

**EAST HERTS COMMUNITY SAFETY
PARTNERSHIP**

DOMESTIC HOMICIDE REVIEW

Overview Report into the death of Louise

August 2022

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.

Introduction

'Louise'

Louise grew up in the Much Hadham area of Hertfordshire, she had attended local primary and secondary schools. Growing up Louise had mostly lived with her parents, she had a good relationship with her maternal grandmother and there were some periods where she chose to live with her. In her late teens she had moved in with Jamie, who was her then boyfriend, in an annex at his parents. Louise was a young mum, giving birth to her son in 2020.

- 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, Hertfordshire 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/or 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. Circumstances that led to the review

- 1.6.1. Louise was found deceased in August 2022, having taken her own life by hanging.
- 1.6.2. 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.
- 1.6.3. 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.

- 1.6.4. This DHR will consider agencies' contact and involvement with Louise and Jamie from the beginning of to the date of Louise's death.
- 1.6.5. 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.
- 1.6.6. This DHR does not take the place of the criminal or coroner's courts, nor does it take the form of a disciplinary process.
- 1.6.7. 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. Timescales

- 2.1. Due to a lack of availability of Independent Chairs, Hertfordshire County Council commissioned an accredited Independent Chair training course by AAFDA (Advocacy After Fatal Domestic Abuse). In January 2023 they had six accredited Independent Chairs trained. Following this, the backlog of DHRs were allocated to the newly qualified Chairs.
- 2.2. This review began on 25th January 2024 and was concluded on 24th October 2024.

3. Confidentiality

- 3.1. 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.
- 3.2. 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

- 3.3. 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.

4. Terms of Reference

- 4.1. 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.
- 4.2. The Review Panel was composed 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 from Health agencies across Hertfordshire was also necessary as Louise had received health care from across the region. Agencies were contacted as soon as possible to inform them of the DHR, invite their participation and to ask them to secure their records.
- 4.3. 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 the date of Louise's death. This represents the period from when agencies became involved in reported domestic abuse and concerns around mental health.
- 4.4. 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.
- 4.5. Key Lines of Inquiry: The Review Panel considered the statutory guidance and identified the following case specific issues:
 - 4.6. Identify examples of good practice, both single and multi-agency.
 - 4.7. 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?
 - 4.8. 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?
 - 4.9. Any evidence of whether any identified risk had been assessed as reaching the threshold for inter-agency information sharing especially linked to domestic abuse.
 - 4.10. 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?
 - 4.11. Were referral pathways followed according to local policies? If not, what was the reason this did not happen? Are these pathways different now?
 - 4.12. 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?

5. Methodology

- 5.1. 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:
- 5.2. “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.
- 5.3. 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.
- 5.4. 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.”
- 5.5. 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.
- 5.6. This DHR has followed the statutory guidance issued following the implementation of Section 9 of the Domestic Violence Crime and Victims Act 2004.
- 5.7. 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.
- 5.8. 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.
- 5.9. 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.
- 5.10. Documents Reviewed: In addition to the above information, several other documents have been reviewed. These are referenced in this report.
- 5.11. 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.

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

- 6.1. 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.

- 6.2. 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.
- 6.3. 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.
- 6.4. 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.

7. Contributors to the review

7.1 The following agencies were contacted, but recorded no contact with the victim or perpetrator:

Probation

East Herts District (recorded having received housing application only)

CGL (Drug and Alcohol Service)

7.2 The following agencies made contributions to this DHR:

Agency	Contribution
Probation	Summary of Engagement
CGL	Summary of Engagement
East Herts District Council	Summary of Engagement
Refuge - IDVA Service	IMR and Chronology
Central Surgery - Primary Care Services	IMR and Chronology
East & North Herts NHS Trust	IMR and Chronology
Herts Community NHS Trust	IMR and Chronology
Hertfordshire Partnership University NHS Trust (HPFT)	IMR and Chronology
Hertfordshire Constabulary	IMR and Chronology
Cambridge University Hospital Foundation Trust (CUHFT)	IMR and Chronology

Hertfordshire County Council – Children’s Services	IMR and Chronology
Much Hadham GP Centre	IMR and Chronology

8. The review panel members

8.1 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 Hackett	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

8.1. 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. The final report was signed off by the East Herts Community Safety Partnership in January 2025.

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

9. Author of the overview report

- 9.1. The chair and author of the review is Kelly McGuire, an independent DHR Chair. Kelly has held specialist domestic abuse roles within both the statutory and voluntary sector organisations. Kelly currently specialises in establishing multi-agency frameworks that are able to effectively respond to high harm high risk domestic abuse perpetrators.
- 9.2. Kelly has received DHR Chair's training from AADFA. She has previously led reviews on behalf of two Local Authority areas in Northwest England. She has extensive experience in the domestic violence sector, having worked in statutory, voluntary and community sector organisations. 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.
- 9.3. *Independence:* Kelly has no connection with the local area or any of the agencies involved.

10. Parallel reviews

- 10.1. Criminal investigations: Jamie and his new partner were interviewed by police after Louise's death in relation to a statement that Louise had provided in June in relation to malicious communications and harassment she was experiencing from Jamie and his new partner. However, no charges were brought in relation to these allegations.
- 10.2. The Coroner's inquest: A Coroner's Inquest opened on 19.08.22 and concluded on 03.08.23 with a verdict of suicide. Cause of death recorded as 1A suspension by ligature and the toxicology report revealed alcohol consumption however, no trace of illegal or non-prescribed substances.
- 10.3. Children: There are no parallel reviews in relation to Child A. At the first Review Panel meeting, it was noted that the ongoing care of the child was beyond the remit of the DHR. However, it was agreed that a summary of the arrangements to date would be provided to assure the Review Panel that appropriate steps had been taken in relation to their care. The Review Panel were informed that after Louise's death, Child A had been temporarily placed with maternal grandparents but after an initial family assessment was completed has now been permanently placed in the care of Jamie, his biological father.

11. Equality and Diversity

- 11.1. 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.
- 11.2. 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.
- 11.3. 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.
- 11.4. 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 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.
- 11.5. 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.
- 11.6. 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.
- 11.7. 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.

11.8. 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.

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

12. Dissemination

12.1 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.

12.2 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

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

13. Background Information (the facts)

13.1. On the day of Louise's death police responded to a report of an adult female who had been found by her friend and father, hanging from a tree in Much Hadham woods, close to her home address. Officers and paramedics attended the scene and Louise was pronounced dead at 05:25hrs. A knife was also recovered from the scene, which family members identified as originating from the family home. Sudden and Unexplained death protocol was instigated and an investigation on behalf of Coroner commenced, as there appeared to be no suspicious circumstances.

13.2. 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.

- 13.3. 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.
- 13.4. 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.
- 13.5. 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.
- 13.6. 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.

14. Chronology

14.1 Prior to the scoping period

- 14.2 Louise became known to the South-East Crisis team (HPFT) in July 2018 via a referral from the Alexandra Hospital following a staggered overdose of paracetamol. Difficulties with her ex-partner, Lee were noted as a factor, specifically verbal abuse which is stated on the referral form as 'boarding on abusive'. The referrer recorded an action to send Louise information relating to domestic abuse support services.
- 14.3 Between July and October 2018 Louise engages consistently with the crisis team and well-being service. There is regular contact between Louise and mental health services. Her mental health during this period seems to fluctuate with reports of her struggling with stress, self-harm and thoughts of suicide. Stress caused by both work and her ex-partner spreading malicious rumours about her of a sexual nature and that she is 'using drugs' are identified as contributing to her decline in mental health.

- 14.4 On 28.10.18 a verbal dispute occurred between Louise and Lee, that resulted in Lee suffering a panic attack after Louise tried to end their relationship. She suddenly drove off from her home address in a vehicle in a distressed state. There were concerns for her safety due to Louise suffering mental health issues, having recently lost her job, and feeling in a low mood. Following an area search by officers, both parties were located and returned to the family address. Louise disclosed she was experiencing suicidal thoughts, hence she was assessed by the mental health triage car. No offences were revealed, and the incident was recorded as a non-crime DA. Louise's sister Katy, was present throughout the incident.
- 14.5 A DASH was completed and assessed as standard (5 ticks) and a child at risk referral (standard) was submitted in respect of Katy, to Children's Services on 29.10.18. Louise was categorised as a 'Repeat Victim'. The referrals were submitted to DART for sharing with partners and relevant services. The circumstances were reviewed by MASH staff, who concurred with a standard assessment. According to her DASH responses, Louise was diagnosed with Depression in May 2018, and she alluded to taking overdoses in May & July 2018. This correlates with the information from HPFT.
- 14.6 Between 25.11.18 and 05.02.19, three incidents were reported to Herts. Constabulary by Louise's parents and the ambulance service related to Louise suffering from mental health crises and suicidal ideation. Each incident was attended by officers and body worn video utilised. Louise was located and alluded to suffering from anxiety and depression and that she no longer wanted to reside with her parents. Louise had attempted to leave home on numerous occasions but was prevented from doing so because her parents were concerned for her welfare and wellbeing. Comments within the incident logs state Louise was known to Mental Health Services since July 2018, with a diagnosis of adjustment disorder.
- 14.7 On 31.01.19, Louise's mother, Janet, reported that Louise had stolen her bank card and withdrawn £530 cash without her consent, to purchase drugs. Louise's mother was unsupportive of Police action and was more concerned about her daughter's deteriorating mental health issues because she had been self-harming and had left suicide notes. Officers attended the family address and completed a DASH (5 ticks), which was assessed as standard and suitable for sharing with relevant partners. Louise's mother stated she wrote her last suicide note in December 2018 and she was known to mental health services. Officers attended and utilised their BWV, recording a crime of DA related Theft. However, due to Janet's unwillingness to pursue a complaint the crime was finalised NFA. Three referrals, each assessed as standard, were completed, and submitted to DAISU: DASH; child at risk in respect of Katy, and a safeguarding referral in respect of Louise.
- 14.8 On 05.02.19, Louise took an overdose and smashed a windowpane, threatening to harm herself and others within the home address, then locked herself in the bathroom. She was referred to the street triage team and advised to seek support from her GP.
- 14.9 On 02.06.19, Louise's partner at the time, Lee, reported a sexual assault on behalf of Louise. Louise provided a statement to Essex Police (as the incident was believed to have taken place in Essex) and initially engaged positively with the investigating officers but, she later withdrew her support due to the trauma she was experiencing. The suspect was identified and interviewed, and a file of evidence submitted to the CPS for further advice. The CPS concluded there was insufficient evidence for a prosecution, hence the case was finalised NFA 15, (named suspect, victim unsupportive).
- 14.10 Louise continued to engage with HPFT during the above incidents between October 2018 and June 2019. Her relationship with Lee appears to be on and off during this time and she reports it has ended by December 2019. There continues to be a connection between timeline of the breakdown of her relationship with Lee and Louise self-harming and taking

overdoses during this period. Louise continues to engage with mental health professionals accessing the well-being service and talking therapies until June 2019. At her last contact with HPFT during this period Louise reports that conflict with her ex-partner is causing issues in her new relationship, with Jamie. After this Louise stops engaging with all mental health services, there are 3 further attempts made to contact Louise and the case is eventually closed to them in November 2019.

14.11 During the Scoping period

- 14.12 On 22.06.19 an ambulance attends Louise's, at the time boyfriend's property and treat Louise for convulsions following an overdose. Louise reports being in a 'low mood'; coercive and controlling behaviour and domestic abuse are logged and an adult safeguarding referral is made. This referral is shown as actioned on the chronology provided by HPFT who are responsible for adult safeguarding in this regard.
- 14.13 On 17.11.19, Jamie's mother reported a verbal argument occurring between Louise and Jamie at his home address in Sawbridgeworth, over Louise being upset about Jamie's drunken behaviour, whilst Jamie was upset that Louise was not sympathetic towards him, after he was assaulted earlier that evening in an unrelated incident. Officers attended the location and completed a DASH assessment with Louise, which was graded as standard. No further police action was required and accordingly, a non-crime DA related incident was recorded, whilst the assault allegation made by Jamie, was recorded, and investigated separately.
- 14.14 On 12.05.20 Louise submits housing application to East Herts Housing stating that Jamie will not be moving to any new property with her.
- 14.15 On 29.6.20 Louise was seen alone following her ultrasound scan. The midwife discussed her history of emotional abuse, Louise stated that this was from a previous partner. Louise stated that she felt safe and well. She denied there was current domestic abuse, Louise also disclosed her history of a drug overdose and self-harm. The Consultant Obstetrician who cared for mothers with mental health difficulties was contacted to triage this case. A longer appointment was arranged for booking.
- 14.16 On 2.7.20 Louise was contacted by CUFT for a telephone booking consultation (Covid-19 outbreak) with a Midwife. She mentioned her history of anxiety in the past when she was 17, due to abusive ex-partner. She stated this was in the past and she stated she was in a stable relationship. She was offered a telephone consultation with the Obstetrician regarding her anxiety. Louise stated that she preferred to inform CUFT later if she felt she needed it. Advised to attend for routine antenatal care with her local community midwife.
- 14.17 Louise was seen on the 20.07.2020 in the GP surgery by the community midwife, she was 16 weeks pregnant at this time. Louise reported to feel well and reported that she had a previous partner who was abusive towards her 18 months ago. She reported that she was happy in her current relationship and reported to feel well supported by boyfriend and family. Louise at that time was living in the annexe of her parents' home and reported that the booking midwife had made a referral to perinatal mental health services at Rosie Hospital – Which she was satisfied with. It was noted in the booking records that Louise suffered with anxiety. Routine domestic abuse enquiry took place at this appointment and Louise denied any concerns surrounding domestic abuse in her current relationship.
- 14.18 On 25.8.20 the Obstetrician called Louise by telephone (Covid-19 restrictions) for well-being check. Louise mentioned her anxiety and depression, stated that she had not had

episodes since a bad relationship and was treated with therapy and antidepressants. She stated she was in a better place now. She was given safety netting advice to call 111 option 2 if her mental health deteriorated. Louise was signposted to talking therapies that she could self-refer to. She was encouraged to access antenatal classes, hypnobirthing classes, mother and baby groups and the virtual tours of the Rosie available online. Documentation shared with GP by letter.

- 14.19 Louise was seen for her 25-week appointment in the GP surgery on 01.10.2020 by her routine community midwife. Louise appeared well; all routine clinical care was provided. Louise provided an update that she had been reviewed by the consultant at the Rosie and no further support/medication was required. Louise reported to feel mentally and emotionally well during this appointment and advised that she had re-referred herself to smoking cessation due to finding it challenging to give up smoking during pregnancy and reported to smoke two cigarettes each day and was counselled on the impact of smoking during pregnancy.
- 14.20 Louise attended her 28-week antenatal appointment on 22.10.2020 in the GP surgery. All clinical care provided, and no concerns were raised surrounding wellbeing of Louise or the unborn baby. Louise reported that she was attending smoking cessation support over the telephone at that time and reducing her smoking in accordance with the plans. Louise reported to have two scans at 30 and 26 weeks planned at the Rosie Hospital (due to identification of smoking in pregnancy).
- 14.21 On 07.11.20 Louise (pregnant with Jamie's baby) attends a midwife appointment. It is reported that she had experienced domestic abuse from her previous partner (not Jamie). Louise also reports struggling with her mental health and previous depression. A peri-natal mental health referral is completed.
- 14.22 Louise was seen for her 31-week antenatal appointment on 12.11.2020, it is unclear where this took place as this was absent from the record keeping, however was seen in person by the community midwife. Louise had reported that she was continuing to cut down smoking to approx. one to two cigarettes a day. All clinical care was provided for Louise and no concerns were raised about her or the unborn baby's wellbeing. Louise noted that she has attended her scan which reflected her baby to be breech.
- 14.23 On 17.11.20 Louise gives birth to Child A and her care is transferred to Public Health Nursing as a result of the premature birth of her child. Herts Community Hospital records note baby delivered, born at 33 weeks gestation.
- 14.24 In the couple of days after Child A's birth Louise reports to the midwife at the Rosie Hospital that she is feeling overwhelmed following the birth and that she is nervous about being discharged while Child A will be transferred to Harlow Hospital to continue his post-natal care; due to covid restrictions only one visitor at a time will be able to visit Child A at Harlow. The midwife reassures Louise who reports feeling better at discharge, she is asked about her mental health and experience of past abuse, but Louise is happy and declines any on-going support at this time. At this point her care is transferred to the community midwife team.
- 14.25 On 26.11.20 information sharing received from Cambridge University Hospital; reported in the last year Louise has a history of self-harm and overdose, history of anxiety and depression linked to abusive ex-partner- now resolved. Good current mental health, requested to monitor in community.
- 14.26 On 16.12.20 the health visitor (1) completed a new birth contact with Louise, Jamie and Child A were present. Domestic abuse not discussed as family member reported to be

present. Louise, Jamie and Child A are noted to be living with Louise's parents, in an annex at this time.

- 14.27 On 23.12.20 the health visitor (1) saw Child A at home to review weight and jaundice.
- 14.28 On 06.01.21 the health visitor (1) completed maternal wellbeing with Louise, Child A was present; no concerns raised. Domestic abuse is discussed and no concerns are raised.
- 14.29 On 17.02.21 Louise submits an application to join East Herts council housing register.
- 14.30 On 15.06.21 Jamie reported being assaulted by Louise, between 13.06.21 and 15.06.21. In summary, Louise alleged that Jamie had fed the baby chicken baby food when she was bringing their son up as a vegetarian because Louise was also a vegetarian. During the verbal argument, Jamie spat at her and threw a mop at her but neither made contact. Consequently, Louise told Jamie to leave and when he failed to so, Louise threw his belongings outside. Jamie retaliated by throwing Louise's belongings outside of the property. Louise called 999 and Officers responded to Louise's address promptly and activated their BWV. Jamie left the location willingly and returned to his mother's in Sawbridgeworth. Louise was neither willing to proceed with a formal complaint nor provide a statement. A DASH was completed with a score of 8 ticks and assessed as standard. A child at risk referral (standard) was also completed and shared with Childrens Services on 23.06.21. Louise's family were unwilling to provide evidence or information to the police. Consequently, the case was referred to DAISU for review and for the BEACON team to progress victim aftercare, safeguarding and support. A crime of DA related Common Assault was recorded.
- 14.31 When child at risk referral is considered by Children's Services it is concluded that there is no risk to the child and therefore not meeting threshold. The notes do acknowledge that there are also private proceedings taking place in relation to Jamie's contact with Child A. Letters are sent to both parents informing them of the referral and signposting them to domestic abuse services.
- 14.32 On the 24.06.21 the health visitor team are notified of a domestic abuse incident between Louise and Jamie on 13.06.21. DASH assessment notes 'on-off' relationship, Louise being on anti-depressants, Jamie suffering with depression, and some concerns over jealousy.
- 14.33 On 25.06.21 the health visitor (2) attempted to contact Louise on the phone but got no reply.
- 14.34 On 28.06.21 the health visitor (1) attempted to call Louise, no reply, text sent to contact.
- 14.35 On 29.06.21 the health visitor (1) saw Louise and Child A at home, reported both feeling stressed with work and looking for a property. Louise reported they had talked and the relationship was back on track. Child A was observed to be smiley and active, reported to be a content child. Phone numbers given for DA support.
- 14.36 On 01.07.21 the health visitor (3) had liaison call with Childrens services following home visit to discuss domestic abuse. Reported that there were no concerns in relation to Child A.
- 14.37 On 12.09.21, Jamie reported an allegation on behalf of Louise after they had been out together for the evening socially. Jamie left their location, leaving Louise with a group of friends. Louise returned home around 4:00am when she disclosed that she had been seriously sexually assaulted after becoming separated from her friends. Louise was distressed and had sustained visible injuries, consistent with her explanation. The offender was unknown to Louise, and she was unable to identify him at the time of reporting. Officers responded to the incident and obtained sufficient details for a crime record to be generated. Louise declined to discuss the circumstances with officers and declined to engage with any evidential processes thereafter. The case was reviewed by a specialist

supervisor and submitted for finalisation as NFA 14 (suspect unidentified and evidential difficulties), on the basis that an evidence-led prosecution was not practicable, due to insufficient evidence to pass threshold test. This decision was ratified by a Detective Inspector and an adult protection referral was submitted on 17.09.21 for ISVA support. An information request was submitted to HPFT.

- 14.38 During the same period as the 3 incidents listed above Jamie was seen 3 times by his GP at Central Surgery. The notes do not show any record of a discussion about any lifestyle and or relationship circumstances that may be contributing to his feeling of low mood depression. Jamie is prescribed medication at the first visit and reports that this seems to be helping at the review appointment so is advised to continue the medication.
- 14.39 On 8.11.21 Louise self-referred to the Wellbeing Service. The referral stated that Louise was experiencing extreme stress and sleep paralysis which were present over the past four weeks. No risk to self is reported. On 12.11.21 telephone contact is made with Louise to arrange an initial appointment on 26.11.21. A letter is sent to confirm telephone Initial Assessment with the Wellbeing Service Louise fails to attend the initial assessment appointment, there are two further calls to Louise in line with policy. No response is received and she discharged from Wellbeing Service due to non-engagement. A letter is sent to Louise advising her that she should contact her GP regarding any suicidal thoughts.
- 14.40 On 14.11.21, Jamie contacts the police again to report that the suspect responsible for sexually assaulting Louise had entered his number into her phone and he had called the next morning. In Jamie's statement relating the allegation made on the 12.09.21 and states that Louise had in fact cheated on him and she fabricated the allegation. Jamie's assertion contradicts video footage retrieved from Louise's phone dated 31.07.2022 recorded by Louise herself during which, she refers to being raped.
- 14.41 On 15.11.21 the nursery nurse (1) saw Child A for 1yr development check with Louise. Louise reported to have recently separated from partner and had found this difficult. Good family support noted. Louise reported previous depression, and has asked for more support from Herts wellbeing and counselling. Nursery Nurse provided activity sheet for Child A to support development. Referral also made to orthoptist for Child A. Louise declined further support from health visitor at this time.
- 14.42 On 30.12.21, Louise reported that Jamie was looking after the baby at her home address whilst she was at work. Whilst there, he hacked into her social media accounts and her laptop and accessed explicit images of Louise without her knowledge and consent. Jamie then issued threats to distribute the images to her friends and referred to her as a slag and whore. Since separating in November 2021, Jamie had randomly turned up at Louise's address on five or six occasions, unannounced. Louise did not wish to pursue any complaints at that stage but did want the incidents recorded. On 30.12.21, a crime of disclosing or threats to disclose private sexual photographs with intent to cause distress, was recorded.
- 14.43 01.01.22 Louise attended Herts Community Hospital with a head injury. She reported having her drink spiked, woke up at bottom of the stairs surrounded by police. Boyfriend not at the pub, multiple wounds noted, blurred vision, possibly assaulted.
- 14.44 A DASH was completed on 10.01.22 and assessed as medium with a variation of 19.17.11 ticks recorded on different police logs. 17./9 ticks on the DASH should have equated to a high-risk assessment. A safeguarding referral was submitted to the Beacon team, to provide specialist safeguarding support. Louise was not supportive of any criminal investigation although she was receptive to engagement from the Beacon team, who provided support

and safeguarding advice. Louise was also receptive to seeking support from her employer to provide protection and prevention of further incidents.

- 14.45 Louise was categorised as a Repeat DA victim, subject of intimidation and deemed vulnerable. A child at risk assessment (standard) was also submitted to Children's Services via DAISU. Children's Services did not consider the threshold was met. Given the above information relating to the different DASH scores had the high-risk score been shared with CS this may have led to the referral being considered to meet threshold. Similarly, there was significant amount of information across services at this time to indicate that Louise's mental health was deteriorating, has this been considered alongside her history of self-harm and the connection between this and the breakdown of her close relationships then further investigation would seem appropriate given the impact that this would have on her ability to parent meet the needs to Child A.
- 14.46 Between the period of 01.11.2021 to 30.12.2021, other offences of Malicious Communications, Stalking, Criminal Damage to Louise's phone and Common Assault were also identified and recorded accordingly. The crime record was finalised NFA 16 (evidential difficulties) on 28.01.21.
- 14.47 On 11.01.22 the health visitor team were notified of Domestic incident between Louise and Jamie. Louise was reported to be unsupportive of police action and noted to not live together but co parent a child. DASH noted relationship ended in November 2021. There were alcohol concerns for Jamie and depression. Louise reported to police on DASH that since breaking up abuse has become more verbal and she has been told to kill herself.
- 14.48 Health visitor 4 called Louise on 11.1.2022. Louise reported they had resolved the issue and no further concerns. Louise said she was aware of impact of domestic abuse and how to contact support. Louise declined health visitor support at this time.
- 14.49 On 3.2.22 here is a further police notification, relating to Jamie accessing Louise's social media and threatening to share sexual images of her. Children's Services send a letter to Louise offering early help.
- 14.50 On 15.2.22 Louise self-referred to the Wellbeing Service. The referral stated that Louise was experiencing low mood, anxiety and depression over the last few months. She reported that she had previously taken medications but was not currently taking these. Risk assessment stated that Louise felt that she was a risk to herself, and others and she was also at risk from others. Louise stated that she was experiencing suicidal thoughts, was unable to properly take care of her son and experienced verbal abuse from her ex-partner. There is no record that this led to a safeguarding concern being raised in relation to Child A or that adult safeguarding was considered in relation to Louise – reviewed as a single incident rather than alongside the case history.
- 14.51 On 25.2.22 the well-being service make telephone contact with Louise to offer an appointment on 14.3.22. Louise does not attend this appointment and does not answer two call attempts that are made. However, Louise emails the well-being service on the 21.3.22 to advise that she had forgotten about her appointment, she is offered an appointment for the 4.4.22.
- 14.52 On 02.04.2022, Jamie reported a Common Assault, whereby, he attended Louise's home address because he was unable to contact her as she had gone out for the evening. He was concerned that his son was not being looked after properly and attended that morning approximately 10.30am. Louise was inside the property and feeding her son. Jamie believed this was too late to be feeding their son and criticised Louise's actions. Jamie also reported that their son had a black eye. Louise repeatedly asked him to leave her property however, he remained there until she threw a butter knife towards him. Jamie recorded

the encounter on his phone whilst Louise accused him of bullying her. An offence of DA related Common Assault upon Jamie was recorded, and finalised NFA 15 (named suspect, evidential difficulties) owing to Jamie being unsupportive of any police investigation.

- 14.53 This incident directly led to a child protection investigation being instigated by Jamie. Officers attended and reported that the child was happy and healthy and interacting with officers. There were no visible signs of any injuries or bruising around the eyes. The officers did not identify any neglect issues or welfare concerns. When spoken to by officers, Jamie also disclosed a historical assault whereby Louise threw a baby toy at him causing a small bruise to his face. Again, he was unwilling to pursue a complaint and declined any further police intervention. Enquiries were made with neighbours with a negative result. In the absence of any offences being revealed, Jamie was advised to liaise with Children's Services regarding his concerns for the child's welfare and future parenting assistance.
- 14.54 On 4.4.22 Louise attended her telephone appointment with the Wellbeing Service. Risk assessment noted feeling at times that life is not worth living and fleeting suicidal thoughts. No intent or plan to act on these thoughts documented. Louise reported historical thoughts of suicide in her previous relationship which was emotionally abusive. With regards to current risk from others, Louise reported that her ex-partner, Jamie and his new girlfriend had made threats to beat and stab her. Louise reported that she had approached the council to move. She did not notify the Police of this but reported that they were aware of other risks. Louise reported feeling harassed. Reported that Jamie makes allegations against Louise's care of their son, Child A.
- 14.55 On 05.04.22 Jamie (father) contacted the Out of Hours team – raising concerns regarding contact, reported aggression from Louise and concerns about her care of child, including reporting a bruise to child's eye.
- 14.56 On 05.04.22 Police record: Child Protection Investigation. DASH and child at risk referrals were completed and assessed as medium and standard respectively. A subsequent DART safeguarding referral dated 02.04.22 was rejected by MARAC, due to the criteria of four incidents in the past twelve months, not being met. On 05.04.22, a referral was also received from Herts. Children's Services to Herts. Constabulary relating to Jamie making complaint of child neglect against Louise, criticising her parenting skills. Louise refused Jamie contact with their son and there was an ongoing dispute between both parents, regarding contact and access to the child. Jamie alleged he attended Louise's home address on the Saturday and their son appeared unwell with a suspected bruised eye. Jamie stated his father was a police officer and he was acting on the advice of his father, having shown him the footage he recorded of Louise's behaviour. According to Jamie's father, he too suspected the child may have bruising to the eye and encouraged Jamie to report the matter to Children's Services.
- 14.57 On 06.04.22 Children's services receive a phone call from Child A's paternal grandmother and an email from Jamie. Both this and the previous report from Herts Constabulary express concern for Louise's care of Child A citing her mental health and alcohol use as factors. Jamie's email relates to the incident in the police report (detailed above); the call from Child A's paternal grandmother refers to the same incident but also refers to additional incidents including Louise pushing the grandmother to get to her son and being unsure whose care Child A is sometimes left in. This information leads the case being identified as having met threshold and the case is allocated to a student social worker for initial assessment with oversight from a senior practitioner.
- 14.58 On 06.04.22 the health visitor team were notified of Domestic abuse incident between Louise and Jamie. Jamie had been recorded as the victim he attended the home and was

requested to leave; Louise had reportedly thrown a butter knife in Jamie's direction. DASH assessment for Jamie noted depression for Louise and previous overdoses, and issues with child contact.

- 14.59 Health visitor 5 responded to a telephone call from social care on duty as per their request, updated following last phone contact re Domestic abuse and reported no support from HV team required. Health visitor 6 attempted to contact Louise to follow up DA notification (from 06.04.2022) via telephone on the 07.04.2022 however no response.
- 14.60 On 11.4.22 Louise attended her follow up telephone appointment with the Wellbeing Service. Louise denied any current risk to self, reported ongoing threats from ex-partner and his girlfriend. Louise and her family reported to be working on getting a non-molestation order in place.
- 14.61 Further attempted by Health visitor 7 to call Louise 12.04.2022 but no response and no option to leave voicemail. However, health visitor 1 did successfully reach Jamie on the 12.04.22, Jamie reported that he had taken out a non-molestation order against Louise.
- 14.62 HV 8 completed section 17 information sharing for Childrens Services. Information sharing noted referral made by Jamie raising concerns about Louise's mental health and ability to care for Child A.
- 14.63 On 13.4.22 Louise attended a phone appointment to discuss risk posed from others. Louise reported threats being made once or twice a week. Last threat was the day before where he said he would come over and did but went home and Police were called. She stated no physical violence and threats were made to scare her. Louise reported that she keeps a record of threats made. Louise reported that her ex-partner cannot appropriately care for their son (such as not knowing how to change him). Louise reported that her ex-partner had reported her to Children's Services and the case was currently open for assessment.
- 14.64 The initial visit from Children's Services also takes place on this date. The notes indicate that this visit was to explain the referral, the assessment process and obtain consent. There is no record that any exploration of mental health/DA made at this appointment, which is standard practice. However given the history and the fact that Louise was responsible for the care of Child A, a conversation to assess the current situation in relation to both her experience of domestic abuse from Child A's father and her mental health could have potentially provided an opportunity for Louise to have felt supported by the process, rather than judged and fearful she would lose her child, therefore paving the way for more open and honest assessment as the process progressed.
- 14.65 On 19.4.22 Louise attended her first telephone treatment session for Behavioural Activation intervention. No changes documented to the risk. Louise reported that her anxiety and low mood was focused around the situation with her ex-partner and the difficulties she has encountered. Louise reported the allegations made to Children's Services were not substantiated.
- 14.66 Information shared that Child A attended Princess Alexandra Hospital 18.4.2022 with Jamie. He stated Louise was in the car outside. Reported Child A lives with Louise but Jamie contacted Childrens services due to Louise being intoxicated one morning, noted parents have little contact and relationship is poor. Child A noted to have a bruise on his head, Louise reported occurred from falling whilst running- no other concerns are recorded.
- 14.67 HV 9 contacted Louise to discuss the above. Louise reported Jamie has made malicious referral to children's services so there is an assessment in progress.
- 14.68 On 20.4.2022, the IDVA service attempted to contact Louise, but got an automatic response which informed that the number was not receiving calls. The IDVA emailed the referrer to confirm Louise's number with the referrer. The IDVA attempted another call on the same

day and received the same automatic response. On 22.2.2022 the IDVA service received a response from the referrer to inform the phone number is correct but does not accept calls from withheld numbers. All further calls to Louise were made with phone number being 'seen'.

- 14.69 Refuge has a policy of attempting contact five times over a two-week period then closing the case if contact could not be established. The IDVA followed this policy and called Louise five times from 20.4.22 to 3.5.22, the service also sent two text messages to reach out to Louise. There was no response to any of the calls or messages and the case was closed on 5.5.2022. The referrer was updated and advised to encourage Louise to contact the service at a time convenient to her. Given that there were other professionals in contact with Louise at the time contact could have been facilitated via HV.
- 14.70 On 27.4.22 Health visitor 1 saw Louise and Child A at home, maternal grandmother also present. Louise reported following separation from Jamie concerns escalated when he started a new relationship and wanted new partner to see Child A. Louise reported feeling anxious to avoid any more police callouts. Louise also raised concerns about Child A spending time at Jamie's home as Louise reported Jamie's mother is a heavy drinker. HV advised to seek legal advice.
- 14.71 On 28.04.2022 Louise cancelled therapy appointment due to appointment with children's services. HPFT had difficulty arranging further appointments. Two attempts were made to contact Louise on 12.5.22 and 27.5.22.
- 14.72 Between the 5th April 2022 and 30th June 2022 Central Surgery receive 4 police safeguarding reports, a Sc17 information sharing request and a notification of an overdose. All of these are discussed at the practice safeguarding meeting and no further action was taken by the GP's practice.
- 14.73 On 2.5.22 May Child A is seen at Princess Alexandra Hospital for concerns relating to them being chesty however Louise and Child A Left after assessment and before treatment. On 3.5.22 they are seen again at the Princess Alexandra Hospital, for a temperature and rash.
- 14.74 On 3.5.22 Children's Services complete separate home visits with both Louise and Jamie as part of the assessment. There is a notes to say that the visit with Louise is 'kept short' as Child A is present, teary and due a nap.
- 14.75 On 12.05.22, Louise made an online report of malicious communications between the period, 10.01.22 to 01.05.22. Louise alleged she was being abused by Jamie and his new partner, both of whom were sending abusive and offensive messages and calling her via social media and digital apps. The messages consisted of goading Louise to kill herself, offensive and iniquitous comments and crude behaviour. Louise captured those messages in screenshots and provided a statement on 14.05.22, detailing those communications. She forwarded the screenshots to the investigating officer on 18.05.22. Louise states she felt scared and depressed since she separated from Jamie in November 2021 because the abuse was getting worse, and Jamie was becoming more controlling. An offence of Malicious Communications was recorded, and the circumstances reviewed by a DAISU Supervisor, who tasked the officer to obtain a further statement clarifying addresses of screen shots. An appointment was made for Louise to provide a further statement on 28.07.2022 (It is explored in the analysis why was this appointment over 2 months despite the fact that Louise reported the abuse was reportedly on-going/escalating and that she was feeling scared) however, she was unable to keep the appointment, hence it was rescheduled to 08.08.22. That appointment never took place because Louise had taken her own life on 01.08.22.

- 14.76 A DASH was completed and assessed as medium (9 ticks) and a child at risk referral was assessed as medium. The referrals were shared with Children's Services and finalised NFA on 13.05.22, with an onward referral to the family centre.
- 14.77 On 17.5.22 the HV team were notified of Domestic Abuse incident between Louise and Jamie, notification. Louise was noted to be victim and reported to have been sent communications telling her to kill herself.
- 14.78 On 17.05.2022, Children's Services submit a request for police checks under section 17 to Herts. Constabulary relating to a welfare check on Louise's son. The checks are completed and children's services are updated there is no further action required. This request was following information supplied by Jamie (to Children's Services) reporting concerns for Child A's welfare and questioning Louise's parenting skills and abilities, due to her mental health. Jamie reported that Louise had thrown a knife at him when the child was sitting in his highchair, just missing Child A. Jamie also stated Child A looked malnourished and Louise left them in the care of a babysitter overnight, so she could go out.
- 14.79 There is no record of the above on the Chronology provided by Children's Social Care and on 19.5.22 a home visit with Louise takes place to inform her that the assessment has been completed and the case will be closed.
- 14.80 On 19.5.22 Louise was referred to Refuge (IDVA) this time by the MARAC. The IDVA contacted and spoke with Louise on 20.5.22, Louise confirmed that she would like further advice and support around domestic abuse. She asked to book a time to discuss her situation, this was arranged for the morning of 23.5.22. Louise declined the offer of a face-to-face meeting, opting instead for support provided over the phone.
- 14.81 Louise said that she had been living with her parents but that this had not been working, so they had issued her with a Notice to Quit. The Council had been helping Louise to find alternative accommodation and had asked her to view a property in Hertford. Louise said that she had heard that Hertford could be unsafe and did not feel comfortable raising her child there. She said that Jamie had shown up at her current address multiple times, so she would feel safer moving, but would like to stay as local as possible for support and work. During this conversation the IDVA attempted to complete Safelives DASH risk assessment. Louise did not have time to do that and asked to complete it during the agreed meeting on 23.5.22.
- 14.82 The IDVA called on 23.5.22 at the agreed time, Louise said that she was on her way to view a property therefore was not able to speak, but that she would send a text after the viewing to arrange another date to discuss her situation and complete a risk assessment. The following additional attempts to contact were made by the IDVA service. The IDVA sent a text to Louise on 24.5.22 asking to arrange a date to call. On 25.05.2022 the IDVA phoned LOUISE' number. It rang to voicemail. The IDVA called on 01.06.2022, LOUISE answered, said that she was out and requested a callback after 4pm. 01.06.2022 – IDVA called after 4pm as requested. Call rang to voicemail.
- 14.83 On 26.5.22 the HV team receive a copy of Childrens Services closure letter which notes no safeguarding concerns.
- 14.84 LOUISE was discharged from wellbeing services on 27.05.2022.
- 14.85 On 8.6.22 the case is closed to Children's Services. There is 3 weeks between the completion of the assessment and the case being closed – further information sharing at the point of closure would have highlighted the case was listed for MARAC.
- 14.86 On 9.6.22 the HV team are notified of domestic abuse notification between Jamie and a new partner, Clare. Jamie and Clare have engaged in a verbal altercation due to Jamie texting another female. Reported Jamie had accidentally dialled 999.

- 14.87 On 9.06.22, the case was heard at MARAC having been referred by Hertfordshire Constabulary on the basis of the incident being the fourth in a twelve-month period between both parties. HPFT are present and share information at MARAC. Given HPFT recent engagement and knowledge of the connection between Louise's previous self-harm and overdose history being connected to issues in her intimate relationships it would have been best practice to have made additional attempts to try to engage with Louise at this time.
- 14.88 There was a MARAC action for the IDVA service to continue trying to contact Louise. The IDVA made 3 attempts to contact Louise by phone and a text between 10.6.22 and 14.6.22. These were all unsuccessful and received no response from Louise – the case was sent for closure on 14.6.22 and closed on 21.6.22.
- 14.89 On 15.06.22, Jamie reported receiving a printed Father's Day card from his son showing Louise's surname on both the card and his birth certificate, instead of Jamie's. Within the communication, Louise also made comments relating to poor CSA payments, which Jamie interpreted as hurtful. At this time Louise was on holiday with her family in Greece and sent an email to Jamie, containing photographs of their son on holiday, with her new partner.
- 14.90 An offence of Malicious Communications was recorded however, the component parts of the offence were not made out and the record was finalised as a no crime, irrespective of Jamie's perception that Louise's communications were motivated by revenge and intended to cause offence.
- 14.91 A DASH was completed and assessed as medium and a child at risk referral was assessed as standard.
- 14.92 On 21.6.22 the HV team were notified of Domestic Abuse incident between Louise and Jamie. Jamie had become upset after seeing photos of Louise and Child A on holiday. DASH stated Jamie overdosed on the 18th June, and further concerns around child contact and use of alcohol by Jamie are noted.
- 14.93 On 29.6.22, Jamie reported an allegation of harassment whereby, Louise was repeatedly sending him emails between 20.06.22 to 28.06.22, despite Jamie informing her that he did not want any contact with her, on the advice of social services. However, Louise persisted with communications, hence the offence of Stalking and Harassment was recorded.
- 14.94 On 1.7.22 the HV team are notified of a report of harassment being made by Jamie, against Louise. A text is sent to Louise requesting contact. This response is inconsistent with the response to Louise's allegations against Jamie where the only action is to request a further interview 79 days later, this is explored in the analysis.
- 14.95 On 21.6.22 Jamie reports to Children's Services that Louise is sending him various communications (Father's Day card/emailing pictures of family holiday with her new partner) to upset him. The Children's Services management review does not show any attempt to discuss this with Louise but states on the record that there is no risk to the child and notes Louise's behaviour as 'antagonising'.
- 14.96 On 11.7.22 the HV team are notified of closure from Children's Services.
- 14.97 On 4.7.22 and 8.7.22 there are 2 further reports from Jamie about Louise's actions. Louise is spoken to about these reports, she presents a very different picture which is identified as presenting a 'dynamic' between the parents. They are advised to be amicable in front of Child A and seek mediation if they are unable to do so. This would seem to be an entirely inappropriate recommendation to a couple where there is DA and is addressed in the analysis and single agency recommendations.
- 14.98 A statement was obtained from Jamie on 31.07.22 with consideration of arresting Louise, following a review by DAISU to compile an investigation strategy. At this time the follow up

interview of Louise was still outstanding; Jamie had not been spoken to about her allegations and now the police are preparing to arrest Louise following his accusations. The factors contributing to this are explored in the analysis along with information about what changes have been made to avoid further such occurrences.

14.99 A DASH was completed and assessed as medium and a child at risk referral submitted. Louise took her own life the following day.

14.100 Police responded to a report of an adult female who had been found by her friend and father, hanging from a tree in Much Hadham woods, close to her home address. Officers and paramedics attended the scene and LOUISE was pronounced dead at 05:25hrs. A knife was also recovered from the scene, which family members identified as originating from the family home. Sudden and Unexplained death protocol was instigated and an investigation on behalf of Coroner commenced, as there appeared to be no suspicious circumstances.

15. Analysis

15.1.1 ANALYSIS OF POLICE INVOLVEMENT

15.1.1 Initial Police Response

Each incident log recorded within Herts. Constabulary and listed in the chronology has been analysed for compliance with force policies, College of Policing APP, legislation, and standard operating procedures that were in existence at that time. The incidents were graded appropriately using the THRIVE¹ risk assessment model and the response type/time accurately assessed and reviewed, by staff in the FCR².

Upon initial attendance at the scenes/addresses, officers correctly and appropriately:

- utilised their body worn video (BWV)
- Obtained explanations from Louise & Jamie where practicable
- Applied the VOICE principles to the child
- Completed some initial investigations and FTA³, including enquiries with neighbours, to secure and preserve evidence
- Completed and submitted DASH, adult, and child risk assessments and referrals
- Recorded relevant crimes in accordance with NCRS⁴, which were also reviewed by Supervisors and Gatekeepers for quality assurance and compliance
- Individual victim needs assessment (IVNA) and safeguarding measures instigated via the OP. BEACON team and specialist safeguarding unit

¹ Threat/Harm/Risk/Investigation/Vulnerability/Engagement

² Force Communications Room

³ Fast Track Actions

⁴ National Crime Recording Standards

- Liaison with specialist teams such as DAISU, SOIT⁵, JAMIEPIT
- Recorded decision making using the NDM⁶
- Finalised incidents and crimes correctly notwithstanding, that both Louise and Jamie declined to make official complaints or provide any statements on a majority of the occasions

The THRIVE model provides a framework to help establish vulnerability needs and risk at the point of contact, for FCR staff.

15.1.2 Revocation of firearms certificate

In 2018, when Louise reported incidents of DA between her and her father, it was apparent from the DASH responses that he was a firearms certificate holder. Louise was still legally a child, and her sibling was aged 14 years. Given the circumstances of the incidents and irrespective of whether the victim was supportive, a review of eligibility of the certificate holder should have been undertaken. A supervisory review within the Athena log suggests that no further action was required regarding the firearms certificate issue, due to the minor nature of the offences and unwillingness of victim to pursue a complaint. This appears to be a transactional response to an issue that posed a potentially high risk of serious harm in the future considering:

- vulnerability of victim
- impact on other family members and relationships
- opportunities and accessibility of the firearm to any persons within the household
- hostility and violence already shown by Louise's father
- Responsibility should sit at a higher level than operational supervisor and as a minimum, at Inspector level, due to organisational risk and HRA⁷ issues, as do powers of search, under PACE⁸

Agency Recommendation – 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.

Current DA policy states *“Where it is identified that there are either firearms or a firearms certificate at the address belonging to any household member then these must be immediately seized, and a referral made to the Firearms Licensing team”*.

15.1.3 Risk Assessments

⁵ Sexual Offences Investigation Team

⁶ National Decision Model

⁷ Human Rights Act 1998

⁸ Police and Criminal Evidence Act 1984

Whilst risk assessments and referrals were completed and graded based on the circumstances presented to the officers at that time, the actual grading of those assessments gives cause for concern based on the following DA indicators:

- Louise's vulnerabilities and the cumulative impact on her mental and emotional wellbeing, as a result of continuous and escalating harassment from Jamie and his new partner
- Frequency of DA incidents reported by both parties
- Child being exposed to DA
- Counter allegations made by Jamie
- Delay in positive action in arresting/interviewing JAMIE, which enabled the harassment to be perpetuated during the intervening period January to July 2022
- Family court proceedings relating to access/custody arrangements of the child having been commenced

The RA process that was in place in 2022 relied upon on officers to complete DASH documents on an individual basis, pertinent to specific incidents and dependent upon the score or number of ticks, to determine the grading. Consequently, incidents were dealt with in isolation, as opposed to an integrated approach, requiring officers/supervisors/managers, to apply their professional judgement during the RA process, and see the 'bigger picture.' This is particularly imperative in cases where:

- an extensive DA history already exists
- both parties have been characterised as perpetrator and victim
- children are being exposed to DA
- other vulnerabilities have been identified such as mental health illnesses, drugs, alcohol, medication etc.

It is unclear as to how DAISU and MASH processes failed to acknowledge or take a holistic approach into consideration, given the: lack of improvement in Jamie's conduct; the increase in DA incidents reported to Police, and the elevated the risks of exposure to DA, for the child. 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. The MARAC referral in May 2022 was submitted on the basis of four incidents having occurred within a period of twelve months.

It is acknowledged that Hertfordshire Constabulary have already transitioned to the use of DARA by officers responding to and assessing risk at domestic incidents. As a risk assessment tool DARA allows officers to use professional judgement and therefore consider the historic dynamics within a relationship, this transition will hopefully improve the way in which risk is understood and assessed.

The relationship between Louis and Jamie was described as toxic and volatile, by family members and incidents of stalking and harassment were exacerbated by new relationships

and access arrangements to see the child. Both were known to have mental health issues, which also intensified the impact of DA on the family unit.

Whilst officers submitted adult at risk referrals relating to Louise and her mental health, information suggests, she had been known to mental health teams previously, due to earlier suicide attempts and self-harming issues throughout childhood. The information was shared with the appropriate partners to enable provision of support Louise and her son.

15.1.4. Finalisation

In cases where there were no offences revealed, there was no requirement to complete an IVNA or signpost Louise or Jamie to other support services such as IDVA. Where offences were revealed, they were recorded in accordance with NCRS and measures such as We Protect, Bright Sky, IVNA, IDVA, NCDV etc. were considered. However, due to their reluctance/refusal to engage with the Police, it was difficult to initiate these. That said, it would be beneficial to furnish all DA victims with that information, should they choose to explore those options themselves at a future date, and to promote ownership of their lives. Force policy at the time required officers to take positive action in all cases and arrests likely where PACE Code G was applicable, and officers should not base a decision to arrest or not, on the willingness of the victim to testify or otherwise.

Furthermore, an all-encompassing risk assessment tool and approach to risk management based on DA history, previous risk assessments, outcomes, and interventions, would be more appropriate in ensuring that information is shared with relevant partners, (including Housing), in a timely and efficacious manner, especially where children and vulnerable adults are affected. Professional Judgement should be applied, as opposed to the number of ticks or perpetrator/victim status. The volume of incidents within a given period, regardless of victim/perpetrator status, should also be considered, to assist objective decision-making and to take positive action.

Chair Recommendation – review risk assessment process and policy for victims of DA, that is bespoke to victims and based on professional judgement

15.1.5 Problem Oriented Policing (POP)

In cases where, positive action, out of court disposals or restorative justice options have been exhausted, but the DA and safeguarding issues persist, then it would be prudent to consider other strategies and initiatives through partnership working, that have the potential to improve:

- a. Demand reduction
- b. Levels of service to victims
- c. Collective safeguarding responsibilities
- d. Impact of harm, anti-social behaviour, and safety, upon families, wider communities, and partners

The reactive police response proved ineffective in dealing with repeated incidents of DA, and more a proactive response through a problem-solving approach, may have enabled, multi-agency and co-ordinated management of the DA issues. Ultimately, this strategy may have proved more proportionate to the needs of the parties, thereby ensuring:

- safeguarding of all parties involved, transparency and accountability with SMART⁹ action plans
 - Designation and responsibility of actions to relevant partners/agencies
 - positive outcomes given the vulnerabilities of all parties
- .1 combined partnership approach to addressing the family's needs including support for their mental and emotional well-being

Non-engagement with Police and the criminal justice process, offer limited resolution options available to officers hence, consideration of Problem Oriented Policing as part of the Prevention strategy, may have been appropriate in these circumstances to address the short, medium, and long-term issues affecting this family. Through a cohesive, concerted synergy of partnership working, alternative solutions and measures could have been explored, to tackle the challenges affecting this family and protect the child and LOUISE's sibling from exposure to DA. That process would undoubtedly, have prompted and encouraged discussions and safety planning between partners and support agencies.

Agency Recommendation – consider POP as an alternative strategy to the management of DA where victims are unwilling to proceed via the Criminal Justice route

Chair Recommendation – consider multi-agency suicide prevention training across the workforce to increase knowledge and awareness of risk factors, especially prevalent in persons with mental health issues

15.1.6 Vulnerability and Safeguarding

Louise presented as vulnerable and a repeat victim of DA and as such, she was entitled to enhanced rights under VCOP¹⁰, as mental health is categorised as an exceptional vulnerability, alongside alcoholism, drug addiction and disability. Furthermore, LOUISE met the conditions of a vulnerable and intimidated witness, legislated by the YJ & CE¹¹ Act 1997, due to the nature of the offences alleged, her mental health issues and the potential for further incidents of DA and/or intimidation. LOUISE was eligible for a video recorded interview (VRI) and her evidence should have been captured using this method in May 2022, as opposed to an MG11. The VRI would have proved beneficial in the event that a evidence led prosecution was going to be pursued and may have prevented the subsequent delay in obtaining further digital evidence. As per the DA policy in 2022, it mandated that all investigations must be approached with an evidence led focus to ensure that all available evidence is gathered at the earliest opportunity

⁹ Specific, measurable, achievable, realistic, timed

¹⁰ Victim's Code of Practice

¹¹ Youth Justice and Criminal Evidence Act 1999

and reliance is not placed solely, on any evidence provided by the victim. LOUISE's vulnerabilities consisted of:

- a history of poor mental health since childhood and previous suicide attempts in 2018 and 2019 when, Louise was suffering from mental health crises. She threatened to harm herself on 01/02/19 and on 06/02/19, when she cut her wrists superficially with broken glass and was threatening suicide
 - premature birth of her son and possibility of post-partum depression
 - diagnosed with depression in 2018 and medicated with Sertraline
 - cumulative impact of DA between her and JAMIE, which included emotional, physical, psychological, and financial abuse
 - lack of support network or signposting to agencies such as NCDV, ISAC, Refuge etc.
 - changes and additional responsibilities during her relationship with Jamie
 - being a single mother and working to financially support herself and her son
 - strained relationships with her family members
 - Callous abuse from Jamie and his new partner between, November 2021 and July 2022
 - previous threats of suicide and suicide note dated 4th July 2022 (recovered following her death)
 - post incident trauma resulting from the sexual assault allegation reported on 12/09/21
 - Repeat victim of DA
-
- Under VCOP persons who are considered for enhanced rights of victims are:
 - vulnerable and/or intimidated
 - a victim of the most serious crime (including a bereaved close relative) has been persistently targeted are more likely to require specialised assistance such as being offered a referral to a specialist support service/being contacted sooner after key decisions and having access to Special Measures

Once a service provider has identified that the victim is eligible for Enhanced Rights, they must ensure that this information is passed to other service providers with responsibilities under the Code and, when appropriate, to services that support victims. Enhanced service is also available to victims of the most serious crime, including domestic violence; a victim who has been targeted repeatedly as a direct victim of crime over a period of time; a victim who has been deliberately targeted; or a victim of a sustained campaign of harassment or stalking. VCOP requires that all organisations with responsibilities under the Code should be informed when vulnerable or intimidated victims are identified. [Intimidated](#) victims and witnesses, e.g. complainants in sexual offence and domestic violence cases, will also always be considered eligible unless they tell the court that they do not want to be considered. Victims and witnesses may be deemed vulnerable for many different reasons and vulnerability is not

always obvious. Each person must be assessed and dealt with according to their needs. Identifying vulnerable/intimidated people includes those who:

- Are in a domestic situation:
- Have difficulty managing their daily life
- they say that intimidation has occurred or is likely to occur
- they give information about the offence but are reluctant to provide a statement
- the nature of the offence could indicate an increased likelihood of intimidation, e.g. sexual offences, assaults, domestic violence, vandalism, and racially motivated crimes are more likely to give rise to intimidation
- the offence is one of a series of incidents and there is some indication of repeat victimisation

Under VCOP, Louise was eligible for VRI, Special Measures and enhanced rights.

Herts. Stalking and Harassment Policy dated 30/03/22 requires that “All allegations of stalking whether they are DA or Non-DA should always be thoroughly investigated and wherever there is consent from a victim a referral to the Independent Stalking Advocacy Caseworkers (ISAC’s) should be completed”. However, it appears this was not done, and no victim personal statements were taken from Louise.

Agency Recommendation – investigators and supervisors to consider VRI’s for victims of DA where conditions are met, to secure and preserve best evidence

Agency Recommendation – investigators, supervisors, and managers, to ensure compliance with VCOP and enhanced rights of victims in DA cases

15.1.7 Ownership & management of Malicious Communications and Controlling/Coercive Behaviour Investigation

Hertfordshire Constabulary’s DA policy states it aims to:

- Protect the victim(s), in order to make sure they, and any children present, are not left at continuing risk
- Conduct a timely and expeditious investigation and effectively gather evidence, where possible, in order to arrest and charge and prosecute the offender
- Adopt a proactive approach in preventing and reducing DA

In Hertfordshire, DA is split into two categories, and this will provide the pathway for which investigative Unit will have primacy. The overriding factor when deciding on the remit of any DA incident (intimate or non-intimate) is that the best possible service is provided to the victim and that whenever possible there is one OIC¹² throughout the life of that investigation. This will prevent the victim having to relive their experiences and ensure consistency of approach from the OIC.

¹² Officer In the Case

All Domestic Abuse crimes, irrespective of risk remain the responsibility of the relevant reporting Local policing teams, which includes arrest of suspect, safeguarding of victim and management of immediate risk until the following has been completed:

- All available evidence has been secured and uploaded.
- The suspect has been arrested and DAISU have been notified of location of handover and accepted it
- An out of custody interview is deemed appropriate and then following review by a DAISU supervisor that all evidence has been obtained, it is agreed that DAISU will take ownership
- The level of risk is so high that following review that DAISU accept responsibility to safeguard the victim
- Where following review by a DAISU supervisor it is agreed that DAISU will lead the investigation

The following timelines, linked to risk, are expected to be adhered to when obtaining evidence for any domestic abuse crime investigation ready for handover to DAISU:

High Risk – All evidence obtained and uploaded within **48 hours**

Medium Risk – All evidence obtained and uploaded within **7 days**

Standard Risk – All evidence obtained and uploaded within **14 days**

Local policing teams retain ownership and management of DA investigations until they are handed over and arrest taskings are subject to DMM¹³ and DTM¹⁴.

In relation to the Malicious Communications reported by Louise on 13/05/22, the attending officer accurately recorded the crime in accordance with NCRS and complied with the SOP¹⁵ by submitting the investigation to DAISU for review. On 02/07/22, a DAISU Supervisor tasked the OIC to obtain further evidence relating to the screenshots of messages that Louise had referred to in her original MG11 dated 18/05/22. The OIC arranged for LOUISE to provide a further statement on 28/07/22 however, Louise was unable to attend Bishops Stortford Police Station and the appointment was re-scheduled for 08/08/22. Louise was found deceased on 01/08/22.

There was 50 days between the attending officer recording the crime on 13/5/22 and the DAISU supervisor tasking the IOC to obtain further evidence from Louise in relation to this crime. There is no explanation offered as to why this delay occurred. This delay contributed to the 79 days that elapsed since the initial report and Jamie remained outstanding as a suspect. A decision had been taken not to arrest JAMIE but interview him out of custody, although the rationale for this decision is not recorded. The decision to arrest an individual rests with each officer based on the prevailing circumstances and must meet the requirements of the necessity test under PACE, Code G. Had Jamie been arrested, the additional evidence could have been obtained whilst Jamie was in custody. Furthermore, in the absence of sufficient evidence to charge, releasing Jamie on conditional bail may have afforded Louise greater reassurance and security, and prevented further offences being committed.

¹³ Daily Management Meeting

¹⁴ Daily Tasking Meeting

¹⁵ Standard Operating Procedure

Between 28/07/22 to 05/08/22, there were seven updates recorded on the crime log including finalisation of the crime as NFA, victim deceased.

Herts DA policy encourages officers arrest of perpetrators, where conditions exist and safeguarding of victims must be prioritised. No positive action appears to have been taken and no ownership or investigative responsibility agreed between DAISU and the OIC. The investigation was not conducted diligently or expeditiously and the lack of intervention, enabled and perpetuated the abusive and controlling behaviour directed towards Louise.

On 02/09/22, a DAISU Detective Inspector reviewed the investigation and directed that an evidence led prosecution should be pursued against Jamie and DAISU would take ownership and lead the investigation. Consequently, Jamie and his new partner were arrested on 02/09/22 for numerous offences including:

- Coercive and Controlling Behaviour
- Stalking and Harassment
- Malicious Communications

The rationale and arrest strategy originated from the actions agreed within a GOLD Group meeting that was convened on 01/09/22. It cannot be established what factors changed to justify the arrests considering, the risks to Louise were eradicated and risks to her son were mitigated because he was safeguarded elsewhere.

Given the correlation between the VCOP factors and LOUISE's circumstances that may have motivated/contributed to Louise's death, it is imperative to note that members of Louise's family had sufficient knowledge and evidence available that was relevant to the criminal investigation, post death. Their statements partially detailed the controlling and coercive behaviour directed towards Louise by Jamie, during their relationship and after they separated, which may have assisted with a evidence led prosecution albeit, the family were reluctant to provide this information when the incidents were initially reported. Additionally, there was potential for the retrieval of digital evidence from the devices that were seized from Louise's home address following her death and from Jamie's address, following his arrest.

On 28/07/23, the investigation was finalised, NFA 15 by a Detective Chief Inspector, due to insufficient evidence being available, to meet the threshold test with a realistic prospect of a conviction.

On 01/09/22, it was discovered that this case had not been referred by Herts. Constabulary to the CSP for a DA related death review for reasons unknown, which also influenced the formation of a Gold group.

Agency Recommendation – Force reviews its policy on DA investigation management, ownership, and investigative strategy in every case

Chair Recommendation – Force to review training of Stalking and Harassment Legislation to ensure persistent DA reports are considered under the legislation

Chair Recommendation – Force reviews the DAISU processes between responding officers submitting case for review and the review taking place to avoid unnecessary delays

Agency Recommendation – appropriate measures are implemented to ensure future DA related deaths and homicides are referred to the CSP at the earliest opportunity

15.1.8 Support Services and Civil Orders

Operation OAK was created to tackle domestic abuse which remains a priority for Herts. Constabulary and its partners. It is a complex and challenging area of policing that cannot be resolved by the police service alone. Under the banner of Operation Oak, the Constabulary's approach to domestic abuse has improved dramatically over recent years through significant investment into DAISU. DAISU was established in 2016 and take ownership of all high-risk DA cases and lead on Stalking and Harassment cases. The SSU¹⁶ and Op. BEACON team also sit under the umbrella of DAISU to provide support, signpost victims to appropriate services and compile safeguarding plans, to afford victims maximum protection. The primary focus of the SSU is to provide an enhanced level of safeguarding to victims of DA by means of:

- Reviewing all high-risk investigations and all stalking allegations to assess if SSU can offer advice/direction on safeguarding or take complete ownership given previous history or complexity of parties involved.
- Progressing Right to Know and Right to Ask 'Clare's Law' and associated safeguarding
- DVPO safeguarding with support from a named safeguarding officer, allocated from SSU to progress safeguarding during existence of DVPO

In the case of Louise, there was a distinct lack of information and support provided in relation to the application processes relevant to civil orders such as, DVPN/DVPO/PHO/SPO/NMO. DAISU lead in terms of knowledge, use and management of DVPN's and DVPO's.

Limited support was offered to Louise in terms of signposting to other agencies such as NCDV, Herts Sunflower, Herts Help, Women's Refuge, Mental Health Teams, IDVA and other support agencies. This may have been due in part, to Louise's reluctant to proceed with formal complaints but this did not preclude the option to refer Louise to voluntary and NGO¹⁷ agencies for assistance. These services would have been essential to Louise, bearing in mind her vulnerability and entitlement to enhanced rights under VCOP.

Agency Recommendation – 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

15.1.9 Perpetrator – Jamie

From the Chronology, it is apparent that Jamie made numerous allegations against Louise and he too, suffered from mental health issues. His PNC¹⁸ record shows warning markers for self-harming and suicidal ideation, from the age of 16 years, and in March 2022, Jamie took an overdose that caused an inverted heart. Jamie also had self-disclosed drugs and alcohol issues and when he was offered the services of LADS¹⁹ whilst in custody on 02/09/22, he refused.

In relation to the counter allegations that Jamie reported, there did not appear to be any consideration as to whether they could be perceived as spurious and vexatious in their nature and timing. There did not appear to be any substance or evidence to support the assertions

¹⁶ Specialist Safeguarding Unit

¹⁷ Non-Government Organisation

¹⁸ Police National Computer

¹⁹ Liaison and Diversion Services

he was making. The relevance of considering this was further supported when officers that attended Louise's address and assessed the wellbeing of the child found there to be no concerns.

According to Jamie, Family proceedings had been instigated regarding custody and visitation to his son and a hearing was impending in August 2022. Within the incident logs and discussions with officers Jamie stated his father was a police officer (unknown force) and had been advising and supporting Jamie. Upon showing his father footage recorded on Jamie's phone, of the incident involving Louise on 12/05/22 (para. 6.7 refers), his father indicated the child had a suspected NAI and this should be reported to Children's Services. Jamie went on to report his concerns to Herts. Constabulary and Children's Services.

The attending officers should have explored the motivation behind Jamie's father's intervention and obtained sufficient details to enable information sharing with the relevant police force for an assessment.

Chair Recommendation – Herts Constabulary to review its policy on disclosure and sharing of information with other forces, where police officers/staff feature with DA investigations

15.1.10 Sudden Death of Louise on 01/08/22

Following the discovery of Louise's body, by her partner and father, officers attended the scene and commenced an investigation on behalf of the coroner and preserved the scene. Officers conferred with Supervisors from the scene however, there is no record of a supervisor having attended the scene to provide guidance, leadership, and direction, as per the Sudden Death policy. A suicide note dated 04/07/22 was not discovered until September when statements were obtained from family members and items were seized from Louise's address for further enquires, following the arrests of Jamie and his partner. The attendance of a supervisor at the scene may have led to the earlier discovery of information pertinent to both the Coroner's and criminal investigation processes, and a more timely referral to the CSP under the DHR protocol.

Agency Recommendation – Force to review the sudden death policy and consider mandatory attendance of a supervisor to non-suspicious deaths and suspected suicides

15.2.1 Analysis of GP Practice (Much Hadham) – Louise

15.2.1 Prior to the scoping period between October 2017 and June 2019 Louise was seen on 14 occasions by her local GP Practice. Although her first appointment was in relation to being unable to sleep, her symptoms soon included anxiety and weight loss which is consistent with clinical depression, and she appears to have been treated for this via prescribed medication and social prescribing. During this period Louise took 3 reported overdoses of prescribed medication and here were also 3 occasions where concerns for her mental health were reported to the practice by family members and her then, ex-partner. Her relationships with other family members and the breakdown of her intimate relationship were cited as factors that contributed to her poor mental health. There were regular check-in appointments with Louise and changes were made to medication and alternative social prescribing is also part of the treatment.

15.2.2 Louise disengages from mental health support and isn't seen by the GP Practice again until May 2022 when she attends to advise that she is pregnant. She discloses that the pregnancy is unplanned but that she is well supported by her mum and partner (Jamie) and wants to continue with the pregnancy. The GP's notes do not state if she attended this appointment alone and although she reports feeling well supported by her partner it would have been good practice to enquire about her relationship at this point. Given the connection between Louise's past mental health and her close relationships this was a missed opportunity to open up the conversation about her relationship and offer advice.

Chair Recommendation: – GP's practice to review policy and practice around the identification of domestic abuse.

Chair Recommendation: - Practice to review DA training provided to all GPs and medical professionals. Consider 'Ask and Act' Training refresh.

15.2.3 Louise is next seen by the practice in March 2021; initially disclosing a low mood and not feeling supported by her partner. She is prescribed medication, but the notes do not indicate that she was asked about her relationship. A new baby can impact on the health of any relationship. Good practice would have been to enquire about her relationship more broadly and unpick whether she may have been experiencing domestic abuse and offer advice and support.

15.2.4 In June 2021 the Practice are notified there has been a DA notification. No action is taken. Louise's last appointment was 3 months ago, at this time she reported a low mood and feeling unsupported. This notification is an indicator that the situation has worsened, and confirmation that she is experiencing domestic abuse. It would be reasonable to think that this would impact on the mental health of someone with Louise's history and would therefore have been good practice to offer an appointment to review how she was feeling at this time.

Chair Recommendation: - Practice to review policy in relation to responding to police domestic abuse notifications.

15.2.5 Louise is next seen in September 2021, at this appointment she discloses a sexual assault by a stranger and reports that this is not the first time this has happened. Louise reports feeling that the police had not taken her initial report seriously and felt they had judged her for 'wearing a short skirt'. She is offered reassurance about not being responsible for what has happened and is given information about relevant support services. The records do not indicate if her mental health and/or her relationship were discussed at this appointment. This is the first time that Louise has been seen at the practice since they received the DA notification and was therefore a missed opportunity to enquire about the dynamics within the relationship and signpost for support if necessary. Similarly in October when Louise attends and discloses an overdose of prescribed medication there is no record of an enquiry about the relationship and the only recorded action is a change of medication. At the 3 week follow up appointment Louise discloses not sleeping and that her relationship with the father of Child A has ended. The end of a relationship is often a period of increased risk; given there has already been 1 reported incident of domestic abuse it would have been important to try to ascertain the state of the relationship between Louise and Jamie after the relationship had ended and may have given rise to a safeguarding referral.

15.2.6 In January 2022, in a telephone appointment, Louise discloses that Jamie is trying to take Child A from her. There are no other records in relation to this appointment. A conversation to

obtain more information about the dynamics of their relationship could have provided important information about the risk Jamie posed to both Louise and Child A and similarly to the above point, may have led to a safeguarding referral.

Chair Recommendation:- Practice to consider how the practice's GPs are trained to use professional curiosity to obtain more information about DA risk and decision making for safeguarding referrals.

- 15.2.7 In April 2022 Louise reports to the Practice that Children's Social Care are now involved following allegations that have been made by Jamie; she is worried about this but if offered reassurance about the role of the social worker and how the Practice can also provide feedback about her care for Child A. She is given an appointment for her and Child A the following day so they can be seen together. Notes show that Louise was given information about domestic abuse support services. There was a good level of continuity of care throughout this period with most appointments taking place with Louise's named GP; given this it would have been good practice for there to have been an open dialogue around her relationship to improve professionals understanding of Louise's experience of domestic abuse and increase the likelihood that the correct support could be offered, and that she would engage.
- 15.2.8 In July 2022 there is a good response from the practice when Louise sends an E-consult disclosing the reoccurrence of suicide ideation; she is contacted the same day and offered an appointment for the following day. At this appointment she is offered social prescribing and encouraged to attend a mum and toddler group and access support for her mental health. This is followed u a week later when Louise discloses that she has joined a group for single mums. It appears that she is encouraged to report counter allegations of harassment at this appointment but there is no record in either of these appointments that domestic abuse and support services are discussed. A couple of days later when Louise contacts the practice to report experiencing increased anxiety, she is advised to continue taking her medications and get back in touch if she needs to. It would have been good practice to offer a follow up appointment; it is possible that this response reduced the likelihood that she would reach out again soon anticipating the same response.
- 15.2.9 Sadly, less than 3 weeks later Louise takes her own life.

15.3 Analysis of CUHFT Rosie Ardennbrookes Hospital

- 15.3.1 Records from the Rosie Hospital show that Louise was only known to them during the period 29.6.20 to 25.11.20 which was in relation to her pregnancy. The initial referral to the Rosie hospital stated that Louise had been subject to emotional abuse from a previous partner (not the father of the baby). This referral was from the Lister Community Midwives. The Rosie Hospital appropriately followed up in a discussion with Louise about both her mental health and her experience of domestic abuse.
- 15.3.2 The guidance from the National Institute for Health and Care Excellence "Domestic violence and abuse" Quality Statement (QS) 116 states that people presenting to frontline staff with indicators of possible domestic violence or abuse are asked about their experiences in a private discussion. Electronic records state that Louise was alone with the midwife, but that there was limited exploration of this as Louise maintained this had been a previous partner and there is nothing further noted. Curiosity about her current relationship may have enabled Louise to open up about any abuse within the relationship.

Chair Recommendation:- CUHFT to consider further training for health professionals to understand the role of professional curiosity to create an opportunity for disclosure.

- 15.3.3 Louise presented with a history of self-harm, anxiety and depression, noted in QS 116 as an indicator of possible domestic violence or abuse. Louise was not referred to local domestic abuse services as this requires consent and Louise stated that abuse was historic and not from her current partner.
- 15.3.4 Louise was offered a referral to the Consultant Obstetrician to review her mental health, as it was correctly noted that she had a history of anxiety, depression and self-harm. Local guidelines suggest referral to the Clinician for assessment and referral to mental health services if necessary. Louise was assessed, and did not meet threshold for referral to the Perinatal Mental Health service, but was signposted to talking therapies (known as the Psychological Wellbeing Service in 2020).
- 15.3.5 Although Louise stated that she would prefer to choose if she needed mental health support it was good practice that the booking midwife requested a Consultant review of Louise's notes to triage due to her past mental health.
- 15.3.6 It was noted that Louise was tearful at times in the postnatal period at the Rosie hospital, on two separate documentations by a Midwife and a Maternity Support Worker (MSW). On both occasions, Louise related this to the overwhelming nature of the birth (the baby being born prematurely) and being separated from the baby. On the first occasion, this related to the baby being in the neonatal unit whilst Louise was being cared for on the postnatal ward of the Rosie, and on the second occasion, around plans to repatriate Child A to Harlow hospital which was the unit closest to home, with Louise being discharged home. Louise did not disclose suicidal ideation or thoughts of self-harm at this point. The MSW escalated her concerns to the Midwife in charge, who asked the MSW to ask Louise directly about her mood and plans (as she had a good rapport with her). Louise denied that she had any negative thoughts or plans and was additionally asked about domestic abuse. Again, Louise stated that she was not frightened, and she felt safe.
- 15.3.7 An after-visit summary was sent to the community midwives (Lister hospital), GP and Healthy Child Programme containing the relevant information following discharge as Louise's postnatal care would continue with the Lister Midwives until 28 days after the birth.
- 15.3.8 There was evidence that Louise had additional vulnerabilities and this should have been shared formally on an information sharing template that is now custom and practice between safeguarding teams of NHS Trusts. At the time, there was no communication between the Rosie and the Lister teams other than the referral. As mother responded negatively to routine enquiry, sharing of this additional information could have supported further exploration when attending for care with the community midwife.

This is a good example of steps that have already been taken by NHS Trusts since 2022 to improve information sharing and improve responses to domestic abuse.

15.4 Analysis of East and North Herts Trust

- 15.4.1 Louise's antenatal care was subject to cross border working arrangements between ENHT and Rosie Hospital. Louise's community midwifery care was provided by ENHT and Louise was seen

- in person for each of her four appointments held by the midwifery service. During the COVID-19 pandemic aspects of maternity care were not routinely provided face to face, however these key contact points remained face to face, and contact was made with Louise.
- 15.4.2 Louise engaged well with her midwifery care, enquiry was made about her previous relationship which she reported to have been abusive. The community midwife explored the information surrounding the history of her previous relationship and sought information about the current relationship and father of the unborn baby, who Louise reported to be supportive. Louise did not make any disclosures of concern in relation to the father of the unborn baby when routine DA enquiry was completed at midwifery appointments. It is important to note that information relating to the nature of the abuse Louise suffered was not documented, however important to recognise that the maternity records were handheld and, in the woman's, own possession.
- 15.4.3 In the event of cross border working, information sharing forms should be completed at booking appointments where noted risks such as domestic abuse, mental health difficulties are recorded and shared with agencies involved with the woman and unborn baby: This includes, GP services, Health Visiting Services and/or Children's Services where applicable. Where cross border working takes place, the Information Sharing Form should be completed at the booking appointment and shared with the hospital providing cross boundary care. This would then be saved onto the patient's file and can be accessed and updated by all midwifery staff (this information sits outside of the woman's own handheld records).
- 15.4.4 The information sharing form is vital in supporting the tracking and updates for a woman where vulnerability has been noted, including providing direction on case management. In Louise's case, there is no evidence that an Information Sharing Form was completed at the point of booking and on contact with our community midwifery services. Where the concerns surrounding Louise's previous experience of domestic abuse and report of mental health difficulties were noted, there was a missed opportunity to raise an information sharing form from the community midwifery service to ensure timely information sharing and supporting ongoing community follow up in the post-natal phase.
- 15.4.5 It is also important to note, that where an information sharing form is completed, a risk assessment and information gathering is conducted by the Safeguarding Maternity Service. This includes access to community records; System one & Shared Care Records to support full risk assessment surrounding the vulnerabilities noted. This would have provided an opportunity for further information gathering and triangulation of risk against known information on local systems.
- 15.4.6 It appears the midwifery service did not have the details of the father of the unborn baby detailed in the record. In the absence of the information sharing form and details of the father of the unborn baby, triangulation of information relating to the current partner would have been essential in supporting a holistic risk assessment and compliance with *the learning from the myth of invisible men report (Sept, 2021)* and understanding the importance of the men in children's lives.
- 15.4.7 Since 2020, the NHS Trust have commenced cross border working meetings between maternity services at ENHT and local hospitals where care for women is shared. These meetings provide a forum for information sharing and gathering surrounding the care of vulnerable women and support action planning across border working. It is recognised that Louise would not have met a threshold for discussion based on the information at that time, however it would have been noted that there was shared care, and the records would now be reviewed by a safeguarding midwife and updates obtained.

This is a good example of steps that have been taken by NHS Trusts since 2020 to improve information sharing and improve responses to domestic abuse.

15.5 Analysis of Herts Community Hospital

- 15.5.1 Involvement prior to the scoping period: Herts Community Hospital had some involvement with both Louise and Jamie, separately, prior to the scoping period. This support was in relation to unrelated incidents of self-harm – Jamie being the patient in 2012 and Louise in 2018; Louise’s incident was an injury sustained during a panic attack, she reported being in medication for depression at the time. In relation to Jamie, he had self-harmed and as referred to CAHMS.
- 15.5.2 Involvement during the scoping period: Herts Community Hospital have primarily provided the universal service provision within the Healthy Child Programme under HCT care, (this is a programme covering pregnancy and the first 5yrs of life, offering an integrated approach for the health and wellbeing of children and their families) to Louise and Jamie since the birth of Child A in November of 2020 until just before Louise’s death. During this time they had a total of 9 Health Visitors (HV) and 1 nursery nurse contacts. A number of these HV’s became involved or made contact to follow up domestic abuse notifications.
- 15.5.3 Information sharing received from midwifery services noting Louise’s pregnancy and baby due in January 2021, this information was added to records on the 17th November 2020. Further information was received on the 22nd November to inform Louise had delivered a baby at 33 weeks gestation. The HV services received an information sharing form from Cambridge University Hospital stating that Louise had a history of self-harm, previous overdose, history of anxiety and depression linked to an abusive ex-partner which was now resolved. Although the referral implied that the abuse was with an ex-partner it was not clear whether this was Child A’s father and it does not appear that the identity of the ex-partner was explored further. The information sharing form requested for community services to monitor.
- 15.5.4 The information in the referral does not seem to have led to any alerts being logged on the system. Given the number of different HV’s who had contact with Louise during the scoping period such alerts would have been an important way of making sure any of the team were aware of the concerns.
- 15.5.5 It was noted that although Jamie was seen by the HV service during a new birth contact in 2020, no information was added to his records, and no information regarding any discussion on his mental health or possible impact on now becoming a father was recorded.

Agency Recommendation: - 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.

Chair Recommendation: - Review standard practices where a father has a noted history of mental health support to include standard discussions about this area of need

- 15.5.6 The HV service were pro-active in responding to police DA notifications by trying to make contact on the same or next day following incident notification being received. The HV service did struggle at times to contact Louise to follow up and discuss the DA incidents which may have contributed to impacted on the HV team’s ability to provide continuity of care. It was good practice that making contact was seen as a priority and each incident was followed up

- by an available member of the team. In June 2021 Louise reported their relationship was back on track; subsequent police information noted relationship ended towards the end of 2021.
- 15.5.7 The HV team records show that they were notified of 7 domestic abuse incidents between Louise and Jamie (1 notification was a duplication of an incident); another one between Jamie and a new partner. In three of these incidents Louise was noted to be the victim; a further two incidents Louise was noted to be the perpetrator, and another incident Jamie was the reporter of the incident, but victim/perpetrator were unclear, and police did not progress as it was felt there was no offence.
- 15.5.8 Following the DA notification in April 2022 which noted Jamie was the victim, the HV team contacted Jamie to offer support. This is in line with HCT Domestic Abuse Policy under which, it is the victim who is contacted by the service to offer support.

Chair Recommendation: - 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

- 15.5.9 We now know that at his time Louise was regularly receiving abusive messages and experiencing harassment from Jamie – information held by police, Children’s Social Care and Louise’s GP. The way in which information is help on different systems across the different health services has, on a number of occasions, limited the knowledge that can be accessed about a case by other health services.
- 15.5.10 Although the HV service pro-actively made timely contact with Louise following the domestic abuse incident in May 2022 where Louise was reportedly told to kill herself by Jamie, there does not appear to have been any specific discussions around her mental health, impact of being told to end her life, or discussion of mental health support services.

Chair Recommendations: - 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

15.6 Analysis of involvement of Refuge: IDVA Service

- 15.6.1 Refuge first received a referral for Louise on 19.4.22, this was from Herts CC Children’s Social Care.
- 15.6.2 The referral stated there were concerns relating to harassment and threatening behaviour from Jamie, father of Child A to Louise. The information in the referral stated that the couple had previously been in a relationship and lived together, however they had separated in November 2021 and the relationship between Louise and Jamie has worsened to the extent that Louise was now filing for a non-molestation order against Jamie.
- 15.6.3 Concerns shared in the referral included her being pushed, grabbed round her wrists which left marks, that the verbal abuse from Jamie was ongoing, that he would tell her to kill herself, name-calling and sending threatening and harassing text messages to her. He had also attended the home without invite and has made allegations of harmful behaviour from Louise towards Child A.

15.6.4 The IDVA responded to the referral by attempting to make contact the following day. There was a delay to the IDVA being able to get through due the use of a with-held number. Although the IDVA did pro-actively follow up with the referrer when the initial call reached an automatic message stating the number was not accepting calls this did delay the initial successful attempt by a further 2 days. Many clients have mobiles that do not receive calls from with-held numbers so attempting to call from a non with-held number immediately after getting the voicemail could have made the initial successful attempt to contact a couple of days sooner and therefore inside the required 48 hours from receiving the referral.

Chair Recommendation: Refuge to consider reviewing response on receiving automated voicemails that could be an indication that with-held number are not accepted.

15.6.5 However, the IDVA service did follow policy of attempting contact five times over a two-week period then closing the case if contact could not be established. The IDVA followed this policy and called Louise five times from 20.04.2022 to 03.05.2022, the service also sent two text messages to reach out to Louise. There was no response to any of the calls or messages and the case was closed on 5.2.2022. The referrer was updated and advised to encourage Louise to contact the service at a time convenient to her.

15.6.6 During this time period Louise was having contact with her GP, the HV team and Children's Social Care so there may have been an opportunity to link in with any of these agencies to facilitate an introductory meeting between the IDVA service and Louise. However, given that the referral did not highlight any concerns about Louise's mental health which may have limited the IDVA service's fully understand the level of need and the importance of trying additional strategies to make first contact.

15.6.7 Louise was referred to the IDVA service again on 19.05.2022, this time by the MARAC. This was again highlighting an escalation in the harassing and threatening messages being sent to Louise from Jamie.

15.6.8 The IDVA service made pro-active contact and spoke with Louise on 20.05.22 which was within 24 hours and therefore good practice. Louise confirmed that she would like further advice and support around domestic abuse, there was an initial conversation about some of her needs, housing seemed to be Louise's priority at the time, having been given a notice to quit for the annex at her parents. Louise said that she didn't have time for further discussion on this call and a follow-up call was arranged for the morning of 23.05.22. Louise was offered a face-to-face meeting but declined, opting instead for support provided over the phone. Due to Louise not having sufficient time for a full discussion the IDVA was also unable to be able to complete a DASH risk assessment.

15.6.9 Over the following month the IDVA service made 7 further attempts to contact Louise by phone, 5 of these went to voicemail and on 2 occasions Louise answered but said she was busy and requested a call back but did not answer when the IDVA called back at the agreed time. The IDVA also sent 2 texts during this period requesting Louise get in touch. On 14.6.22 the case was sent to a manager for closure and was subsequently closed on 21.6.22.

15.6.10 The IDVA service complied with the information-sharing protocol for the MARAC, which was attended by the IDVA to present information about the service's involvement with Louise. The IDVA service reacted pro-actively to each of the referrals with contact attempts.

15.6.11 During the period between the second referral received on the 20.5.22 and the case being closed on the 21.6.22 the IDVA made 9 attempts to contact Louise, updated the referrer on the progress of the case and timely of the closure. There do not appear to have been any

attempts to be pro-active and facilitate contact through other agencies who may have had contact with Louise at the time, Children's services were in the process of completing their assessment at this time and there may have been a missed opportunity to complete the DASH risk assessment in a joint or facilitated meeting with the Social Worker given that there was a MARAC referral during this time indicating an on-going escalation of the risk.

Chair Recommendation: The IDVA service to consider the benefits of utilising the relationships between clients and other professionals as a way to facilitate/maintain engagement.

15.7 Analysis of HPFT Involvement

- 15.7.1 Prior to the scoping period: Louise's first contact with Mental Health Services was in 2018 following a referral received from Princess Alexandra Hospital (PAH) in Harlow, Essex. Louise had no mental health history or contact with services prior to this. Louise had not been detained any section of Mental Health Act (MHA) 1983 and had no psychiatric inpatient admissions. Louise had two main periods of care under Secondary Mental Health Services in 2018 and 2019 and three periods of care under Primary Care Services 2018, 2021 and 2022. There were additional contacts recorded within the Secondary Care electronic records which did not lead to any extended period of contact. There were no open referrals to HPFT services at the time of Louise's death.
- 15.7.2 In 2018, following the referral from PAH, Louise was supported by the Crisis Team for approximately one month. During this time, the team provided a short period of intensive support and offered appropriate review and care planning which is documented to have been reflective of Louise's needs and wishes. There is evidence that those supporting Louise, namely her parents and a family friend, were included within her care, though no carers assessment were offered.
- 15.7.3 In line with the Standard Operating Policy of both teams, Louise's care was appropriately transferred to ACMHS for a period of just under three months. There were references made to abusive behaviour towards Louise from both an ex-partner and others in the community. A number of social issues were present at this time but there was no offer of a Social Care Assessment and eligibility for additional support under the Care Act 2014 was not identified as a need by services. When identified that Louise's needs no longer met criteria for secondary services, she was appropriately stepped down to the Wellbeing Service and appropriate procedures followed.
- 15.7.4 Louise was discharged from the Wellbeing Service following her step down from ACMHS. When seen by Street Triage, the Wellbeing Service promptly reopened the referral on request before a further discharge to the GP. On both occasions, discharge was due to non-engagement and the service followed the Did Not Attend (DNA) procedure as part of their Standard Operating Policy.
- 15.7.5 Louise was referred to the ACMHS in 2019 following an overdose and safeguarding concern around domestic abuse in a previous relationship. No intervention was provided as Louise did not attend and then declined an Initial Assessment with the ACMHS. There is evidence of the DNA procedure being followed appropriately. The intervention offered with regards to the safeguarding concern will be discussed separately within this report.
- 15.7.6 In November 2021 Louise self refers to the well-being service stating that she is experiencing 'extreme stress and sleep paralysis' that has been going on for 4 weeks. There is pro-active

contact the following day and Louise is offered an assessment appointment in 2 weeks' time. Louise fails to attend this appointment and as a result a discharge letter is sent and she is advised to contact her GP in relation to any suicidal thoughts. Given Louise's history of suicide ideation and overdose it would have been good practice to have made more pro-active efforts to engage Louise with support – how might it feel to be experiencing poor mental health and receive a letter from the well-being service suggesting that you go to the GP?

15.7.7 In February 2022, Louise accessed support from the Wellbeing Service. The self-assessment of risk identified that Louise felt at risk from herself and others, in the form of verbal abuse from her ex-partner that had been negatively influencing her mental health. She also stated that she felt unable to take proper care of her son. There is 10 days between this referral and the first attempt to contact Louise who answers this call and is offered an assessment which is a further 18 days later. There is no record that this is considered a child safeguarding concern and no evidence that any enquiries are made to Children's Social Care, any information sharing takes place or that a referral is submitted.

15.7.8 Louise does not attend the appointment 18 days later and a letter is sent to her and the GP advising she has missed the appointment which was arranged for the 14.3.22. On 21.3.22 Louise emails the well-being service to advise that she had forgotten about the appointment. She is then offered a new assessment appointment on the 4.4.22. At her assessment appointment on 4.4.22 Louise reports feeling that life isn't worth living and experiencing suicidal thoughts. It is recorded that Louise says she has no plans or intent. Given Louise's history of ideation and overdose it would have been good practice to complete an individual safety plan with Louise. Louise also reports feeling harassed and that her ex-partner has been threatening her and has also made allegations about her care of their son (Child A). There is no record of any professional curiosity around this disclosure which further indicates there may be a risk to Child A. This case is discussed in supervision the same day but there does not seem to be any recognition of the potential risk to the child, there is no log of this raising a safeguarding concern, no evidence of information sharing with children's services and no referral submitted. The risk Louise poses to herself is 'not considered to be high or immediate' and there is no record that Louise was offered any advice or support. It appears the assessment of the risk Louise posed to herself was not considered alongside her mental health history but instead as an isolated episode. Had there been professional curiosity in either the assessment appointment or the supervision that followed this would have exposed a pattern of behaviour connected to a cluster of events, in particular Louise's experience of abuse following the breakdown of a relationship and the deterioration in her mental health which has previously seen periods of suicide ideation and numerous overdoses. This added to the self-reported concerns for her ability to care for her son properly and the allegations from her ex-partner, which whilst on the one hand may have been part of the coercive and controlling behaviour, may on the other hand have had some validity given Louise's mental health at the time.

15.7.9 It is also unclear from the records was information was shared between Children's Services and HPFT; information sharing would have revealed that there was already a safeguarding referral for Child A.

Chair Recommendation: HPFT to review training and guidance for practitioners understanding of the impact of experiencing domestic abuse on mental health and suicide ideation

Chair Recommendation: HPFT to review guidance for making referrals to Adult and Children's Services to include historic dynamics and patterns of behaviour

15.7.10 Following a further call with Louise, a week later, during which she reports the threats being made to her from Jamie and his new partner the case is discussed in supervision, this time identifying the safeguarding concerns to the child and stating an email should be sent to the corporate safeguarding team and that Louise should be advised of this and more information obtained from Louise about what contact is taking place between Child A and Jamie and how this is being managed. When the call with Louise takes place 2 days later Louise discloses that she has concerns about Jamie's ability to care for Child A and that the case is open to Children's Services for assessment following allegations from Jamie about Louise's ability to care for Child A; Louise advises that these allegations are untrue.

15.7.11 It is a further 6 days before the email is sent to the corporate safeguarding team, which is 8 days since the supervisor set this as an action. The corporate safeguarding response is that Louise had *'taken appropriate action to safeguard herself, advised for Louise to continue to report to the Police and signpost to domestic abuse support. No child safeguarding referral felt to be required based on information provided'*. It is unclear what 'information provided' this is referring to, there is no record of information sharing between Children's services or the Police and HPTF which suggests that this decision was based on the information Louise had self-reported.

Chair Recommendation: 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

15.7.12 In the 5 weeks that followed the call with Louise that led to the email to corporate safeguarding team there is a session cancelled by Louise (reason provided as clash with children's services appointment), a session cancelled by HPFT (due to therapist being unwell) and an unanswered call from HPFT to Louise. At this point an opt-in letter is sent and later followed up by a discharge letter when no response is received after 10 days.

15.7.13 The case is heard at MARAC 2 weeks after the discharge letter was sent to Louise. It is unclear from the records at what point HPFT became aware of the case being listed for MARAC but good information sharing would have highlighted the circumstances leading to the MARAC referral and provided an opportunity for the DA risk to be considered alongside Louise's mental health.

Chair Recommendation: HPFT to review information sharing processes and how information is used to inform assessment of risk and decisions to discharge

15.7.14 HPFT's IMR identified challenges with the system used to record and store information as contributing to some of the gaps in information within the case. *'There is no record that liaison took place between children's services and HPFT, this may have been beneficial for a dynamic risk assessment for both agencies'*.

On 06.06.2022 an alert was added to the PARIS electronic record system indicating that the case was to be heard at MARAC. The team attending MARAC and the Wellbeing team use different IT systems, therefore, the Trust MARAC representative (from secondary care Adult Community Mental Health Services) would not have been aware that there had been recent contact with the victim within Wellbeing services. The Trust are already aware that this can be an issue and are working to come up with a solution.'

15.8 Analysis of Herts CC Children's Services

- 15.8.1 Children's Services first Child and Family assessment was completed in April/May 2022. Prior to the initial assessment there were 3 domestic abuse incident notifications received by Children's Services during the period June 2021 and February 2022. Each of these reports was with Louise as the victim of abuse from Jamie which included one verbal incident, obtaining and threatening to share explicit images of Louise, name-calling and damage to her property. Although none of these incidents met threshold for intervention Louise was on each accession offered access to support services (Beacon/Early Intervention) which was good practice. However, the pattern of behaviour does paint a picture of the dynamics within the relationship which does not appear to have been considered in relation to the Child and Family Assessment completed in May 22.
- 15.8.2 The Child and Family Assessment completed in May 22 was the result of a phone call from the paternal grandmother of Child A to Children's Services. She reported being concerned about the well-being of Louise and described some of her behaviours which included swearing and being very aggressive, getting drunk every other week, took the changing bag and bottles away so child was left with nothing, pushed Grandmother to get to Child A, previously threatened to kill Grandmother, throwing a knife at Child's Father, Jamie when he was stood in front of child A. She also reported seeing Child A looking dehydrated, having had a slapped cheek and that Louise seems to go out and they are unsure of who is looking after the child when this happens. Child A tends to smack head his head and she is unsure if this is random or learned behaviour. Grandmother reported feeling that there were many red flags and was concerned for the welfare of Child A. This call is followed up by an email from the Police to Children's Services after it appears that Jamie has reported similar concerns to them. This is assessed as having met threshold to be stepped up to LCS.
- 15.8.3 The case is allocated to a student social worker with oversight and support from a Senior Practitioner and a Child and Family Assessment is undertaken. The assessment was completed on 13.5.22 and did not identify any safeguarding concerns for Child A in his Louise's care. The assessment recommended that a referral to the Family Centre was made for Louise to access local groups and additional support if she felt this was necessary. Louise and Jamie were also encouraged to consider how they communicate with Child A present. There was an ongoing issue surrounding contact between Child A and his father, and parents were advised to seek legal advice in respect of this matter. The case closed on 8.6.2022.
- 15.8.4 During the period that the assessment was active (4.4.22 when the report from the paternal grandmother was received and the assessment completion date 13.5.22) there are 4 police DA reports and a notification of an overdose; the records of other agencies document that they received notifications of these DA incidents; it is unclear if Children's Services received these notifications and if so if they were considered as part of the assessment.
- 15.8.5 On the 27.4.22 Louise reported to the health visitor that she was concerned about more police reports and shares concerns about Child A spending time with the paternal grandmother due to her being a 'heavy drinker'.

Chair Recommendation: Children's Services to review processes around receiving and recording Police DA notifications.

Chair Recommendations: Children's Services to review how information from other agencies is used to inform assessment of DA risk and impact on Children

- 15.8.6 On the 12.5.22 Louise reports malicious communications from Jamie and his new partner, these communications include telling her to kill herself. The police report shows that Louise states that Jamie's behaviour is becoming worse, he is increasingly controlling, and she is feeling scared.
- 15.8.7 The case is reviewed on 12.5.22, this entry is headed Team Manager review. This review states that 'Risks reduced now parents have separated'. This is of concern as the initial referral was sent to Children's Services after they had separated suggesting this cannot in fact be an indicator that the risk has reduced; additionally, the police referral to the IDVA service stated that that the domestic abuse has increased since separation. The assessment also states that there is 'on-going conflict over child contact', again a factor that is stated by other agencies as increasing the risk. The review should have considered the information of the case in detail and not only focus on whether the rationale provided. Had the full details of the case been considered it would have been clear that the rationale for closure cannot be the same as the reason for referral and should also have highlighted that the assessment failed to consider Louise's mental health and or the historic dynamic of domestic abuse between Louise and Jamie.

Chair Recommendation: Children's Services to review guidance for the completion of case reviews to ensure that the full details of the case are understood by the supervisor.

- 15.8.8 What is unclear from the Children's Services records is whether they were aware of the reports from Louise to the police on the 12.5.22. The recency of conflict between Jamie and Louise would further question the closure rationale around the risk reduction. These incidents triggered a MARAC referral, again indicating the level of risk was high. The reason for the MARAC referral was that there had been 4 DA incidents within a 12-month period, evidencing there was also an increase in frequency. This information would have been crucial; not only does it clearly show that there is a current DA risk that is increasing but the fact the case was listed for MARAC would have required the case remain open.

15.9 Analysis of the involvement of MARAC

- 15.9.1 Minutes were reviewed from the MARAC held in May 2022, where it was noted that the IDVA service were attempting contact, Louise was unresponsive of police action, and main support required was in relation to housing. There does not appear to be any mental health review or discussion, although information did note previous mental health support for both Louise and Jamie.
- 15.9.2 One of the factors that appears to have not been considered at the MARAC (was it at the same time or were these allegations after) was the systematic attempts made by Jamie to isolate Louise from her professional support network – Jamie had made allegations to the police, children's social care and the health visitor team which represented all of the professionals that Louise was engaging with at that time. Yet this pattern does not seem to have been identified at MARAC. A discussion about the impact that this may have on Louise, if considered alongside her mental health may have highlighted to professionals that there was an increased risk to Louise, not only from Jamie, but also from herself.

15.10 Analysis of Central Surgery – GP Jamie

15.10.1 The chronology provided by central surgery is specific to June 2021 and June 2022. During this time there are 7 DA notifications (2 standard/5 medium risk from the police to Central Surgery). Each one of these is recorded to have been reviewed in the practice safeguarding meeting with an outcome of 'no action'. There are 2 appointments recorded after the first DA notification, at each of these Jamie is treated for depression and prescribed medication. There is no record that his relationship was discussed at these appointments. This was a missed opportunity to gain more understanding about the dynamics of his relationship with Louise and fully understand the risk.

15.10.2 The summary in the analysis of involvement from Central Surgery provides the following information only:

Central Surgery's involvement with Jamie was based on his health needs. He was suffering from depression and had taken an overdose 19th June 2022 due to stress created by his ex-partner, (Louise). He was assessed by Essex Partnership University NHS Foundation Trust and then referred to the single Point of Access. To our knowledge there were no injunctions or protection orders against Jamie.

15.10.3 There is no record that Jamie was seen by Central Surgery prior to or following the overdose recorded on the 19th June 2022, was this information based on information sharing from Essex Partnership University NHS Foundation Trust? The language is concerning referring to the cause of the overdose being 'stress caused by his ex-partner'. In a dynamic where there is only 1 police incident where Louise is recorded as the Perpetrator and Jamie as the victim it would appear there is a lack of professional curiosity leading to this statement. There is no recorded follow-up to this information, and in fact no record of the information being received by Central Surgery other than the reference in the IMR.

16. Conclusions

16.1 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'.

16.2 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 health is directly impacted on during periods of relationship breakdown.
- 16.3 Audits into suicide and risk factors show that mental health is the number one risk factor (in approximately 70% of suicides mental health was the highest presenting need), 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.
 - 16.4 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.

17. Lessons to be learnt

- 17.1. 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.
- 17.2. 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 a GP appointment may be for, say, 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.
- 17.3. 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.
- 17.4. 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.

- 17.5. 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 ENGAGE²⁰ 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 standards²¹ for engaging perpetrators looking at early intervention.
- 17.6. 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.
- 17.7. 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.²²
- 17.8. 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 .
- 17.9. 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 clearly a history of ongoing domestic abuse. The family was subject to statutory Child and

²⁰ [ENGAGE | WWP European Network \(work-with-perpetrators.eu\)](https://www.gov.uk/government/publications/standards-for-domestic-abuse-perpetrator-interventions)

²¹ <https://www.gov.uk/government/publications/standards-for-domestic-abuse-perpetrator-interventions>

²² <https://www.kcl.ac.uk/mental-health-and-psychological-sciences/research/lara-vp-download>

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 mediation 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.

- 17.10. 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.

18. Recommendations

The review would like to thank agencies for their single agency learning not all agencies made individual recommendations for their agency, however the Chair has noted within the analysis where agencies make their own individual recommendations as well as where further single agency recommendations have been made by the Chair. All of the single agency recommendations are in the action plan.

The review would ask that Hertfordshire Domestic Abuse Partnership monitor action plans and that outcomes are impact assessed within the organisations. The following **multi-agency recommendations** are made to Hertfordshire Domestic Abuse Partnership:

Recommendation 1: For Hertfordshire Domestic Abuse Partnership to review existing risk assessment tools and processes used by agencies that offer early intervention²³ 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.

²³ <file:///early-intervention-in-domestic-violence-and-abuse-full-report.pdf>

Agencies screening and/or making assessments²⁴ of domestic abuse cases 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.

A Joint Strategic Needs Assessment (JSNA) should be completed, through this mechanism system connectivity should be explored and there should be more information sharing between Services using the DASH risk assessment tool and the commissioned specialist service to revise the recording of the DASH for victims of domestic abuse to enable the monitoring of post separation abuse and ensuring the right agencies are aware of current risk to offer the right interventions. Thus, enabling safeguarding referrals for those at risk to be actioned. This would improve sharing of information in the context of mental health and suicidal ideation alongside ongoing coercive control, with repeat incidents being captured at MARAC and therefore timely and up to date information around risk being communicated in real time.

Hertfordshire Constabulary have already transitioned to the use of DARA by officers responding to and assessing risk at domestic incidents, learning from this transition and early indicators of the impact this is having could be used to inform the guidance.

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.

To develop meaningful engagement of those who harm by including a diverse approach to address the lived experiences of all parties experiencing abusive behaviours that are controlling and harmful. A whole family approach would contribute to reducing risk of misinterpreting motivation and behaviours in the context of coercive controlling abuse by abusers²⁵. As mentioned, using a training package such as the ENGAGE²⁶ model for those less familiar with interviewing those who harm would be of benefit. Early intervention in addressing harmful behaviours would follow recent Government recommendations.

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.

When completing referrals or sharing information agencies should not only consider the information that supports the reason for referral but also consider what other information will support the risk and needs assessments of the agency they are sharing the information with as well as information that may be helpful in identifying 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

²⁴https://new.basw.co.uk/sites/default/files/resources/181181_basw_england_domestic_abuse_guidance.pdf

²⁵ <https://www.gov.uk/government/publications/standards-for-domestic-abuse-perpetrator-interventions/standards-for-domestic-abuse-perpetrator-interventions-accessible>

²⁶ [ENGAGE | WWP European Network \(work-with-perpetrators.eu\)](https://www.engagenetwork.eu/)

and provide guidance to ensure that they are aware of the benefits of incorporating them practically in assessments.

Practice improvement and recognition in ability to respond to signs of domestic abuse, demonstrating improved professional curiosity and asking about domestic abuse during consultation when presenting with indicators of domestic abuse. This will ensure future practice includes mapping incidents and the use of the 8 stage models to identify abusive patterns as a method of fully understanding historical dynamics and how this informs risk.

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.

Hertfordshire Domestic Abuse Partnership to share with health practitioners the recent new NICE quality standards regarding clinical indicators of domestic abuse and NICE²⁷ guidelines on Self-harm: assessment, management and preventing recurrence 2022. A resource to support mental health professionals identify and respond to Domestic Violence and Abuse is available. Also consider guidelines and training around developing mental health risk assessment to consider formulations which link domestic abuse and suicide risk where appropriate. Using individual mental health safety plans which consider risk posed by domestic abuse and risk of suicide.

This would assist in relieving the burden on those who hear disclosures of suicidal ideation to have awareness of options of where to refer or support someone to access appropriate interventions e.g. A&E, crisis team or Samaritans.

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.

Hertfordshire Domestic Abuse Partnership with all partners to continue to promote awareness around suicide prevention²⁸ in line with the National Suicide Prevention Alliance best practice guidance. Consider domestic abuse in local and national suicide prevention strategies. Hertfordshire Domestic Abuse Partnership are now part of the real time surveillance for suicide which is best practice and linking reviews to a strategic suicide prevention oversight group or equivalent.

National Recommendations: ²⁹

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 victim units should consider referrals to suicide prevention interventions in setting safeguarding actions when CCB is identified.

²⁷ <https://www.nice.org.uk/guidance/NG225>

²⁸ <https://www.gov.uk/government/collections/suicide-prevention-resources-and-guidance>

²⁹ www.vkpp.org.uk/assets/Files/Domestic-Homicide-Project-Year-2-Report-December-2022.pdf

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 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 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.

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.

<p>professional curiosity to inform their actions as required.</p>						
<p>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.</p>	<p>Local</p>	<p>For Hertfordshire Domestic Abuse Partnership to improve how perpetrators are held accountable for their actions and understanding the impacts on those affected.</p>	<p>Hertfordshire Domestic Abuse Partnership</p>	<p>“For Baby’s Sake” specifically work with couples and unborn child up to age 2.</p> <p>The Chrysalis centre also offers a variety of perpetrator intervention programs; however, these are all consent based. The directory of programs is attached:</p> <div style="text-align: center;">  <p>Chrysalis-Centre-DA-Service-Directory.pdf</p> </div>	<p>Complete</p>	<p>Complete</p>
<p>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</p>	<p>Local</p>	<p>For the Hertfordshire Domestic Abuse Partnership to develop a consistent referral form and risk and needs assessment.</p>	<p>Hertfordshire Domestic Abuse Partnership</p>	<p>There is ongoing work on the development of One Stop Shops with 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</p>	<p>June 2025</p>	<p>Ongoing</p>

<p>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.</p>				<p>participating organizations is part of this project.</p>		
<p>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</p>	<p>Local</p>	<p>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</p>	<p>Hertfordshire Domestic Abuse Partnership</p>	<p>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.</p>	<p>Ongoing.</p>	<p>Ongoing.</p>

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.

<p>line with the National Suicide Prevention Alliance best practice guidance.</p>			<p>plan is provided, ie the discharge befriending service.</p> <p>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.</p>		
<p>Recommendation 7:</p> <p>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</p>	<p>National</p>				

<p>victim units should consider referrals to suicide prevention interventions in setting safeguarding actions when CCB is identified.</p>						
<p>Recommendation 8:</p> <p>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</p>	<p>National</p>					

<p>dying by suicide, which reinforces the importance of identifying, recording and charging for controlling or coercive behaviour in a timely and accurate manner.</p>						
<p>Recommendation 9:</p> <p>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</p>	<p>National</p>					

<p>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.</p>						
<p>Single-agency recommendations</p>						
<p>Hertfordshire Police</p>						
<p>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.</p>	<p>Local</p>	<p>Allocated to DCI GRIFFITHS- Recorded on AMS system</p>			<p>Awaits update – deadline set 13/12/24</p>	

<p>Recommendation 2 – To review risk assessment process and policy for victims of DA, that is bespoke to victims and based on professional judgement.</p>	<p>Local</p>	<p>Allocated to DCI GRIFFITHS 14/10/24- Recorded on AMS system</p> <p>Awaiting review by DCI Gilbertson to add any further comment prior to finalisation.</p>		<p>This has been subject to recent review which has resulted in the DARA model being adopted over the DASH model.</p> <p>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</p>		
<p>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.</p>	<p>Local</p>	<p>Allocated to DCI GRIFFITHS 14/10/24- Recorded on AMS system</p>			<p>Awaits update, deadline set 13/12/24.</p>	
<p>Recommendation 4 – To consider multi-agency suicide prevention training across the workforce</p>	<p>Local</p>	<p>Allocated to DCI MACBETH 14/10/24- Recorded on AMS system</p>			<p>Awaits update, deadline 13/12/24</p>	

<p>to increase knowledge and awareness of risk factors, especially prevalent in persons with mental health issues.</p>		<p>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.</p>				
<p>Recommendation 5 – investigators and supervisors to consider VRI’s for victims of DA where conditions are met, to secure and preserve best evidence.</p>	<p>Local</p>	<p>Allocated to DCI GRIFFITHS 14/10/24- Recorded on AMS system</p>			<p>Awaits update, deadline set 13/12/24</p>	
<p>Recommendation 6 – investigators, supervisors, and managers, to ensure compliance with VCOP and enhanced rights of victims in DA cases.</p>	<p>Local</p>	<p>Allocated to DCI GRIFFITHS 31/07/24- Recorded on AMS system.</p> <p>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.</p> <p>Action passed to DCI Griffiths to complete force messaging.</p>		<p>VCOP compliance and scrutiny is currently and agenda item at Performance Framework and an agenda item at DMM.</p>	<p>Awaits update. Deadline 13/12/24</p>	

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	

<p>between responding officers submitting case for review and the review taking place to avoid unnecessary delays.</p>						
<p>Recommendation 10 – appropriate measures are implemented to ensure future DA related deaths and homicides are referred to the CSP at the earliest opportunity.</p>	<p>Local</p>	<p>Allocated to DCI GRIFFITHS 14/10/24- Recorded on AMS system</p> <p>Awaits update/review by DCI GRIFFITHS and DI PICKARD who has delivered this training.</p>		<p>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.</p> <p>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.</p>	<p>Deadline 13/12/24</p>	


<p>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.</p>	<p>Local</p>	<p>Allocated to DCI GRIFFITHS 14/10/24- Recorded on AMS system</p> <p>Awaits update by DCI GRIFFITHS</p>	<p>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</p>	<p>Deadline 13/12/24</p>	
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				<p>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</p>		
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				<p>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'</p> <p>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.</p>		
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	<p>Allocated to DCI GRIFFITHS 14/10/24- Recorded on AMS system</p> <p>Awaits update/review by DCI GRIFFITHS</p>			Deadline 13/12/24	
Recommendation 13 – Force to review the sudden death policy and consider mandatory attendance	Local	<p>Allocated to DCI GILBERTSON 16/04/24- Recorded on AMS system.</p>		Additional DAISU training has been provided at all Twilights to DI and DSs.	Deadline 13/12/24	Completed.

<p>of a supervisor to non-suspicious deaths and suspected suicides.</p>		<p>For review and closure</p>		<p>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.</p> <p>The SOP mandates supervisory attendance at suicide with consideration of DA as a motivator.</p>		
<p>Much Hadham GP surgery</p>						
<p>Recommendation 1 – GP’s practice to review policy and practice around the identification of domestic abuse.</p>	<p>Local</p>	<p>Policy reviewed in clinical meeting November 2024.</p> <p>Discussions around identification and what action to take. A couple of current case studies discussed.</p>	<p>Much Hadham Health Centre</p>	<p>Policy updated – linked to safeguarding</p>	<p>End of November 2024</p>	<p>Completed 30th November</p>
<p>Recommendation 2 - Practice to review DA training provided to all GP’s and medical professionals. Consider ‘Ask and Act’ Training refresh.</p>	<p>Local</p>	<p>In-house refresher training via Blue Stream Academy online. Face to face to be set up in 2025.</p>	<p>Much Hadham Health Centre</p>	<p>To update all clinicians first followed by all staff.</p> <p>Consider Ask and Act or any other DA in person training for 5 local practices.</p>	<p>Clinicians to complete by end of January 2025. Staff by March 2025. PTL lead has added to training agenda in 2025.</p>	<p>Ongoing</p> <p>Ongoing</p>

		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 30 th 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

<p>father has a noted history of mental health support to include standard discussions about this area of need.</p>		<p>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.</p>		<p>prompts/questions on mental health.</p>		<p>rolled out across the county and is due to start in September 2024.</p>
<p>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.</p>	<p>Local</p>	<p>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.</p>	<p>Hertfordshire Community NHS Trust (HCT)</p>	<p>Raising of awareness with Public Health Nurse champions so they can disseminate with their colleagues and encourage staff to use professional judgment as meeting</p> <p>DA policy to be updated in 2025</p>	<p>February 2025</p> <p>April 2025</p>	<p>Ongoing</p> <p>Ongoing</p>

<p>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.</p>	<p>Local</p>	<p>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.</p> <p>2, Amendment to domestic abuse template to remind staff of PHQ9 and GAD7 questions.</p> <p>3, Circulation of changes to public health nursing leads.</p> <p>4, Amendment to Domestic Abuse policy to highlight importance of reviewing mental health in association with domestic abuse.</p>	<p>Hertfordshire Community NHS Trust (HCT)</p>	<p>Discussion with Public health nursing education leads to review the operation procedures and consideration to including PHQ9 and GAD7 as part of assessment.</p> <p>Discussion to also be held with domestic abuse champions to help disseminate any changes agreed.</p>	<p>August 2024</p>	<p>Completed August 2024</p> <p>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.</p> <p>Task and Finish group to be held in Jan 2025 to review implementation.</p>
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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

<p>mental health and suicide ideation.</p>		<p>HPFT Safeguarding team to be represented at HPFT risk assessment CQI to ensure DA is considered alongside other forms of risk.</p> <p>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.</p>		<p>Professional Lead for Safeguarding adults part of CQI group</p> <p>Professional Lead for Safeguarding adults linked in with suicide pathway leads.</p> <p>Domestic Abuse included within training package</p>	<p>December 2025</p> <p>July 2024</p> <p>August 2024</p>	<p>December 2025</p> <p>July 2024</p> <p>August 2024</p>
<p>Recommendation 2 - HPFT to review guidance for making referrals to Adult and Children’s Services to include historic dynamics and patterns of behaviour.</p>	<p>Local</p>	<p>‘Making Good referrals’ guidance and 7-minute briefing to be reviewed to ensure consideration of historic dynamics and patterns of behaviour is included.</p> <p>All referral pathway flowcharts to be reviewed and updated with links to respective policies.</p>	<p>HPFT</p>	<p>Guidance and 7-minute briefing reviewed.</p> <p>Guidance and briefing circulated via QRMs.</p> <p>Flowcharts reviewed and updated</p>	<p>January 2025</p> <p>February 2025</p> <p>December 2024</p>	<p>Ongoing</p> <p>Ongoing</p> <p>December 2024</p>

<p>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.</p>	Local	<p>HPFT safeguarding team to follow up all verbal advice given with email summary including guidance to cut and paste into EPR.</p> <p>Where advice is given by email, include guidance to cut and paste into EPR.</p> <p>Recording section of adult and Child safeguarding training to be reviewed and updated.</p>	HPFT	<p>Written summary of advice given with guidance to include in EPR.</p> <p>Training slides include guidance to ensure includes need for clear recording of information informing decision making.</p>	<p>December 2024</p> <p>January 2025</p>	<p>Completed December 2024.</p> <p>Ongoing.</p>
<p>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.</p>	Local	<p>Discussion at Risk CQI group to help inform process/ documentation changes as required.</p>	HPFT	<p>Discussion at CQI panel.</p>	January 2025	January 2025
<p>Hertfordshire Children’s Social Care</p>						
<p>Recommendation 1 - Children’s Services to review processes</p>	Local	<p>Police ‘notifications’ to no longer be accepted as a referral. Police transition to submitting full Children’s Services referrals</p>	<p>Children’s Services and Police (overseen by</p>	<p>Transition conversations underway and referral tools drafted</p>	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

<p>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.</p>	<p>Local</p>	<p>The Better Me Better Us intervention programme currently used to be updated</p>	<p>CS Safeguarding</p>	<p>Roll out of the revised programme</p>	<p>March 2025</p>	<p>June 2025</p>
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