intervention. This is now more widely understood as inappropriate in cases of domestic abuse.

During the Early Help work in LBBD, the worker met with Graham twice, but there was no reference to any challenge about his position as an alleged perpetrator. Indeed, he was seen together with Linda during one visit and at the TAF meeting which suggested an absence in seeing him as an alleged perpetrator by the service. Graham also cancelled home visits for the family, which was accepted by the service. This was despite the MASH instructions relating to domestic abuse. Both parents were referred to RELATE at one point also which again minimised the presence of domestic abuse and potential coercive control.

The parents work within the assessment service was very much "one-sided" which the single assessment refers to, because Graham "resisted" contact with the social worker,

until Linda left and went to the Refuge. They noted that several attempts were made to contact him in March 2021 but with no success. Therefore exploration of Graham's use of harmful behaviours towards Linda could occur.

LBBD feel the Social Worker would have been confident in undertaking work around DA with Graham if they'd been given the opportunity. The Early Help worker in LBBD does not seem to have referenced any challenge or reference to him being a possible perpetrator, even though there were clear directions given about risk assessment by MASH. They were described as having discussed the impact of DA with the parents, but this was not recorded anywhere on file, so it's difficult to ascertain what impact this would have had, if any.

As discussed, there is provision for those using harmful behaviour in Barking and Dagenham but this did not appear to be a consideration for any service.

There was no record to suggest Hertfordshire services engaged with Graham to encourage him to consider a domestic abuse programme whatsoever.

Section Five

Conclusions

5.1 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.

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 chronology.

5.2 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.

5.3 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. In April 2021 the Domestic Abuse Housing Alliance published a discussion paper exploring the benefits of identifying accommodation for perpetrators of domestic abuse.[41]

5.4 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.

5.5 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.

[41] accommodation-for-perpetrators-of-domestic-abuse-discussion-paper-apr-21.pdf (dahalliance.org.uk)

5.6 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.

5.7 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.

5.8 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.

5.9 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.

5.10 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. Infact, 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.

5.11 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 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 it maybe she reached out to them and had the opportunity to build a relationship and gain the adequate support. This is further considered within the Lessons Learned and Recommendations section.

5.12 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.

Section Six - Lessons to be Learned

6.1 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.

6.2 Lesson 2

Narrative

LBBD 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.

6.3 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 in adequate 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.

6.4 **Lesson 4**

Narrative

The Homes and Money Hub appears to be a positive and helpful initiative in LBBD. 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 Homes and Money Hub (housing) 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.

6.5 **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

Services must acknowledge the potential for harassment, stalking and coercive control 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.

6.6 **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 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 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.

6.7 **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.

Section 7 - Recommendations

Recommendation (SMART goal)	Scope of recommendation (i.e. local or regional)	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target Date	Date of completion and Outcome
Multi agency recommendations arising from panel process						
Recommendation 1 During their assessment, Refuge to consider the individuals access to their safe support networks to enable friends and family to stay connected.	Local	1, Operations managers to be updated in monthly operational managers meeting. 2, Front line staff to be cascaded update in team meetings between August and October. 3, Risk assessment and ongoing risk management policy to be updated to reflect need to consider safe support	Refuge		1, August 2024 2.October 2024 3.October 2024	

		networks during needs assessments.				
Recommendation 2 Safer accommodation will refer to MARAC where an eviction takes place / someone leaves their accommodation and the perpetrator remains in their lives.	Local	There are different circumstances that lead to a person's licence being ended or a person ending their licence within safe accommodation. The current process includes referrals that are required dependant on circumstance and risk. This process will be updated to include a referral to MARAC where there is a continued threat of domestic abuse.	SAHWR	The current process is being updated and will be implemented with immediate effect.	July 2024	
Recommendation 3 Hertfordshire Children's Social Care to review the practitioner domestic abuse	Local	1, DA training to be delivered by the IDVA service. 2, DA toolkit to be reviewed taking	Hertfordshire Children's Social Care	Updated domestic abuse training is being delivered by our IDVA service to the staff within the Gateway on 09.10.24. The training	October 2024	

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.		into account the DASH and DARA.		will focus on stalking, harassment and the increasing use of tech abuse and its impact upon victims. Following this the Domestic abuse tool kit will be reviewed taking into account the information provided in the DASH /DARA , this will be updated where appropriate with support and collaboration from the IDVA service.		
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	Local	To confirm current MARAC referral criteria and whether these circumstances would meet it, if not then does there need to be an addition.	Risk Management Sub-Group		July 2024	Completed in July 2024. Chair of MARAC has confirmed referrals will be accepted based on agreed criteria which includes an

potential continued risk.						agency's professional opinion that someone is at high risk of harm, such as someone evicted from a refuge who continues to be harassed by the perpetrator.
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.	Local	MARAC team implementing system to include details of referrals not accepted to MARAC. Information will include the agency referring, the reasons referral isn't accepted and whether the referral is re-referred by the agency. This will be sent to HCC monthly and also	Risk Management Sub-Group	Agreement made on information to be recorded and where this information is to be shared.	September 2024	

		be discussed at RMSG.				
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.	Local	The Homelessness and Multiple Disadvantage Team at Hertfordshire County Council to add an additional tab to their monitoring workbooks to ask for further detail around the eviction.	Hertfordshire Domestic Abuse Partnership	Additional tab will be added to monitoring workbooks by the end of 2024; however, these will be monitored by refuge and not by district.		To be completed by the end of 2024**.**
Recommendation 7 For the Homes and Money Hub in LBBD 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.	London Borough of Barking and Dagenham		Head of MASH Improvement (LBBD), Partnerships and Emergency Duty Team	The HAMH are now a MASH partner and are in the process of signing all the ISAs etc., The HAMH are also using Liquid Logic, wherein we are in discussion about creating more direct referrals/pathways, but need assurance on the detailed training they would need to work with survivors/perpetrators	In place	Completed, July 2024.

				based on the access given or information received. We are also considering adding them to the MARAC list, and then use MARAC flags on their systems too, which would cover off high risk flags and then a contact back to MARAC for further info.		
Recommendation 8 Where a family is evicted from refuge and the perpetrator's continued contact with the victim is concerning, 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	Local	1, Strategy meetings are always held by Hertfordshire Children's Social Care at the earliest opportunity in line with the Hertfordshire Safeguarding Children Partnership's Procedures. 2, The Practice Guidance will be	Hertfordshire Children's social Care		December 2024	

the long term impact of living with domestic abuse, stalking and harassment with appropriate risk assessment, risk mitigation plans and interventions considered.		amended to include the consideration of long-term DA, stalking and harassment, risk assessment and risk mitigation.				
Recommendation 9 Where an individual with or without children is evicted from safe accommodation, the provider will complete the MEAM 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	Local	Eviction template to be finalised and circulated to providers.	Hertfordshire Domestic Abuse Partnership	Since Hertfordshire has become a MEAM area, we have been looking at ways to improve how people move through systems and how information is shared. Therefore, when someone is evicted from a supported accommodation the eviction template should be filled out so there is a continuation in support. We require organisations to complete the template at the first		Completed in July 2024. Eviction template was circulated and all providers are aware that it should be completed at the first point in which an eviction is considered.

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.				point in which an eviction is being considered and to provide as much information as possible on the cause and what would also be a solution. We would like providers to approach this template in a strengths-based approach and to be solution focused. We will be collating these templates to look at any gaps in our current services and to build a better picture as to why people are being evicted from supported accommodation's and promote partnership responses to prevent evictions where possible.		

				MEAM%20Eviction%20Template.docx		
Single agency recommendations						
NELFT						
Domestic abuse champions	Local	Ensure champions have been identified within B&D area. Clear role and responsibilities with NELFT. Awareness within NELFT of domestic abuse champions	NELFT	Offer made September 2023 by partnership to be discussed within senior management meetings	January 2024	Local arrangement are underway. MARAC children's leads have undergone the DARAC training and that's to be rolled out locally.
7-minute think family	Local	To circulate organisation wide	NELFT	Completed to be shared	January 2024	A think family 7 minute briefing was completed. This will be rolled out via the local and trust-wide August

						leadership team meeting report. A request will be made to include in the NELFT trust-wide weekly bulletin for August 2024.
Professional curiosity training being delivered	Local	Audit impact of training	NELFT	Sessions have been offered to all NELFT operational teams with children and adult services	March 2024	The training was completed by the NELFT safeguarding team through local and trust-wide sessions by March 2024.
Level 3 Safeguarding training updated	Trust wide	Named Professionals to deliver training	NELFT	Ongoing	2023-2024	All safeguarding training level 3 is being reviewed and updated with the view

						of going back to face-to-face classroom sessions. Professional curiosity will be a feature throughout the training with case scenarios and learning from reviews included. Face-to-face sessions are currently being planned and the aim will be to start delivery by quarter 3. This is being monitored via the NELFT safeguarding work plan,

						which is presented at our Safeguarding Assurance Group and attended by NELFT senior leads and ICB safeguarding partners. It is also reviewed weekly by the safeguarding senior managemen t team.
Relaunch revised protecting children, young people and adult from domestic abuse SOP	Local	Through all trust electronic communications	NELFT	Currently under review	January 2024	The Domestic Abuse SOP is currently under review. Expected deadline for completion is end of

						September 2024. This is monitored through the NELFT safeguarding work plan.
Launch of Domestic Abuse Workstream for NELFT 2024 (policy, practice guidance, training, and professional toolkit)	Across the service	Head of Safeguarding and Named Professionals	NELFT	To launch Sprint 2024	April 2024	As above, policies, procedures, training, professional toolkits and training requests will be discussed in the Safeguarding Operational and Learning Group, Safeguarding Assurance Group and Divisional Safeguarding Meeting and local leadership

						team meetings. All requests, scheduled reviews or gaps highlighted from incidences and learning will be included in the NELFT Safeguarding Work Plan and monitored weekly within the Divisional Safeguarding Meeting and by the Domestic Abuse Trust Lead.
External Domestic Abuse Training is being provided through NELFT	Across the service	Practitioners and clinicians to engage in training	NELFT	Ongoing	2023-2024	Ongoing.

LBBD Children's Social Care						
LBBD Continuum of need to be reviewed with MASH and EH 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. LBBD EH to update on its position in accurately risk assessing contexts of DA, recognising, and working with coercive control and which referral pathways are commonly utilised today, including joint working protocols. This to ensure that EH have necessary training and practitioner/manage	Local	MASH and EH managers and (where relevant) staff to 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	CSC MASH and EH	Children will have MASH assessing SW's who will know and demonstrate the processes and procedures which govern the assessment of and working with DA and coercive control, which affects them. There will be visible key levels of management accountability built in and reference to relevant risk assessment tools, which ensure children and victims are heard. The recommendations will be meaningful to whole family context displaying research and refence to history and background/previous work, including al	End of April 2024	

r knowledge and expertise to address risk effectively around DA.		control? How will these be resolved?		police reporting and risk analysis. Indications of whether MASH inquiries are undertaken will have management oversight clearly displayed on file. Children will experience EH managers and practitioners who will have the skill set, tools and knowledge to effectively address DA and coercive control, where it appropriately sits within the service regarding continuum of need. Children's EH workers will recognise the impact upon children and victims that key elements of coercive control have, and risk assess accordingly. They will use accepted child-		

				focused tools, referring on to expert agencies for further assessment in a timely manner, using TAF meetings to revisit SMART planning and resolve unmet items involved in assessment of risk. Managers will use supervision to track, monitor and update on this planning, holding oversight at every point of work achieved, to clearly evidence best outcomes for the child, displaying this clearly on file.		
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;	Local and regional	PSW and DA Lead to include reference to relevant processes, knowledge, procedures, and policies/legislation involving	CSC and partners	Children will know that Practitioners in CSC and across the partnership will know how to effectively assess declining parental mental health and history of traumatic background	Feb 29th at CLIP CSC managers meetings, thereafter to team meetings.	

what are the agency pathways to address this currently within LBBD, do practitioners know how to recognise the links and analyse impact?		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 to potentially 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-		within the context of increasing DA and coercive control. This to ensure that accurate knowledge, visibility of processes and where expert knowledge is held. Correct child-focused risk assessments to be used to inform practice and all relevant CSC assessment will contain reference to mental health and trauma and the impact of this upon the child's daily experiences when discussing DA. Trauma informed training soon to be rolled out to CSC, will determine to address the vulnerabilities present for those suffering in domestically abusive	To One panel- tbd	

		agency/disciplinary response and any gaps present.		relationships, where previous trauma and ACES have been identified and the impact these have upon the child.		
Additionally, given the work we are doing around CSA, we need to explore the impact of Linda's previous sexual abuse and the vulnerabilities which this opened up with reference to DA and coercive control.	Local	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.	CSC	Staff will have a much better working knowledge about the links between childhood trauma suffered and the likelihood for engaging in future traumatic relationships. They will know what interventions they can put into place and who to refer to for help, to help limit this.	Initial discussion at learning review Feb 29th 2024.	
A focus on the use of professional curiosity for MASH and EH practitioners; what does this look	Local	Within the context of service meetings, EH and MASH need to have the uses of	MASH and EH services	Children will have MASH and EH managers and staff who will recognise what professional	MASH and EH service meetings to discuss this as	

like, how is it recorded and what are the safeguards to challenge, and quality assure this?		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		curiosity looks like in assessments and on file, also what the lack of it means regarding potential labelling, sharing of inaccuracies and ultimate gaps in ongoing assessment of the child's needs. This will mean a visible reference to for e.g., historical background, all police reporting, other LA involvement and completion of holistic chronologies, when considering cumulative risk assessment of the child's needs. Also, the gentle challenge of information carried across at every step across to ensure child and family expertise is privileged, acknowledging that information is only as	appropriate by the end of June 2024. Awaiting facilitator outline- to go live by May 2024.	

		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?		good as the informer and their interpretation of this. New CSC professional curiosity bitesize workshops to be rolled out in-house to bring examples of what professional curiosity looks like and its impact upon our work with children and families. This will be core for front door services.		
LBBD Assessment service to indicate which risk assessment tools	Local	Assessment managers need to indicate which tools they currently	CSC assessment service	Children will have Assessment workers who will increase their use of and reference	End of April 2024.	

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.		use, and at which agreed points in the assessment process, how these are included in management oversight and are than analysed for decision making regarding risk. How are practitioners trained to use these and what is the role of managers in holding oversight? 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		to DA tools on file- there will be a visible sign of these being uploaded and the analysis of the results will appear in the finished assessment, informing planning going forward for the child; specifically, where there is evidence of coercive control, the impact of this on the victim and children will be accurately analysed. All oversight and child-focused reflective supervision will carefully monitor the use of these tools and their meaningfulness to the assessment process. Children will have the relationship of MARAC in CSP with the Assessment service clearly defined, along	L&D will now send out all MARAC training as part of regular comms. MARAC coordinator to be invited to service meetings as	

		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.		with the points in assessment whereby escalation of risk to MARAC is indicated. Managers will know how to refer and discuss this regularly in supervision this being clearly displayed on the child's file. Regular MARAC training will be attended by staff and become embedded in assessment culture regarding DA and all forms of coercive control. Where no use of risk assessment is utilised regarding the child and victim, appropriate explanations used as oversight will appear on file, or performance escalations will occur. SMs will have regular final oversight of risk	appropriate .	

				assessment uses by teams as part of ongoing auditing.		
LBBD 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.	Local	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	CSC assessment	Children will have workers who will know what a good chronology looks like and the meaningfulness of this to the child's assessment; that without this there is an indication that professional curiosity has been limited and subsequently the child's assessment remains incomplete. Staff will know how to access key EH information on the child and family and have an embedded culture of timely accessing of other LA/ other agency/all external historical and police information to properly inform risk assessment and give	End of April 24 all staff have attended the chronology bitesize training. Potential discussion at CIB by May 2024	Completed. End of April 24 all staff have attended the chronology bitesize training.

		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?		the family the best chances to succeed. Children need their information held on systems which speak to each other. System separations leading to gaps in information used to assess, and poor privileging of the family's chances to succeed, will be evaluated and resolved where possible. This will need a conversation with LCS performance.		
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.	Local	Family's need the earliest possible intervention where DA is identified, specifically evidence of coercive controlling behaviours. Children need to know that there is	CSC SIS and EH	There will be a review of the use of child-focused FGC's at EH stage – with answers as to if this this happening and if so, how often; what is the capacity of the service to fulfil this, what are the aspirations for this, and which	End of June 24 for initial dialogue.	

		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.		additional resources are needed to become effective? What is the current view of EH in the use of FGC's benefitting the child's outcomes and at which point of need would this prove useful when addressing DA?		
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.	Regional	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	EH, MASH and Assessment, Police	Police checks and much of the information regarding risk is usefully held, actioned, and accessed by MASH. Children need to know that this crucial information is leading to effective risk assessment, aimed at reducing risks concerning their healthy development. MASH staff will know how to analyse and add police information and	End of April 24	

		chronology-this needs to be reviewed by the manager during supervision.		patterns of risk to the child's chronology or pass these checks to the Assessment/EH worker to do so. Clear protocols about who will do this, when and how, need to be made known. Children will know that the pathways by which police information is fed back are known, regular and transparent, with no significant information concerning the child, remaining unknown regarding DA and coercive control, due to for e.g., updated checks not being actioned etc.	MASH to address this with police by end of June 24	
A learning review of Linda and the children's context to be led by LBBD DA	Local and possibly for partners	Police information is vital in correctly informing ongoing cumulative risk	CSC and partners	Linda's children's context although unique to them, will also be like many	Feb 2024	

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 her children.		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. 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		other children we work with. Their mother's plight and the impact of the harm upon their lives will be looked at during the learning review with comprehensive recommendations made and relevant improvement planning. This will be tracked for outcomes against the recently updated LBBD DA offer and will specifically use the lens of our Safe and Together approach.		

		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 Community Trust						
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.	Local	•Embedded learning around DA risk assessment in Safeguarding Children training. •For HCT practitioners to continue to use the DASH risk assessment tool as part of understanding wider risk around DA. •Circulated reminder widely	HCT	HCT DA training is already embedded and mandatory for PHN within first 18 months of employment – includes Assessing and Responding to Domestic Abuse and is also offered to all newly qualified Health Visitors in post.	April 2024	All identified actions completed 4th of April 2024.

		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				

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.	Local	•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	HCT	For more staff to be aware of the training. • HCT safeguarding newsletter cascaded March 2024 Newsletter MASH and SG MAR 24.pdf 7 Min Briefing_Professional (Ask the Question Competency Band 4	April 2024	All actions completed.

		networks, including the GP and other health services and partner agencies.				
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.	Local	•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.	HCT	• All learnings embedded within training. • Supervisees reminded at each supervision to bring complex cases. It is embedded in part of the supervision process. • Shared at all relevant HCT communication platforms. CP74 Policy for the Delivery of SGC Super	April 2024	Completed.

		•Supervisors reinforce at safeguarding supervision sessions and actively enquire regarding cases which may not reach statutory threshold.				
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.	Local	•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	HCT	• Learning embedded within all HCT Safeguarding training. • The children safeguarding specialist nurse leads for domestic abuse have advised the champions to reinforce the importance of record keeping.	April 2024	Completed.

		within PHN for cascade. •Shared at SGC Forum as formal safeguarding governance and assurance mechanism. •DA Champions use training opportunities within PHN teams to reinforce.				
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.	Local	•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.	HCT	• The importance of voice of the child is well embedded in training, supervision and record keeping. • Seven-minute briefing circulated on the voice of the child in 7 mins breifing - voice of the child.pp	April 2024	Completed.

To ensure records from out of area/County are received and reviewed as per the Movement in process SOP and flow chart.	Local	•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.	HCT	• There is Public Health Nurse (PHN) SOP around transfer in and out. • PHN team leads have reinforced the transfer in and out process. • Recommendations for PHN's to audit SOP compliance. Which is in place. • Domestic abuse Champions continue to reinforce the movement in process. Refuge HV SOP.docx	April 2024	Completed.
To ensure that all HCT practitioners continue to work in line with DA policy and Refuge SOP to	Local	•DA audit to continue to monitor compliance to DA policy.	HCT	• HCT DA audit continues to measure compliance to HCT policy 6 monthly.	April 2024	Completed.

support victims of domestic abuse.		•DA champions to use training opportunities to cascade any updates to DA policy and learnings from audit.		FINAL Clinical Audit Outcome Report F		
Awareness raising around the escalation and challenge process when there is professional disagreement around case progression.	Local	•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.	HCT	• Escalation policies well embedded in practise. • Awareness raising re escalation and challenge when there a professional disagreement cascaded in Safeguarding newsletter and bulletin in February 2024 and is available on the Safeguarding Children intranet. year-of-learning_case-escalation_7-min	April 2024	Completed.
Hertfordshire Partnership NHS Foundation Trust						

HPFT Domestic Abuse Resource Pack	Local	Resource pack to be developed Resource pack to be shared across all HPFT staff	HPFT	Resource pack developed and available on Trust Intranet.	25/11/2023	In progress
Routine Enquiry	Local	Routine Enquiry training to be developed and rolled out trust-wide.	HPFT	Training package completed In person training sessions rolled out Webinar sessions scheduled	25/11/2023 Dec 2023 April 2024	Completed Ongoing Ongoing
Staff seek supervision/ escalation	Local	Basic Safeguarding adults and children training to include information on supervision/ escalation.	HPFT	Changes implemented in training packages.	Ongoing	Ongoing
Completion of DASH Risk Assessment and referral to MARAC	Local	All HPFT Domestic Abuse training to include info on DASH/ MARAC. Hertfordshire MARAC guidance to be circulated to teams re: MARAC referral process.	HPFT	Changes implemented in training packages. Guidance circulated via email.	Dec 2023 Jan 2023	Completed Ongoing

Domestic Abuse Training	Local	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.	HPFT	Topics included in training programme for 2024-25. Changes implemented in training packages.	April 2023 November 2023	Ongoing Completed

Glossary of Terms

Acronym	Name
ACMHS	Adult Community Mental Health Service
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)[42]
FGC	Family Group Conference
HMH	Homes and Money Hub[43]
IDVA	Independent Domestic Violence Advisor
IFST	Intensive Family Support Team
IGVA	Independent Gender Violence Advocate
LBBD	London Borough of Barking and Dagenham
MASH	Multi Agency Safeguarding Hub
MARAC	Multi Agency Risk Assessment Conference
NELFT	North East London Foundation Trust[44]
NCD	Non Crime Domestic
OCD	Obsessive Compulsive Disorder
PPIMHS	Perinatal Parent Infant Mental Health Service[45]
SPA	Single Point of Access[46]
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

[42] Early help | London Borough of Barking and Dagenham (lbbd.gov.uk)
[43] Homes and Money Hubs | London Borough of Barking and Dagenham (lbbd.gov.uk)
[44] Providing care for people in London, Essex, Kent and Medway. Employing over 7,000 staff, over 200+ locations. | NELFT NHS Foundation Trust
[45] Perinatal parent infant mental health service-bdhvrbwf | NELFT NHS Foundation Trust
[46] Single point of access service :: Central London Community Healthcare NHS Trust (clch.nhs.uk)