EAST HERTS COMMUNITY SAFETY

PARTNERSHIP

DOMESTIC HOMICIDE: Executive Summary: Louise

Independent Chair and Author of Report: Kelly McGuire

Date: December 2024

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Condolences

The panel wishes to offer deepest condolences to Louise’s family for their tragic loss.

1. Introduction

1.1. The key purpose for undertaking DHRs is to enable lessons to be learned from homicides where a person is killed as a result of domestic violence and abuse. 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, and most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future.

1.2. This report of a domestic homicide review examines agency responses and support given to Louise, a resident of Much Hadham prior to the point of her death in August 2022.

1.3. In addition to agency involvement the review will also examine the past to identify any relevant background or trail of abuse before Louise's death, 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.

1.4. The review will consider agencies contact and involvement with Louise from June 2019 to August 2022. This relates to the period from which services first became aware that Louise was experiencing domestic abuse within her intimate relationship. There is some information included in the report prior to the scoping period, this is considered relevant as it relates to Louise's past mental health.

1.5. The key purpose for undertaking DHRs is to enable lessons to be learned from homicides where a person is killed as a result of domestic violence and abuse. 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, and most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future.

1.6. Louise was found deceased on in August 2022, having taken her own life by hanging.

1.7. Louise appears to have separated from her estranged ex-partner Jamie in November 2021 although they continued to have contact as they had a child together.

1.8. The East Herts Community Safety Partnership is keen to establish lessons from agencies that may have worked individually and together to safeguard Louise. The review will explore whether there were missed opportunities to have engaged with the family to offer any relevant support, whether the risk to Louise was recognised and whether there were any barriers to Louise accessing services that may have offered support to reduce risk around suicide. If so, the report will consider what can be done to raise awareness of domestic abuse linked to those who experience suicidal ideation in such circumstances and of the services available to victims of domestic violence and abuse in this context.

1.9. This DHR will consider agencies contact and involvement with Louise and Jamie from the beginning of to the date of Louise's death.

1.10. In addition to agency involvement, the DHR will also examine the past to identify any relevant background or trail of abuse before Louise's death, whether support was accessed within the community and whether there were any barriers to accessing support.

1.11. This DHR does not take the place of the criminal or coroner's courts, nor does it take the form of a disciplinary process.

1.12. The Review Panel expresses its sympathy to the family of Louise and respect their wishes not to be involved in this process. Insert summary of the circumstances that led to a review being undertaken in this case.

2. Confidentiality

2.1. The findings of this review are confidential until it has been approved for publication by the Home Office. In the meantime, information is available only to participating officers professionals and their line managers.

2.2. The following pseudonyms have been used in this review to protect the identities of the victim, other parties, those of their family members, and the perpetrator:

Name	Relationship to Louise
Louise	n/a
Jamie	Ex-partner (father of Child A)
Child A	Child
John	Father
Janet	Mother
Katy	Sister
Lee	Ex-Partner (prior to Jamie)
Clare	New partner of Jamie

2.3. The choice of pseudonyms used in this report were not discussed with Louise's family as they did not wish to be involved in this process.

3. Dissemination

3.1 Once finalised by the Review Panel, the Executive Summary and Overview Report will be presented to the East Herts Community Safety Partnership for approval and thereafter will be sent to the Home Office for quality assurance.

3.2 Once agreed by the Home Office, the Executive Summary and Overview Report will be shared with:

Review Panel Members

The Home Office

The Domestic Abuse Commissioner

Police and Crime Commissioner

3.3 The recommendations will be owned by the Hertfordshire Domestic Abuse Partnership, who will be responsible for monitoring the recommendations and reporting on progress.

4. Methodology

4.1 Throughout the report the term ‘domestic abuse’ is used interchangeably with ‘domestic violence’, and the report uses the cross-government definition of domestic violence and abuse as issued in March 2013 and included here to assist the reader to understand that domestic violence is not only physical violence but a wide range of abusive and controlling behaviours. The definition states that domestic violence and abuse is:

4.2 “Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass, but is not limited to, the following types of abuse: psychological; physical; sexual; financial; and emotional.

4.3 Controlling behaviour is: a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.

4.4 Coercive behaviour is: an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim.”

4.5 This definition, which is not a legal definition, includes so-called ‘honour’ based violence, female genital mutilation (FGM) and forced marriage, and is clear that victims are not confined to one gender or ethnic group.

4.6 This DHR has followed the statutory guidance issued following the implementation of Section 9 of the Domestic Violence Crime and Victims Act 2004.

4.7 On notification of the Louise’s death being considered for a DHR, agencies were asked to check for their involvement with any of the parties concerned and secure their records. A total of 12 agencies were contacted to check for involvement with the parties concerned with this DHR. Of these, 3 had only limited contact and submitted a Summary of Engagement only. However, 9 had more extensive contact and were asked to submit Individual Management Reviews (IMRs). A narrative chronology was also prepared.

4.8 Independence and Quality of IMRs: The IMRs were written by authors independent of case management or delivery of the service concerned. The IMRs received were for the most part comprehensive and enabled the Review Panel to analyse the contact with Louise, Jamie and Child A and to produce the learning for this DHR.

4.9 9 IMRs made recommendations of their own, and in some cases reported changes in practice and policies over time. These are described in the analysis, section 16.

4.10 Documents Reviewed: In addition to the above information, several other documents have been reviewed. These are referenced in this report.

4.11 Interviews Undertaken: There were no interviews undertaken by the chair for the purposes of this DHR. This is due to the Louise’s family not wishing to be involved in this process.

5. The review panel members

5.1 The Review Panel members were:

Name	Organisation	Job Title
Kelly McGuire		DHR Chair
Ildiko Cseri	Hertfordshire County Council	Monitoring and Commissioning Officer
Carol Harwood	Hertfordshire County Council	Business Administration (Minutes)
Cathy Shea	Hertfordshire County Council	CLA Service Manager, Children Services
Kate Johnson	Hertfordshire Partnership University NHS Foundation Trust	Professional Lead for Safeguarding Adults / Approved Mental Health Professional
Terri Heredia	Hertfordshire Constabulary	Detective Inspector, DHR Reviews
Sarah Corrigan	East and North Hertfordshire NHS Trust	Childrens Safeguarding Lead
Jonathan Geall	East Hertfordshire District Council	Head of Housing and Health, Corporate Lead for Safeguarding
Lauren Hacket	Hertfordshire Partnership University NHS Foundation Trust	Specialist Safeguarding Practitioner/Approved Mental Health Professional
Pushpa Guild	Hertfordshire Constabulary	Review Officer
Cathy Mcarevey	Hertfordshire and West Essex Integrated Care Board	Designated Safeguarding Nurse
Ross Williams	Hertfordshire County Council	Head of Family Safeguarding East, Children and Families, Childrens Services
Ayonike Atere	Refuge (IDVA service)	Senior Operations Manager, Refuge, IDVA
Andrew Wilkinson	Much Hadham Health Centre	Practice Manager
Gillian Harrington	Cambridgeshire University Hospital	Child Protection Team, Paediatric Intensive Care and Paediatric High Dependency Unit
Julie Pomfrett	East Hertfordshire District Council	Community Safety and ASB Manager
James Luxon	Hertfordshire Constabulary	Detective Chief Inspector, DHR Reviews
Liz Scott	Central Surgery, Sawbridgeworth	Practice Business Manager
Sue Thompson	Hertfordshire Community NHS Trust	Named Nurse Safeguarding Children

5.2 The Review Panel met a total of five times, the first meeting was on the 25th January 2024. There were further meetings on the 25th April 2024, 10th May 2024, 20th August and the 26th September 2024. Thereafter, the Overview Report and Executive Summary were agreed electronically, with Review Panel members providing comment on a final draft and signing off the final report by email during October 2024.

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

6. Author of the overview report

6.1 The chair and author of the review is Kelly McGuire, an independent DHR Chair. Kelly has received DHR Chair's training from AADFA. She has previously led reviews on behalf of two Local Authority areas in North West England. She has extensive experience in the domestic violence sector, having worked in statutory, voluntary and community sector organisation.

6.2 Kelly is currently the National Programme Lead for Drive the High Harm High Risk response to perpetrators and is a licensed expert court witness for domestic abuse.

6.3 Independence*:* Kelly has no connection with the local area or any of the agencies involved.

7. Equality and Diversity

7.1 The chair and the Review Panel considered the Protected Characteristics described by the Equality Act 2010 i.e., Age, Disability, Gender Reassignment, Marriage and Civil Partnership, Pregnancy and Maternity, Race, Religion and Belief, Sex, and Sexual Orientation during the DHR process.

6.1. There is extensive research to support that in the context of domestic violence, females are at a greater risk of being victimised, injured, or killed. In fact, the term "Femicide", which refers to the killing of women by men because they are women, was coined in the 1970s to raise awareness of the violent deaths of women.

6.2. Homicide represents the most extreme form of violence against women, a lethal act on a continuum of gender-based discrimination and abuse. As research shows, gender-related killings of women and girls is a problem across the world, in countries rich and poor. Whilst most homicide victims are men, killed by strangers, women are far more likely to die at the hands of someone they know.

6.3. Women killed by intimate partners or family members account for 58% of all female homicide victims reported globally last year, and little progress has been made in preventing such murders, with a total of 18 OFFICIAL SENSITIVE 87,000 women being killed across the world in 2017 alone. More than half of them (58%) were killed by intimate partners or family members, meaning that 137 women across the world are killed by a member of their own family every day. A third of these women were killed by a current or former partner - someone they would normally expect to trust.

6.4. Between 2009 and 2018, at least 1,425 women were killed by men in the UK, meaning a man killed a woman every three days on average. The report shows that women are killed by their husbands, partners, and ex-partners, by sons, grandsons, and other male relatives, by acquaintances, colleagues, neighbours, and strangers. Unfortunately, but unsurprisingly, a

huge number of women were killed in the context of intimate partner violence. The link between domestic abuse and suicide is also a consideration within this review and is identified later within the report.

6.5. The protected characteristic of pregnancy and maternity was relevant as Louise's pregnancy was during the scoping period and she was therefore a mother at the time of her death.

6.6. In addition, we know through research that death rates from suicide are consistently higher for men, and thus many interventions to reduce the suicide rate amongst populations are aimed at men. Although this good work should not be undermined, it means that women's experience of suicidal ideation is often side-lined. Given that women are significantly more likely than men to attempt suicide, responding to women's suicidal ideation should also be a priority: The role of traumatic experiences, such as being subjected to domestic abuse, as a precursor to suicidality has already been formally recognised at national (Department of Health, 2012) and international (WHO, 2014) levels. However, the scale, dynamics and complexity of this intersection, and the ways in which positive interventions may be secured, remain significantly under-researched, particularly in the UK.

6.7. Women's experiences of suicide need to be featured and prioritised within research, particularly within the context of domestic abuse. Failure to prioritise resources for female victims' experiences of suicide does not pay due regard to their protected characteristic of sex. If services and responses for suicide reduction are aimed at men, women are indirectly discriminated against. The panel make further multi-agency and national recommendations in response to these aspects.

6.8. There was no evidence that Louise was directly discriminated against by any agency.

8. Terms of Reference

8.1 This DHR aims to identify the learning from this case, and for action to be taken in response to that learning: with a view to preventing homicide and ensuring that individuals and families are better supported

8.2 The Review Panel was comprised of agencies from East Herts Community Safety Partnership, as Louise and Jamie were living in that area at the time of the Louise's death. Representation form Health agencies across Hertfordshire was also necessary as Louise had received health care from across the region.

8.3 Agencies were contacted as soon as possible to inform them of the DHR, invite their participation and to ask them to secure their records.

8.4 At the first meeting, the Review Panel shared brief information about agency contact with the individuals involved, and as a result, established that the period to be reviewed would be from 22.06.2019 to date of Louise's death. This represents the period from when agencies became involved in reported domestic abuse and concerns around mental health.

8.5 In addition, agencies were asked to provide a brief background of any significant events and safeguarding issues prior to the scoping period. This will include any significant event

that falls outside the timeframe if agencies consider that it would add value and learning to the review.

8.6 Key Lines of Inquiry: The Review Panel considered the statutory guidance and identified the following case specific issues:

8.7 Identify examples of good practice, both single and multi-agency.

8.8 Analyse the quality of risk assessments undertaken. Were links between Mental Health and Domestic Abuse identified at any risk assessment? Was suicide ideation identified at any point and if so, connected with Mental Health and/or Domestic Abuse. Have there been changes in services since 2019, particularly policies and training?

8.9 Whether risk was or was not identified, where can practitioners within your agency receive advice or support if they suspect domestic abuse? Was this taken up in this case? If this is available would the advice extend to consultation or referral across agencies?

8.10 Any evidence of whether any identified risk had been assessed as reaching the threshold for inter-agency information sharing especially linked to domestic abuse.

8.11 Any evidence of communication and information sharing between agencies? How could information sharing, and communication have been improved during the scoping period both within and between agencies? Did the cross-boundary context impact on information sharing and if so, how?

8.12 Were referral pathways followed according to local policies? If not, what was the reason this did not happen? Are these pathways different now?

8.13 Was consideration given to issues of culture, race, religion or belief? What role if any, did these issues or issues of language for any family member play?

9. Engagement with friends and family

9.1 From the outset, the East Herts Community Safety Partnership decided that it was important to take steps to offer the family the opportunity to be involved in the review. The parents of Louise were contacted on 2 occasions by letter but did not respond to the communication. The chair subsequently wrote to Louise's parents and offered to make contact by telephone; no response was received. As there were several attempts to involve the family made by both letter and telephone it was agreed the review would continue without the involvement of family as to respect the wishes of the family to not be involved in this process.

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

9.3 Consideration was given to whether Jamie should be involved in this review. There were mixed feelings from panel representatives. On balance it seems difficult to fairly respect the wishes of Louise's family not to be involved and at the same time include the voice of the perpetrator.

9.4 As a result, there is no information directly from Jamie in this DHR. Nor was it appropriate to identify any family or friends that could be spoken to.

10. Background Information, Chronology and Overview

Background

10.1 Background Information relating to the Victim: At the time of her death, Louise was 22 years old. Louise was British and had grown up in the Much Hadham area with her parents and younger sibling, Lisa. During 2018, when Louise would have been 18 years old, there are 3 reported incidents of verbal arguments between Louise and her parents; during this time Louise's grandmother also reports concerns about the treatment of Louise by her parents and expresses concern for Louise's mental health. In 2020, Louise had given birth to her son, Child A. Louise had no known disabilities although her mental health has been a concern for agencies on a number of occasions since 2018. It has not been possible to ascertain what her faith was.

10.2 Background Information relating to the Perpetrator: At the time of the Louise's death, Jamie was 25 years old. Jamie's background is recorded on police systems as 'other white background' and it has not been possible to ascertain his faith. Jamie does not have any recorded disabilities although his mental health has been of concern at times during the scoping period, most notably in the few months prior to Louise's death and the immediate period following.

10.3 Synopsis of relationship with the Perpetrator: Louise and Jamie appear to have started a relationship sometime in 2019. Their relationship first came to the attention of services in November 2019 following an incident where officers attended what was reported as a verbal argument. Louise reports they have been arguing for a couple of days, they have both thrown each other's belongings and Jamie has spat at her and thrown a mop at her.

10.4 In December 2021 Louise reports that she is no longer in a relationship with Jamie and that he is threatening to share sexual images of her. Between January 2022 and May 2022 there are 4 incidents reported by Louise, these involve stalking and receiving unwanted calls and messages, and 2 incidents reported by Jamie which involve concerns about Louise's care of their son and malicious communications.

10.5 Members of the family and the household: At the time of her death, Louise resided in her parents annex and had care of Child A. Her parents and younger sibling lived in the main property. Jamie resided with his mother.

Chronology

10.6 The chronology examines the period from June 2019 up to the time of Louise's death. However, there is a brief history prior to the scoping period that has also been included, this section provides some background information relating to Louise's mental health which is considered to be relevant in that it shows that as Louise's personal relationships deteriorate there is a direct correlation with her ability to manage her own mental health. During the period prior to the scoping period Louise experiences difficulties in her relationship with her father and also an early intimate relationship. During these difficulties

Louise accesses mental health support. This is a pattern that we see repeat during the scoping period, on these occasions the breakdown of her relationship with Jamie are cited as a factor contributing to an increase in her anxiety, depression and general deterioration of her mental health.

10.7 At one time or another during the scoping period Louise has contact with all of the agencies that have contributed to the review. Louise's engagement with all agencies is inconsistent but what is consistent is the correlation between Louise's engagement and the health of her personal relationships.

10.8 In most cases the chronology shows that agencies respond according to policy and there re examples of good practice. However, there are also gaps; gaps in the information held by agencies; gaps in the way agencies use and share information; gaps in professional curiosity leading to missed opportunities to recognise the pattern between Louise's mental health and her experiences within her relationship.

10.9 The chronology also highlights that in the period immediately prior to her death the level of abuse and harassment Louise was experiencing from Jamie had escalated following their separation and that child contact was a key feature.

10.10 The increased abuse from Jamie, which included him reaching out to the key agencies that could have supported Louise to make allegations against Louise and her ability to parent, coincided with her disengagement with services. However, none of the agencies recognised this connection. Louise's ability to disclose what was happening in terms of the abuse and her mental health became compromised, the agencies she was in contact with were also in contact with Jamie who was making false allegations.

10.11 The chronology shows that at the time of Louise's death the safeguarding referral to children's social care had been closed and she was advised to seek mediation. The well-being service had closed Louise's case due to disengagement. Louise had reported experiencing abuse and harassment from Jamie which had not been followed up for over 79 days and there was a warrant outstanding for her arrest following allegations of unwanted calls and messages made by Jamie the week prior to her death.

11. Analysis using the Terms of Reference

11.1 The analysis highlights that the vast majority of the actions taken by agencies were within policy and adhered to practice guidelines; any exceptions to this have been captured in the full analysis and appropriate recommendations set to address this moving forward. What is also evident is that there has already been a significant amount of learning across Hertfordshire, specifically in relation to domestic abuse risk assessment and information sharing and at much of this learning has already led to changes in policy and practice.

11.2 All police call outs were responded to and graded appropriately. Risk and vulnerability assessments were completed for each incident and there was appropriate liaison with specialist teams (i.e. DAISU) where necessary.

11.3 Good continuity of care was provided by Louise's GP surgery and there was a good, immediate response when she initially disclosed experiencing suicide ideation.

11.4 During pregnancy, a referral was made to the Consultant Obstetrician to review her mental health due to her history.

11.5 The Health Visitor team respond immediately to all DA notifications and made immediate contact.

11.6 The IDVA service were pro-active in making initial contact with Louise following the case being heard at MARAC.

11.7 There were a number of agencies working with Louise during the scoping period; it seems that all of them had access to information about her mental health, her suicide ideation and previous overdoses and that she was experiencing domestic abuse. However, it doesn't appear that any of the agencies fully explored the connection between these factors. One of the factors that contributed to this was the way in which information was stored by agencies; for example, there were at least 3 health services (Herts Community NHS, GP and CUFT) engaging with Louise in some way during the period leading up to her death. Yet there was no-where that all the information could be accessed in one place and furthermore none of the professionals had access across all of the systems, meaning that they were unable to build a full picture of what was happening in Louise's life at the time.

11.8 The panel were advised that in relation to use of information sharing and use of multiple systems within HPFT and other areas of Health there has been some progress but there are still limitations. HPFT now have a limited dashboard overview on whether social worker/GP appts are in place – but finding out what these appointments might be for would still require the health professional to make contact with the other service – an unrealistic expectation given that GP appointment may be for a simple virus. The internal systems still do not really speak to each other, although a dashboard is available to search a name, but without access to all systems, this still doesn't allow a good overview, but confirmed that this is work in progress.

11.9 Herts Community NHS use a different system, confirming that they wouldn't be able to access HPFT and ENHT systems, and that they were only able to see the GP information of those using System 1. There are still issues in relation to accessing information and sharing. Notifications from the Police where there is a child under 5 and some MARAC information is shared but there are clearly some gaps that need to be addressed.

11.10 Whilst risk assessments were completed by Hertfordshire Constabulary there is some inconsistency in the way in which information was analysed which impacted on the level of risk assigned to the case. There is some confusion as to the final score of one assessment, this meant that the case was allocated as requiring medium level response when the score had in fact met the high risk, this led to a missed opportunity for the case to be heard at MARAC.

11.11 The other factor in relation was the way in which all agencies assessed the risk at a moment in time and failed to consider the historic dynamics of the case; analysis of the history shows that the domestic abuse continued to escalate after the point of separation and centred around child contact. Similarly, looking at risk in relation to specific events meant that the relationship between Louise's mental health and her experience of domestic abuse was not identified. This contributed to agencies closing her case when she disengaged with services rather than becoming more concerned about her safety.

11.12 Hertfordshire Constabulary have now transitioned to the use of DARA as assessment tool to enable officers to consider the history of a case and apply professional judgement to inform the overall level of risk following an incident. This transition has included all frontline officers receiving training in how to use the DARA effectively and how to use professional judgement to inform the risk assessment.

11.13 Suicide ideation was identified by Louise's GP and there was a prompt and appropriate response; however, there is no record of an individual safety plan. The well-being service offered a good level of support to Louise when she self-referred. No agencies seemed to engage professional curiosity to explore the cause of the deterioration in Louise's mental health which meant that her experience of domestic abuse during this time was unclear despite the fact that there were police reports and a child and family assessment happening simultaneously, both the result of domestic abuse between Louise and Jamie.

11.14 Agencies have made some progress in relation to understanding the relationship between domestic abuse and mental health. Training to address this has been commissioned by Hertfordshire Domestic Abuse Partnership for all frontline professionals.

12. Lessons to be learnt

12.1. There were several agencies working with Louise during the scoping period; it seems that all of them had access to information about her mental health, her suicide ideation and previous overdoses and that she was experiencing domestic abuse. However, it doesn't appear that any of the agencies fully explored the connection between these factors. One of the factors that contributed to this was the way in which information was stored by agencies; for example, there were at least 3 health services (Herts Community NHS, GP and CUFT) engaging with Louise in some way during the period leading up to her death. Yet there was no-where that all the information could be accessed in one place and furthermore none of the professionals had access across all the systems, meaning that they were unable to build a full picture of what was happening in Louise's life at the time.

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12.4. Having a professional who had a clear understanding of the lived experience of domestic abuse and the impact on mental health and wellbeing could have made a significant difference in the support that Louise received from agencies. It was evident suicidal ideation was a known risk in Louise's case, and that difficulties in her intimate relationships were a trigger, if any of the professionals had identified the significance of this and been

able to advocate on Louise's behalf there would have been a better understanding of the risks and agencies would have been able to better support Louise with an effective safety plan in place.

12.5. It is acknowledged that engagement with Jamie the person identified as causing harm in the safeguarding context is important, it was of concern that the historic dynamic and pattern of abuse from Jamie to Louise was not seemingly considered in the assessment. It is unclear from the records provided by Children's Services whether they had the information but records from Herts Constabulary, Louise's GP, the Health Visitor Team and HPFT who were providing support for Louise's mental health at the time the Children and Family assessment took place all show they information request was completed and/or all information was shared. Training named ENGAGE[1] is available for professionals who are less familiar on approaches to interviewing those who harm in domestic abuse cases. It outlines a roadmap of options highlighting high risk factors and promoting safe enquiry to support engagement from a holistic perspective. Recently the Government have published the new national standards[2] for engaging perpetrators looking at early intervention.

12.6. DASH- RIC Risk assessment was used to identify the level of harm by Police. It is dependent on the information provided primarily by the identified victim with limited opportunity to verify details. This is a strength in that a first-hand account of an incident is captured from source, however the flaw is that it can also be a deficit because traumatised victims may minimise, confuse incidents leading to an inaccurate impression of the level of risk. Police databases referred to different scores on the DASH documents at times, which affected the overall grading and safeguarding strategies. At no time were any of the DASH assessments graded as High – however the differing scores do list 17-19 on one of the assessments which would have met the criteria for high risk and triggered a MARAC referral. The MARAC referral in May 2022 was submitted based on four incidents having occurred within a period of twelve months, an earlier referral had been refused as it hadn't met this criteria, however the DASH-RIC has an option for "professional judgement" to be included as part of the assessment which would have allowed the case to be argued that given the escalating pattern and frequency of incident and the risk to self for Louise a referral was necessary. The DASH RIC has no practice guidance on exploring the suicidal risk with the client which is gap when working with a traumatised victim. Had the earlier referral been considered there may have been an opportunity to information to be shared across agencies sooner and early intervention to take place. When the subsequent referral in accepted Louise has been experiencing the abuse over a longer period and her engagement with Children's Services and the IDVA has ended and become less frequent with the midwife team and mental health service.

12.7. Louise seemed to have a good relationship with mental health services but struggled to maintain consistent engagement. Case notes do acknowledge Louise's difficulties with her mental health and to a lesser extent her experience of domestic abuse but lack the professional curiosity required to fully understand how the two are connected. A resource to support mental health professionals identify and respond to Domestic Violence and Abuse is available. [3]

12.8. The Marac provides an effective way for agencies to share information, identify, patterns of abuse and put plans in place to mitigate risk to protect victims and hold the perpetrator to account .

12.9. A key point raised was about using professional curiosity much earlier as part of an early intervention strategy, in looking at the motivation behind certain actions when there was

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[1] ENGAGE | WWP European Network (work-with-perpetrators.eu)

[2] https://www.gov.uk/government/publications/standards-for-domestic-abuse-perpetrator-interventions

[3] https://www.kcl.ac.uk/mental-health-and-psychological-sciences/research/lara-vp-download

clearly a history of ongoing domestic abuse. The family was subject to statutory Child and Family Assessment, there is evidence suggesting that when parental conflict is frequent, intense, and poorly resolved it can put children's mental health and long-term outcomes at risk. In the information that is recorded to have been given to Children's Services it was clear that there was a pattern of coercive and controlling behaviour from Jamie to Louise but it appears that as the concern for Child A's well-being was raised by Jamie, this history is never considered, nor does it appear to have been considered that his allegations could in fact have been part of the coercive and controlling behaviour. Instead, both parents are given the same advice, consider the impact of conflict in front of Child A and seek mediation if necessary. (need to reference guidelines for mediation where domestic abuse is present). The oversight of this case does not seem to have identified that the assessment failed to consider the impact of the domestic abuse on Louise's mental health; didn't consider the historical dynamic pattern of abuse experienced by Louise or that the allegations could form part of the coercive controlling pattern; the inappropriateness of a recommendation for meditation in this case and that the couples separation had in fact led to the increase in risk and not a reduction as implied in the assessment.

12.10. There was also a significant delay in the review of the case by Police when Louise initially reported the harassment and threats, she was receiving from Jamie and his new partner. This will undoubtedly left Louise feeling unsafe and vulnerable. Louise had also been failed to be recognised as a vulnerable victim when the initial statement, which will also have impacted on the support that she would have received. During this delay, Jamie makes a report that he is being harassed by Louise and a warrant is issued for Louise's arrest. It is unclear whether Louise would have been aware of this at the time of her death and Louise sadly takes her own life before a follow-up statement is taken from her about her allegations against Jamie.

13. Conclusions

13.1 Information was not always shared between agencies which meant that decisions about risk, support needs and case progression were made without a full understanding. Where information was shared it is unclear how it was considered in decision making around risk. For example, Children's Services records log that information from all agencies was requested however it is unclear how this information was considered when the Children and Family Assessment does not make any recommendations relating to Louise's mental health. Similarly, there is no reference to Louise's mental health needs in the referral that Children's Services sent to the IDVA service. It is also difficult to understand how the reason stated on the referral form, 'risk has increased since separation', can in fact also provide the rationale for closing the case, 'risk now reduced due to separation'.

13.2 When assessing risk to Louise, from both herself, and from others, agencies seem to consistently consider her mental health OR her suicide risk OR the DA risk; although the records often log that there are issues across these areas the connection between them is not considered. There is little record of her history being considered which highlights this pattern further; Louise's history of mental health, suicide ideation and overdose consistently shows a pattern where her mental heath is directly impacted on during periods of relationship breakdown.

13.3 Audits into suicide and risk factors show that mental health is the number one risk factor (approximately 70%), closely followed by relationship/family issues (50%). The information

also shows that approximately 1/3 of suicides occurs in people who have had previous suicide attempts.

13.4 When agencies responded to incidents where Jamie had been recorded as the victim the responses did not appear to consider look at the clusters of incidents taking account of historical dynamics of abuse not just the current incident as recommended by Prof Jane Monkton Smith in the Homicide Timeline model. Looking at the historical dynamics would again have revealed a pattern of abusive and coercive controlling behaviour from Jamie to Louise. This would also have highlighted that the counter allegations from Jamie appear to start at the same time that Louise commences a new relationship and that the conflict over child contact escalates. Lack of professional curiosity at times meant that the full extent and impact of Jamie's behaviour on Louise could not be understood.

14. Recommendations

Recommendation 1: For Hertfordshire Domestic Abuse Partnership to review existing risk assessment tools and processes used by agencies that offer early intervention[4] and develop guidance to increase the consistency of an approach that basis assessment on a fuller picture of the context and mapping of abuse by taking account of historical dynamics of abuse incidents, not just the current incident, using professional curiosity to inform their actions as required.

Recommendation 2: For Hertfordshire Domestic Abuse Partnership to identify appropriate training for agencies dealing with families affected by domestic abuse to improve how perpetrators are held accountable for their actions and understanding the impacts on those affected.

Recommendation 3: For the Hertfordshire Domestic Abuse Partnership to develop a consistent referral form that supports not only the reason for referral but also includes information that will support the risk and needs assessment of the agency they are sharing the information with as well as identifies the best method of communication to achieve engagement.

Recommendation 4: Hertfordshire Domestic Abuse Partnership to provide training to all partner agencies working with families effected by domestic abuse to improve professionals understanding of Prof Jane Monckton Smith's eight-stage domestic homicide and Suicide Timeline pattern models and provide guidance to ensure that they are aware of the benefits of incorporating them practically in assessments.

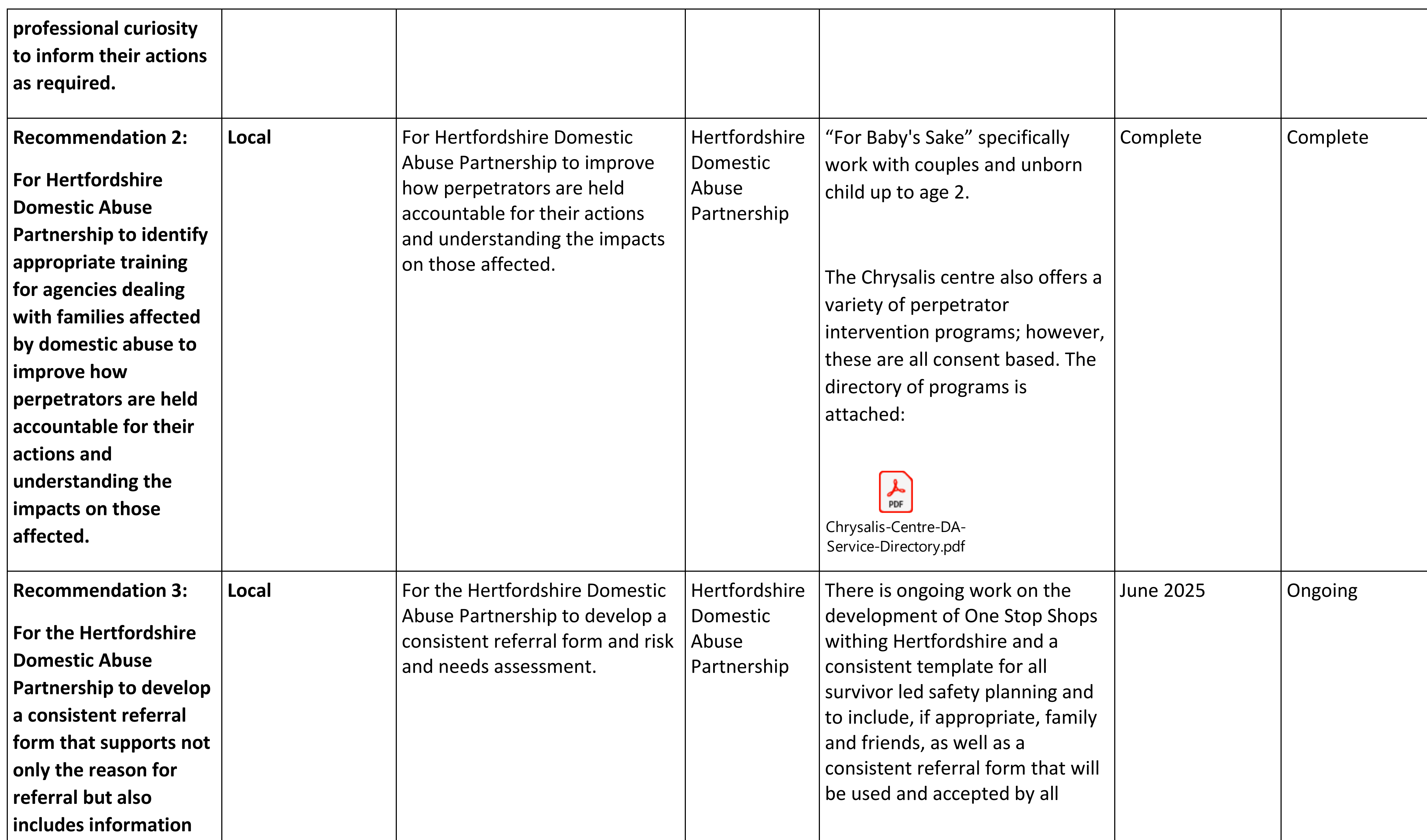
Recommendation 5: To Improve identification and understanding of the links between domestic abuse and suicide and to ensure understanding of the local and national referral pathways for support at crisis point using a trauma informed approach.

Recommendation 6: Hertfordshire Domestic Abuse Partnership with all partners promote awareness around suicide prevention in line with the National Suicide Prevention Alliance best practice guidance.

[4] file://early-intervention-in-domestic-violence-and-abuse-full-report.pdf

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

Recommendation (SMART goal)	Scope of recommendation (i.e. local or regional)	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target Date	Date of completion and Outcome
Multi-agency recommendations						
Recommendation 1: **For Hertfordshire Domestic Abuse Partnership to review existing risk assessment tools and processes used by agencies that offer early intervention and develop guidance to increase the consistency of an approach that basis assessment on a fuller picture of the context and mapping of abuse by taking account of historical dynamics of abuse incidents, not just the current incident, using**	**Local**	For Hertfordshire Domestic Abuse Partnership to review existing risk assessment tools	Hertfordshire Domestic Abuse Partnership	There is ongoing work on the development of One Stop Shops withing Hertfordshire and as part of this project, a consistent referral form and risk and needs assessment form is being developed.	June 2025	Ongoing.

professional curiosity to inform their actions as required.						
Recommendation 2: **For Hertfordshire Domestic Abuse Partnership to identify appropriate training for agencies dealing with families affected by domestic abuse to improve how perpetrators are held accountable for their actions and understanding the impacts on those affected.**	**Local**	For Hertfordshire Domestic Abuse Partnership to improve how perpetrators are held accountable for their actions and understanding the impacts on those affected.	Hertfordshire Domestic Abuse Partnership	“For Baby's Sake” specifically work with couples and unborn child up to age 2. The Chrysalis centre also offers a variety of perpetrator intervention programs; however, these are all consent based. The directory of programs is attached:  Chrysalis-Centre-DA-Service-Directory.pdf	Complete	Complete
Recommendation 3: **For the Hertfordshire Domestic Abuse Partnership to develop a consistent referral form that supports not only the reason for referral but also includes information**	**Local**	For the Hertfordshire Domestic Abuse Partnership to develop a consistent referral form and risk and needs assessment.	Hertfordshire Domestic Abuse Partnership	There is ongoing work on the development of One Stop Shops withing Hertfordshire and a consistent template for all survivor led safety planning and to include, if appropriate, family and friends, as well as a consistent referral form that will be used and accepted by all	June 2025	Ongoing

that will support the risk and needs assessment of the agency they are sharing the information with as well as identifies the best method of communication to achieve engagement.				participating organizations is part of this project.		
Recommendation 4: **Hertfordshire Domestic Abuse Partnership to provide training to all partner agencies working with families effected by domestic abuse to improve professionals understanding of Prof Jane Monckton Smith's eight-stage domestic homicide and Suicide Timeline pattern models and provide guidance to ensure that they are aware of the benefits of incorporating them**	**Local**	Hertfordshire Domestic Abuse Partnership to provide training to all partner agencies working with families effected by domestic abuse to improve professionals understanding of Prof Jane Monckton Smith's eight-stage domestic homicide and Suicide Timeline pattern models	Hertfordshire Domestic Abuse Partnership	Currently there is work ongoing withing Hertfordshire County Council on a partnership wide VAWG training, which is looking at embedding a yearly VAWG training programme where this recommendation will also be considered.	Ongoing.	Ongoing.

practically in assessments.						
Recommendation 5: **To Improve identification and understanding of the links between domestic abuse and suicide and to ensure understanding of the local and national referral pathways for support at crisis point using a trauma informed approach.**	**Local**	For the Hertfordshire Domestic Abuse Partnership to link in with the Suicide Prevention Team to jointly raise awareness of domestic abuse and suicide, better risk identification, intervention and assessment.	Hertfordshire Domestic Abuse Partnership	A resource guide is already available, and the Suicide Prevention Team is looking at developing training modules that relate to domestic abuse. Risk identification, the link between suicidality and domestic abuse is being developed as part of this training module which also involves work with DA charities. The suicide prevention team will use the real time suicide surveillance system to identify suspected suicides and suicide attempts related to DA. This has already been addressed and systems of recording being improved to capture necessary information although conscious of Data Protection Impact Assessment requirements where appropriate.	Completed and ongoing.	Completed and ongoing.
Recommendation 6: **Hertfordshire Domestic Abuse Partnership with all partners promote awareness around suicide prevention in**	**Local**	For the Hertfordshire Domestic Abuse Partnership to link in with the Suicide Prevention Team to jointly raise awareness around best practice suicide intervention and bespoke suicide prevention plans.	Hertfordshire Domestic Abuse Partnership	Level 1 and Level 2 suicide intervention training is available, including how to do a safety plan with those at risk. The Suicide Prevention Team commission some services where a safety	Completed.	Completed.

line with the National Suicide Prevention Alliance best practice guidance.				plan is provided, ie the discharge befriending service. The Suicide Prevention Team also commission 'Togetherall' that provides 24/7 support for those with low to moderate mental health issues, with clinicians available on the platform for those in crisis with a clear escalation process. Resources on the platform also include information on domestic abuse and support. This service is available to anyone living or working in Herts.		
Recommendation 7: **The Police and partner agencies involved in Domestic Abuse cases should be made aware of an elevated risk of both intimate partner homicide and of victim suicide where coercive or controlling behaviour (CCB) is present. Frontline and supervisory personnel within safeguarding**	**National**					

victim units should consider referrals to suicide prevention interventions in setting safeguarding actions when CCB is identified.						
Recommendation 8: **There should be a continued push within policing to identify, record and take positive action where coercive or controlling behaviour (CCB) is identified. The number of convictions around CCB is disproportionate to the number of reports, with only a small number of cases where the specific offence of controlling or coercive behaviour is recorded or charged. The nature and extent of prior coercive control is severe in situations which culminate in a victim**	**National**					

dying by suicide, which reinforces the importance of identifying, recording and charging for controlling or coercive behaviour in a timely and accurate manner.						
Recommendation 9: **It is recommended that the College of Policing, in consultation with the Home Office and NPCC develop training to directly address the evidential issues experienced in domestic abuse cases where suicide and/or coercive or controlling behaviour is identified to enable abusers to be made accountable. The College of Policing has developed a DA Matters Investigators' Immersive Learning Hydra programme to give officers a better**	**National**					

understanding of how to evidence coercive and controlling behaviour, how to progress 'course of conduct' investigations and develop effective case files. This training is for those officers who investigate and progress domestic abuse cases and is a two-day Hydra programme to be delivered in-force by trained trainers.						
Single-agency recommendations						
Hertfordshire Police						
Recommendation 1 Force to review policy pertaining to decision making, accountability, and rationale relating to firearms certificate holders in cases of DA, regardless of risk assessment grading.	Local	Allocated to DCI GRIFFITHS- Recorded on AMS system			Awaits update – deadline set 13/12/24	

Recommendation 2 – To review risk assessment process and policy for victims of DA, that is bespoke to victims and based on professional judgement.	Local	Allocated to DCI GRIFFITHS 14/10/24- Recorded on AMS system Awaiting review by DCI Gilbertson to add any further comment prior to finalisation.		This has been subject to recent review which has resulted in the DARA model being adopted over the DASH model. New DA policy implemented which incorporates the use of DARA as our adopted risk assessment process. Governance of this is monitored through SPB. DARA is a more detailed nationally recognised method of risk assessing DA victims. Fully adopted for some time in force with appropriate training and comms. Recommended for sign off to LPSB		
Recommendation 3 – To consider POP as an alternative strategy to the management of DA where victims are unwilling to proceed via the Criminal Justice route.	Local	Allocated to DCI GRIFFITHS 14/10/24- Recorded on AMS system			Awaits update, deadline set 13/12/24.	
Recommendation 4 – To consider multi-agency suicide prevention training across the workforce	Local	Allocated to DCI MACBETH 14/10/24- Recorded on AMS system			Awaits update, deadline 13/12/24	

to increase knowledge and awareness of risk factors, especially prevalent in persons with mental health issues.		Await update from DCI Angi Griffiths and DCI Michael Macbeth MHPT conduct joint training with Street Triage to identify people in crisis and adapt communication style.				
Recommendation 5 – investigators and supervisors to consider VRI's for victims of DA where conditions are met, to secure and preserve best evidence.	Local	Allocated to DCI GRIFFITHS 14/10/24- Recorded on AMS system			Awaits update, deadline set 13/12/24	
Recommendation 6 – investigators, supervisors, and managers, to ensure compliance with VCOP and enhanced rights of victims in DA cases.	Local	Allocated to DCI GRIFFITHS 31/07/24- Recorded on AMS system. ACC Bell reviewed - Forcewide messaging needs to be delivered on enhanced rights for DA victims and auditing needs to be completed to test compliance before we are in a position to sign off. Action passed to DCI Griffiths to complete force messaging.		VCOP compliance and scrutiny is currently and agenda item at Performance Framework and an agenda item at DMM.	Awaits update. Deadline 13/12/24	

Recommendation 7 – Force reviews its policy on DA investigation management, ownership, and investigative strategy in every case.	Local	Allocated to DCI GRIFFITHS 14/10/24- Recorded on AMS system For Sarah Gilbertson to review and close action.		Scrutiny has increased with regards to 1- 6 investigation strategies and the quality of them is checked via DI and DCI dip sampling. Power Bi Dashboards provide additional scrutiny and this is discussed at Safeguarding DMM daily. Force Investigative Strategy Policy has been subject of complete review and preparation for up coming HMICFRS inspection. Safeguarding command has been included in consultation at each step and this is due for signing off on the 6th June 2024.	Deadline 13/12/24	
Recommendation 8 – Force to review training of Stalking Protection Act 2019 and the use of Stalking Prevention Orders to ensure persistent DA reports are considered under the legislation.	Local	Allocated to DCI GILBERTSON 26/11/24- Recorded on AMS system.			Deadline set 26/02/2025	
Recommendation 9 – Force reviews the DAISU processes	Local	Allocated to DCI GILBERTSON 26/11/24- Recorded on AMS system.			Deadline set 26/02/2025	

between responding officers submitting case for review and the review taking place to avoid unnecessary delays.						
Recommendation 10 – appropriate measures are implemented to ensure future DA related deaths and homicides are referred to the CSP at the earliest opportunity.	Local	Allocated to DCI GRIFFITHS 14/10/24- Recorded on AMS system Awaits update/review by DCI GRIFFITHS and DI PICKARD who has delivered this training.		Review conducted by Police in 2024 and a number of measures put in place including DHR training provided to all SMT and detectives, DHR section written into sudden death attendance policy, OST staff now present at daily Safeguarding DMM and all sudden deaths and suicides attended by police and reviewed by OST. DHR Guidance has been added to the Sudden Death Policy. Attendance of OST review team at SG DMM and Force DMM. Training has been delivered to Force Exec, Senior managers and DI Twilight., OST team now conduct monthly review on reported suicides. OST are notified by Safeguarding Command of all cases and discussed monthly.	Deadline 13/12/24	

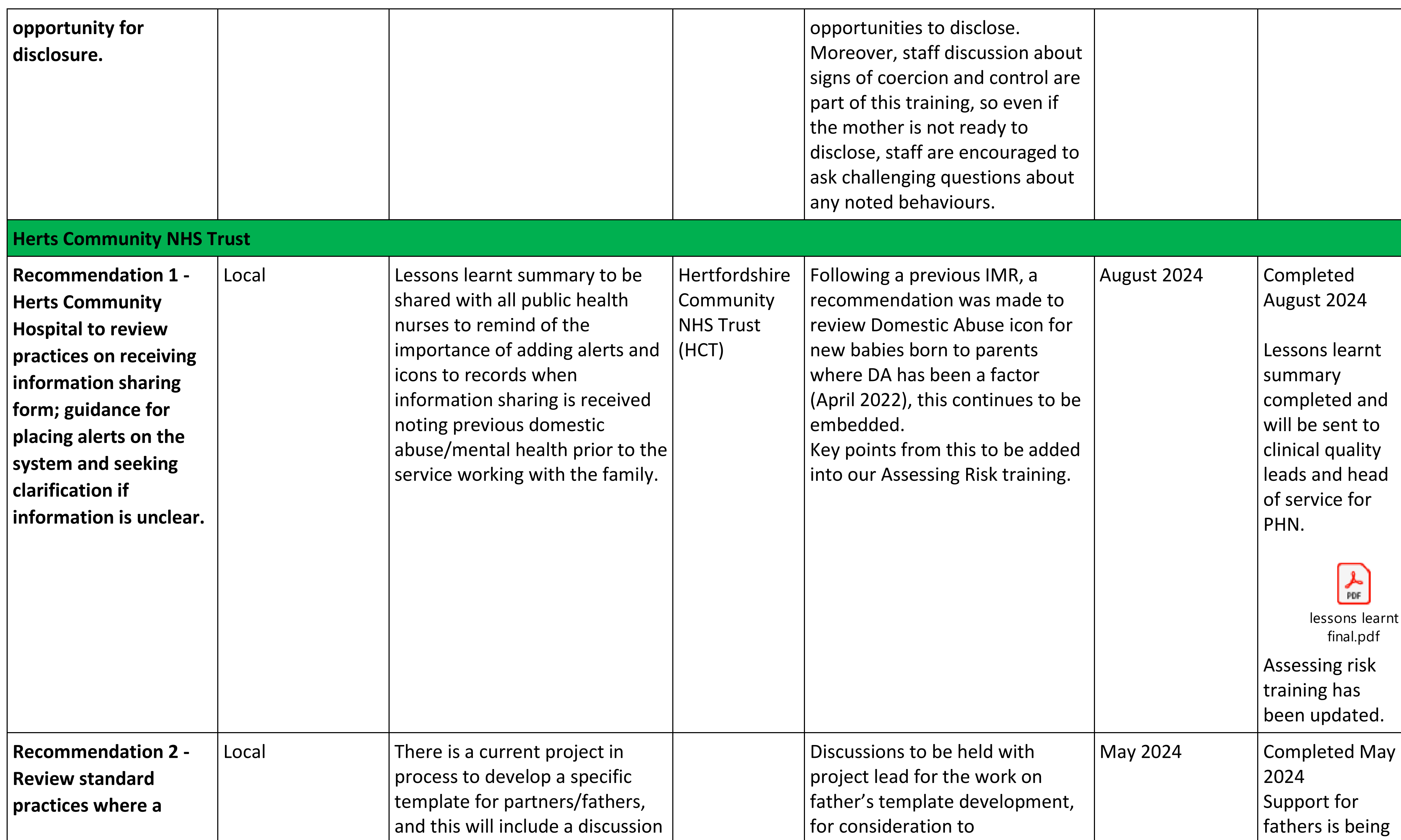
Recommendation 11 – review policy regarding support services offered to vulnerable victims where no criminal investigation is pursued, and effectiveness of civil orders to maximise safeguarding and protection for all parties.	Local	Allocated to DCI GRIFFITHS 14/10/24- Recorded on AMS system Awaits update by DCI GRIFFITHS		Recommendation briefed into Safeguarding Command. Hertfordshire Constabulary has improved both processes and guidance in relation to DVPN's and other civil orders. There is a specialist team dedicated to processing Civil Orders established within DAISU to review all DA reports and look for opportunities to proactively use DVPO's. We recognised that as a force we were not using these sufficiently and a collective push within the safeguarding departments and the LPC has led to a vastly improved picture. A dedicated DVPN/O officer has been placed in Daisu for intimate DA, and one in CIT for non-intimate DA. These officers will prepare the cases identified and present the DVPN to the Magistrates Court to obtain DVPOs. DAISU review all DVPOs across the county, these are listed on a SharePoint page and Chief Inspectors are held accountable for ensuring that regular checks are conducted during the 28-day period of the DVPO. This is reported on daily at the Force Daily Management	Deadline 13/12/24	

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

				but the investigation is in progress. This could be where a decision is made to caution the perpetrator or take no further action (NFA), or when the suspect is bailed without conditions’ Oversight of DVPO/Ns is being taken to DMM on a daily basis. There is a new DVDS team who are dealing with Clare's Law requests. DVPO is a mandatory consideration for all case direction. Allocated DVPN officer who takes all orders to court and prosecutes all breaches.		
Recommendation 12 – Herts to review its policy on disclosure and sharing of information with other forces, where police officers/staff feature with DA investigations.	Local	Allocated to DCI GRIFFITHS 14/10/24- Recorded on AMS system Awaits update/review by DCI GRIFFITHS			Deadline 13/12/24	
Recommendation 13 – Force to review the sudden death policy and consider mandatory attendance	Local	Allocated to DCI GILBERTSON 16/04/24- Recorded on AMS system.		Additional DAISU training has been provided at all Twilights to DI and DSs.	Deadline 13/12/24	Completed.

of a supervisor to non-suspicious deaths and suspected suicides.		For review and closure		Revised and relaunch of Sudden Death Policy completed in 2024. New policy advertised and trained at DI Twilight and training events. Published on the Intranet for accessibility to frontline staff. There is a specific chapter on DHR criteria included within the new policy with links to HO guidance. The SOP mandates supervisory attendance at suicide with consideration of DA as a motivator.		
Much Hadham GP surgery						
Recommendation 1 – GP's practice to review policy and practice around the identification of domestic abuse.	Local	Policy reviewed in clinical meeting November 2024. Discussions around identification and what action to take. A couple of current case studies discussed.	Much Hadham Health Centre	Policy updated – linked to safeguarding	End of November 2024	Completed 30th November
Recommendation 2 - Practice to review DA training provided to all GP's and medical professionals. Consider 'Ask and Act' Training refresh.	Local	In-house refresher training via Blue Stream Academy online. Face to face to be set up in 2025.	Much Hadham Health Centre	To update all clinicians first followed by all staff. Consider Ask and Act or any other DA in person training for 5 local practices.	Clinicians to complete by end of January 2025. Staff by March 2025. PTL lead has added to training agenda in 2025.	Ongoing Ongoing

		AW has requested local F2F training by PCN in protected learning time	Stort Valley and Villagers PCN			
Recommendation 3 - Practice to review policy in relation to responding to police domestic abuse notifications.	Local	Discussed at clinical meeting above. No change to current policy i.e. on receipt of notification this is passed to safeguarding lead and usual GP for review	Much Hadham Health Centre	Reviewed and no change to policy	End of November 2024	Completed 30th November
Recommendation 4 - Practice to consider how GP's are trained to use professional curiosity to obtain more information about DA risk and decision making for safeguarding referrals.	Local	Discussed at clinical meeting in November. GP felt it would be helpful to have specific training about professional curiosity and assessing DA risk. Would be worth including in protected learning time within locality PCN	Much Hadham Health Centre and PCN	Recommendation discussed and agreed training would be beneficial to all GPs in-house and in PCN	April 2025	Ongoing
Rosie Addenbrookes Hospital						
Recommendation 1 - CUHFT to consider further training for health professionals to understand the role of professional curiosity to create an	Local	CUHFT to consider further training for health professionals to understand the role of professional curiosity to create an opportunity for disclosure.	Rosie Addenbrookes Hospital	All Midwives/MCA's/Obstetricians have yearly safeguarding training and there has been more emphasis on domestic abuse and mental health since the initial report to the DHR. Women are asked about domestic abuse routinely so there are	Completed	Completed



opportunity for disclosure.				opportunities to disclose. Moreover, staff discussion about signs of coercion and control are part of this training, so even if the mother is not ready to disclose, staff are encouraged to ask challenging questions about any noted behaviours.		
Herts Community NHS Trust						
Recommendation 1 - Herts Community Hospital to review practices on receiving information sharing form; guidance for placing alerts on the system and seeking clarification if information is unclear.	Local	Lessons learnt summary to be shared with all public health nurses to remind of the importance of adding alerts and icons to records when information sharing is received noting previous domestic abuse/mental health prior to the service working with the family.	Hertfordshire Community NHS Trust (HCT)	Following a previous IMR, a recommendation was made to review Domestic Abuse icon for new babies born to parents where DA has been a factor (April 2022), this continues to be embedded. Key points from this to be added into our Assessing Risk training.	August 2024	Completed August 2024 Lessons learnt summary completed and will be sent to clinical quality leads and head of service for PHN. lessons learnt final.pdf Assessing risk training has been updated.
Recommendation 2 - Review standard practices where a	Local	There is a current project in process to develop a specific template for partners/fathers, and this will include a discussion		Discussions to be held with project lead for the work on father's template development, for consideration to	May 2024	Completed May 2024 Support for fathers is being

father has a noted history of mental health support to include standard discussions about this area of need.		on their mental health. The learning from this IMR will be shared over to the project lead for this to again highlight the importance of father's mental health and the correlation to domestic abuse.		prompts/questions on mental health.		rolled out across the county and is due to start in September 2024.
Recommendation 3 - A review DCT DA Policy and how it is applied in practice; it would be good practice to consider the pattern of abuse within a relationship and the use of professional judgement to make a decision to contact both parties, where appropriate. For example, where, as in this case, it may be unclear who is the primary perpetrator and/or the history would indicate that the police report is unlikely to reflect the full picture.	Local	Current DA policy include RAG guidance which assists allows staff to use their professional judgement when deciding when and who to contact. Policy to be reviewed to ensure it supports this practice. .	Hertfordshire Community NHS Trust (HCT)	Raising of awareness with Public Health Nurse champions so they can disseminate with their colleagues and encourage staff to use professional judgment as meeting DA policy to be updated in 2025	February 2025 April 2025	Ongoing Ongoing

Recommendations 4 - HCT to review HV's understanding of the connection between mental health and domestic abuse and provide further training to ensure that HV's feel confident to have difficult conversations with both parents.	Local	1, Amendment to public health nursing operation procedures to include consideration of PHQ9 and GAD7 when reviewing domestic abuse notifications/disclosures, particularly when there is a known history of mental health concerns. 2, Amendment to domestic abuse template to remind staff of PHQ9 and GAD7 questions. 3, Circulation of changes to public health nursing leads. 4, Amendment to Domestic Abuse policy to highlight importance of reviewing mental health in association with domestic abuse.	Hertfordshire Community NHS Trust (HCT)	Discussion with Public health nursing education leads to review the operation procedures and consideration to including PHQ9 and GAD7 as part of assessment. Discussion to also be held with domestic abuse champions to help disseminate any changes agreed.	August 2024	Completed August 2024 Following discussion it was concluded that as majority of domestic abuse notifications are followed up over the phone – health visitors will ask the first 2 questions on both the GAD-7 and PHQ-9 over the telephone. If a home visit is warranted then a health visitor will complete assessment of emotional wellbeing face to face. Task and Finish group to be held in Jan 2025 to review implementation.
Refuge IDVA service						

Recommendation 1 - Refuge to consider reviewing response on receiving automated voicemails that could be an indication that with-held number are not accepted.	Local	Include in staff induction and training that the third attempt to contact client must consider not withholding the phone number. Where there are concerns regarding risk of alleged perpetrator seeing the number, this must be discussed with the service manager and an assessment and risk management plan implemented.	Refuge		With immediate effect, then ongoing.	Ongoing.
Recommendation 2 - The IDVA service to consider the benefits of utilising the relationships between clients and other professionals as a way to facilitate/maintain engagement.	Local	Add to Practice Guide and Effective Case Management training. Staff are already encouraged to do this in order to facilitate engagement, however it did not happen in this case which indicates that more regular communication of the point is necessary.	Refuge		With immediate effect, then ongoing.	Ongoing.
Hertfordshire Partnership NHS Foundation Trust						
Recommendation 1 - HPFT to review training and guidance for practitioners understanding of the impact of experiencing domestic abuse on	Local	Review Domestic Abuse resource Kit information re: DA and Suicide. Domestic Abuse and Suicide webinar to be included in 2024-25 safeguarding training programme.	HPFT	DA resource kit reviewed and updated Webinar included within programme 3x Webinar delivered.	January 2025 February 2025 April 2025 – Mar 2026	Ongoing Ongoing Ongoing

mental health and suicide ideation.		HPFT Safeguarding team to be represented at HPFT risk assessment CQI to ensure DA is considered alongside other forms of risk. HPFT Safeguarding team to link in with system wide suicide prevention pathway training module (led by HPFT) to ensure that domestic abuse is included as a risk factor.		Professional Lead for Safeguarding adults part of CQI group Professional Lead for Safeguarding adults linked in with suicide pathway leads. Domestic Abuse included within training package	December 2025 July 2024 August 2024	December 2025 July 2024 August 2024
Recommendation 2 - HPFT to review guidance for making referrals to Adult and Children's Services to include historic dynamics and patterns of behaviour.	Local	'Making Good referrals' guidance and 7-minute briefing to be reviewed to ensure consideration of historic dynamics and patterns of behaviour is included. All referral pathway flowcharts to be reviewed and updated with links to respective policies.	HPFT	Guidance and 7-minute briefing reviewed. Guidance and briefing circulated via QRMs. Flowcharts reviewed and updated	January 2025 February 2025 December 2024	Ongoing Ongoing December 2024

Recommendation 3 - Decisions made by all professionals state clearly what the information they are using, and where the information has come from to inform the decision. Using 'the information provided' is unclear.	Local	HPFT safeguarding team to follow up all verbal advice given with email summary including guidance to cut and paste into EPR. Where advice is given by email, include guidance to cut and paste into EPR. Recording section of adult and Child safeguarding training to be reviewed and updated.	HPFT	Written summary of advice given with guidance to include in EPR. Training slides include guidance to ensure includes need for clear recording of information informing decision making.	December 2024 January 2025	Completed December 2024. Ongoing.
Recommendation 4 - HPFT to review information sharing processes, in particular how information can be shared across teams within agencies and how information is used to inform assessment of risk and decisions to discharge.	Local	Discussion at Risk CQI group to help inform process/ documentation changes as required.	HPFT	Discussion at CQI panel.	January 2025	January 2025
Hertfordshire Children's Social Care						
Recommendation 1 - Children's Services to review processes	Local	Police 'notifications' to no longer be accepted as a referral. Police transition to submitting full Children's Services referrals	Children's Services and Police (overseen by	Transition conversations underway and referral tools drafted	31 March 2025	Ongoing

around receiving and recording Police DA notifications.		using the online referral portal, in line with other agencies. Referrals to consider cumulative risk and the voice of the child.	sub group that sits between HDAP and HSCP)			
Recommendations 2 - Children's Services to review how information from other agencies is used to inform assessment of DA risk and impact on Children.	Local	Review of response to domestic abuse referrals – thinking innovatively about how we support those impacted and improve the early response.	Children's Services	Multi Agency thinking space underway.	31 March 2025	Ongoing
Recommendation 3 - Children's Services professionals to access training on engaging with domestic abuse perpetrators to improve holding perpetrators to be accountable for their actions and understanding the impacts on those affected.	Local	CS Safeguarding to review its risk assessment tools and interventions with Probation Domestic Abuse Officers and CS Domestic Abuse Practitioner	Children's Services Safeguarding	Update of training programme and training schedule	March 2025	June 2025

Recommendation 4 - To improve assessments to offer early intervention to inform a fuller picture of the context and mapping of abuse by taking account of historical dynamics of abuse incidents, not just the current incident, using professional curiosity to inform their actions as required.	Local	The Better Me Better Us intervention programme currently used to be updated	CS Safeguarding	Roll out of the revised programme	March 2025	June 2025