Welwyn Hatfield Community Safety Partnership

Domestic Homicide Review

Overview Report

Marie * (August 2017)

Author: Mary Mason
June 2021

Table of Contents

Tribute to Marie from her family and friends

Marie was a very much-loved mother, daughter, sister, and friend.

Her mother describes her as "caring, funny, affectionate, bubbly and kind. She didn't have a bad bone in her body."
One of her children said: "She cared for me, and she was my mum .... she would message 'How you doing?' I miss that."
Her friends have paid tribute to an "angel" who "was always there for a cuppa and a chat whenever you needed one."
A friend spoke of her "My dear friend, I will love and miss you forever. Rest in paradise until we meet again."
A neighbour described how "She always used to joke about taking our garden fence down …. we always helped each other out when needed, with a cuppa, chat or hug."
Friends described how Marie was mischievous, funny, and always 'made you laugh' was loyal, caring and was 'always there for you, whatever…'

"Marie a light as bright as yours can never be extinguished. You will shine forever."

1. Introduction

1.1 This Domestic Homicide Review (DHR) was commissioned by Welwyn Hatfield Community Safety Partnership (CSP) following the death of Marie by suicide in August 2017. An original Review reported in late 2018 but following a successful appeal by the family for the inquest to be re-heard and concerns about the first DHR, Welwyn Hatfield CSP decided to reconvene a panel under a new Chair and Author.

1.2 Hertfordshire County Council, on behalf of Welwyn Hatfield CSP, informed the Home Office of this decision on 19 March 2020. The

Home Office were told:

> *We are … consulting with the family of Marie regarding reconvening the Panel for this DHR. There was a high-profile criminal trial for this case, which saw the first conviction in the UK for controlling or coercive behaviour in an intimate relationship after the death of the victim.*
>
> *Unfortunately, both the Chair and Overview Report Writer for this DHR retired after the Panel signed off the report and it was sent to the family. Further to feedback from the family, and having reviewed the DHR, we feel there is much more learning to be gained. We will reconvene a panel as soon as is possible, in the current climate, and will appoint a Chair from our Approved List with the relevant expertise so we can produce a really thorough and well informed DHR.*

1.3 The first panel meeting of the reconvened DHR was held on 22 October 2020. This report examines agency responses and support given to Marie, who was born, brought up and resident in the Welwyn Hatfield Borough Council area of Hertfordshire prior to her death in 2017.

1.4 In addition to agency involvement the review will also examine the past to identify any relevant background or trail of abuse before the death of Marie, 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.

1.5 Marie was born in 1987. She was a young, white, British mother of three children and suffered from a traumatic history of domestic abuse, with all four of her significant intimate partners being abusive to her. She had her first child at 15 and the first three perpetrators of domestic abuse were also the fathers of her three children. The fourth, Christopher, was a serial perpetrator of domestic abuse. Marie was in a relationship with Christopher for approximately five months before she was driven to take her own life as a direct result of his coercive and controlling behaviour. Christopher was charged with five offences of assault, beating, and engaging in coercive or controlling behaviour under the Serious Crime Act, 2015. He was found guilty of controlling or coercive behaviour in an intimate relationship, assault by beating and assault occasioning actual bodily harm in March 2018. He was sentenced to four years and three months imprisonment, which included three months of a suspended sentence for cocaine possession in 2017.

1.6 The Judge also imposed a Criminal Behaviour Order, lasting 10 years, requiring Christopher to inform police of any sexual relationship he has in future lasting more than 14 days, and to notify police within 21 days of the start of the relationship. In summing up, the Judge said:

> *You inveigled your way into her affections and her house, and you then sought to dominate and control her. You treated her as a meal ticket that was yours to control. You treated her as a possession. You beat her and you ground her down and you broke her spirit.*
>
> *Her texts and Facebook messages show the contempt and hostility with which you treated her. You are by your own admission a jealous man. You regard women as objects to use as you wish.*

1.7 This report will consider the contact and involvement that agencies had with Marie, Christopher, and Marie's three children from the date of birth of Leo, when Marie was 15 years old, to the date of her death in August 2017 when she was 30 years old. In addition, this report also examines any relevant history of abuse and incorporates the views, thoughts and questions raised by Marie's family and friends.

1.8 The key purpose of DHRs is to enable lessons to be learnt from homicides/suicides where a person is killed as a result of domestic abuse. 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.

1.9 Marie called the police for help a number of times in response to domestic abuse. There were also other police call outs relating to domestic abuse and concerns about her care for her children while under the influence of alcohol. Marie was told about support services, mainly in relation to her children and once for domestic abuse, but she did not self-refer into agencies. She was not the subject of MARAC and not referred into IDVA services. The police

did not inform Marie about Christopher's history. They could have used Claire's Law to inform her about his previous abuse of women he was in an intimate relationship with.

1.10 Marie engaged with her children's nursery and primary school and with health and maternity services as well as health visitors, although eleven different Health Visitors were assigned to Marie over the years. Four different Children's Services assessments were carried out, all of which found that the children were safe in her care.

1.11 This DHR provides multiple opportunities for learning, including about recognising and responding to domestic abuse where thresholds for access to MARAC or Children's Social Care are not met. It also provides opportunity for learning about the impact of revictimization of intimate partner violence by multiple partners and the impact of trauma on Marie and on the children. Finally, through the lens of hindsight, we are able to examine how agencies responded to different situations and shared information. The learning this gives us will, we hope, prevent such tragedies in the future.

1.12 The panel wishes to express their condolences to Marie's family and friends; their contribution and steadfastness has been invaluable in providing essential background information and in making recommendations pertinent to the suicide of a young mother.

1.13 It is also with great sorrow that we have to report the death of Debra, Ella's paternal grandmother, who died in January 2021 whilst this review was still taking place. Debra's love for and loyalty to her grandchild drove her to ensure the inquest was successfully challenged and a second DHR take place. She will be greatly missed but her influence lives through this report.

1.14 The panel would also like to thank all those who have contributed to the review.

1.2 Timescales

1.2.1 A DHR notification was sent by the DHR sub-group Chair to Welwyn Hatfield CSP on 28 August 2017. The CSP Chair confirmed a DHR should be held on 29 August 2017. The Panel met six times (25 September 2017, 2 November 2017, 16 January 2018, 27 February 2018, and 19 June 2018) and reported in November 2018.

1.2.2 On 10 March 2020, the CSP Chair confirmed that the DHR Panel should be reconvened with a new Chair. The Home Office were notified on 19 March 2020. All Hertfordshire DHRs were suspended due to COVID on 30 March 2020 and resumed in July 2020. The Chair was identified from an Approved List of DHR Chairs and agreed to take on this DHR on 20 August 2020. This was formalised on 5 October 2020.

1.2.3 Once the new Chair was in place, the Panel met a further four times: 22 October 2020, 15 December 2020, 16 March 2021 and 22 April 2021. The report was approved by Welwyn Hatfield CSP on 21 June 2021.

1.3 Confidentiality

1.3.1 The findings of this review remained confidential and were only available to participating officers/professionals, their line managers, members of the domestic homicide review panel and the two family members who met with the panel.

1.3.2 To protect the identity of the family members, anonymised terms and pseudonyms have been used throughout this review. Pseudonyms have been agreed with the family and used in the report to protect the identity of those involved. Marie's mother, Lisa, assisted with and agreed the above tribute to Marie.

1.3.3 Marie, the victim was 30 years old when she was taken into hospital in August 2017. She died 3 days later.

1.3.4 Christopher, the Perpetrator was also 30 years old when Marie took her own life.

1.3.5 The three children are:

- Leo aged 14 when Marie died.
- Ella aged 11 when Marie died.
- Chloe aged 3 when Marie died.

1.3.6 The fathers of the children are:

- Jake father of Leo
- Andy father of Ella
- Tom father of Chloe

1.3.7 Lisa is Marie's mother.

1.3.8 Debra is the paternal grandmother of Ella

1.3.9 Grandfather is Debra's partner and Ella's step grandfather.

2. Terms of reference

2.1 Methodology

2.1.1 The review was conducted in accordance with the Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (2016) under Section 9 (3) Domestic Violence, Crime and Victims Act (2004).

2.2.2 Welwyn Hatfield CSP first commissioned a DHR in 2017, which reported on 20 November 2018. The delay in the review starting, following the initial notification, was due to the criminal trial of Christopher. The CSP reviewed the circumstances against the criteria set out in the Multi Agency Statutory Guidance for the conduct of Domestic Homicide Reviews (2013) and recommended that a Domestic Homicide Review should be undertaken. The Chair ratified the decision to commission a Domestic Homicide Review and the Home Office was notified on 31 August 2017. An independent chair and author were commissioned to manage the process and compile the overview report. The CSP, in partnership with the Hertfordshire Domestic

Abuse Partnership Board, decided to reconvene the DHR on 10 March 2020. There was a delay in appointing a Chair until October 2020 because the Home Office advised that work on the DHRs should be suspended during the pandemic.

2.2.3 The Panel first met on 22 October 2020 to agree the Aims and Key Lines of Enquiry, the timetable, and any further panel members. IMRs were also agreed at that meeting. The timetable for the Review was changed to 2003 to 2017, when Marie died. This was to include earlier history absent from the first review, which reported from 1 May 2014.

2.2.4 A full IMR was not requested from all agencies as most had already written a first IMR. All agencies were, however, asked to review their IMR and add further information to reflect the changed dates of the DHR. Further to this, the Chair met with all panel members individually to discuss their reviews in light of the changed Aims and Key Lines of Enquiry.

2.2.5 Aims and Key Lines of enquiry

The aim of this review is to:

i. Establish what lessons can be learned from Marie's death about the way in which professionals and organisations work individually and collectively to safeguard victims.
ii. Identify how and within what timescales those lessons are to be acted on, and what is expected to change as a result.
iii. Prevent domestic homicides and related suicide by improving the way services respond to all victims of Domestic Abuse and their children, through improved understanding and intra and inter agency working.
iv. Apply those lessons to service responses including changing policies and procedures as appropriate.
v. The timeline of this review to be from April 2003 to August 2017, when Marie died.

Key lines of enquiry:

i. Police attendances at Marie's home from April 2003 to August 2017, in particular but not solely on 17 July 2017.
ii. Police knowledge of the history of domestic abuse by Christopher, in previous relationships.
iii. Whether agency reports addressed both the 'generic issues' set out in the Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (2016) and the following specific issues identified in this particular case:
    a) The history of domestic abuse experienced by Marie.
    b) Marie's history of trauma and alcohol use.
    c) Marie's fear of having her children removed from her care.
    d) Whether Marie was offered support in approaching domestic abuse agencies for help and if not, why not?
    e) What support was offered to Marie's children around their experiences of domestic abuse?

f) What knowledge do agencies now have in general and historically about Marie's three children, about the impact of trauma on a child.
g) What knowledge or information agencies had that indicated that Marie and her children might be at risk of abuse, harm, or domestic abuse and how the agency responded to this information?
h) If any agency had information that indicated that Marie and her children might be at risk of abuse, harm, or domestic abuse and if so, whether this information was shared and if so, with which agencies or professionals?
i) If any agency had knowledge of Marie and her children which influenced professionals' decision making in any way. Whether bias impacted in any way on support and professional decision making. Whether this was related to direct and/or unconscious bias because of Marie's needs, her use of alcohol and her position as a single mother.
j) Whether agencies were then and are now limited by lack of capacity or resources and whether at the time this had an impact on the agency's ability to provide support to Marie and her children.
k) Whether agencies were limited by lack of capacity or resources and whether this had an impact on the agency's ability to provide support to or to prevent Christopher, from repeatedly perpetrating domestic abuse.
l) Whether lack of capacity or resources had then and have now an impact on any agency's ability to work effectively with other agencies.
m) Whether staff in all agencies are trained and supported in their practice around all areas of domestic abuse including coercive control.
n) Whether agencies are confident in asking questions about domestic abuse, particularly when the alleged perpetrator is at the meeting and including when the meeting is on-line.
o) Whether agencies are confident in how to respond to domestic abuse and know how to refer cases to other agencies.

iv. What changes have taken place in agencies since 2017 to address the needs of survivors of domestic abuse and prevent Domestic Homicides, including suicide? What further changes are required?

2.2.6 IMRs, including a chronology were requested and received from:

- Hertfordshire Constabulary
- Hertfordshire Community NHS Trust
- Hertfordshire Children's Services
- East and North Herts NHS Trust

Reports were requested and received from:

- Clarion Housing
- Victim Support
- Refuge

In addition, the Chair spoke with:

- Advocacy After Fatal Domestic Abuse (AAFDA)
- Bhatt Murphy Solicitors
- Dr Vanessa Munro, Professor of Law, University of Warwick
- Hertfordshire CC Strategic Partnership Team (Domestic Abuse leads)
- Hertfordshire Domestic Abuse Helpline
- Ludwick Nursery School
- Safer Places
- Trauma Recovery CIC (Herts)

2.2.7 All authors of the information reports were independent of the case (i.e., they were not involved in the case and had no management responsibility for any of the professionals involved).

2.2.8 In addition, the report author carried out research into domestic abuse and suicide, domestic abuse and multiple disadvantage, revictimization of intimate partner violence by multiple partners and trauma and alcohol use.

2.2.9 The Chair held a one-to-one meeting with all contributors to clarify and agree recommendations. The Panel then met in April 2021 to discuss and agree the final draft report. The report was agreed by Welwyn Hatfield CSP on 21/06/2021.

2.3 Involvement of family, friends, work colleagues, neighbours, and wider community

2.3.1 The Chair met with the paternal grandparents of two of the children, and Marie's mother on several occasions. Unfortunately, these have all been on Zoom due to COVID restrictions. Leo's father said that Leo did not feel able to speak to the Chair. The Chair spoke with Ella, who described a warm but difficult relationship with Marie. Ella experienced bullying in school at the end of last year which was hugely difficult for her and then her grandmother passed away in January 2021.

2.3.2 The Chair made several attempts to contact Marie's brother, friends and neighbours but did not receive a response. This was perhaps because they had already given evidence at the trial of Christopher. The Chair has therefore relied on witness statements from family and friends and information from the first review.

2.3.3 Ella's paternal grandparents contributed to the Review. Witness statements, from Marie's brother and friends taken by the police for the trial of Christopher and information from the Coroner's Office from the first inquest, have been used to gather information and evidence for this Review.

2.3.4 The Chair met with Ella's grandmother and Marie's mother prior to the first panel meeting in order to understand the main issues they were raising and to make sure this informed the Review itself. The terms of reference and scope of the review were shared with them, and they then attended the first meeting which agreed amendments to the draft terms and key lines of enquiry.

2.3.5 In addition, the family's advocate from AAFDA has been hugely supportive in facilitating contact. The family's solicitor, who represented the family so that the inquest was successfully overturned, has also been very helpful in ensuring papers from the Inquest were made available for this Review.

2.3.6 The family have been updated regularly. They have been sent the draft report to comment on and have been invited to the first part of the final panel meeting to discuss this.

2.3.7 All those who wished to contribute were able to do so but it should be noted that this has not been easy for the three children. The chair has offered to speak with all three children (one of whom is now a young adult) but has only spoken to one of the children, as the others did not wish to speak to her.

2.4 Review Panel Members

The reconvened panel met four times on: 22 October 2020, 15 December 2020, 16 March 2021 and 22 April 2021. All members were independent of the case (i.e., they had no direct management responsibility for any of the professionals involved in the case).

Mary Mason	Independent Chair
Louise Bayston	Senior Operations Manager, IDVA service, Refuge (domestic abuse specialist)
Anna Borella	Detective Chief Inspector, Hertfordshire Constabulary (substituted for DCI Walsingham at one meeting)
Vicky Boxer	Senior Social Worker, Spectrum CGL (Drug & Alcohol Specialist)
Sian Chambers	Head of Community and Housing Strategy, Welwyn Hatfield Borough Council (CSP rep)
Tracey Cooper	Associate Director or Adult Safeguarding, East & North Herts CCG and Herts Valleys CCG.
Sarah Corrigan	Children's Safeguarding Lead, E&N Herts NHS Trust
Louise Coulson	Senior Operations Manager, IDVA Service, Refuge (Domestic Abuse specialist). Superseded by Louise Bayston.
Danielle Davis	Senior Development Manager, Domestic Abuse, HCC. Local Authority Statutory Member.
Katie Dawtry	Development Manager Domestic Abuse, HCC. Previously Local Authority Statutory Member. Superseded by Danielle Davis.

Brenda Evans	Therapeutic Lead & Hertfordshire Manager, For Baby's Sake (ACE specialist)
Stephenie Evis	Named Nurse for Adult Safeguarding, East & North Herts CCG and Herts Valleys CCG (substituted for Tracey Cooper at one meeting).
Enda Gallagher	Adult Safeguarding Lead Nurse (ENHTT)
Alison Hopkins	Senior Probation Officer, NPS
Janet Jones	Head of Assessments, Children's Services, HCC
Sheila Middleditch	Safeguarding Children Nurse Manager, HCT
Rachel Millar	Senior Business Development & Communications Manager, Safer Places (Domestic Abuse specialist)
Susan Pleasants	Victim Team Manager, National Probation Service. Superseded by Alison Hopkins.
Grace Robertson	Clarion Housing (formerly Affinity Sutton Housing
Sue Thompson	Named Nurse Safeguarding Children & Rapid Response Lead Unexpected Child Deaths (for Sheila Middleditch)
Graeme Walsingham	Detective Chief Inspector, Herts Constabulary (Police representative).
Sarah Wells	Head of Operations (East), Clarion Housing (formerly Affinity Sutton Housing)

2.5 Author of the overview report

2.5.1 The chair and author of this review is Mary Mason. Mary is an independent freelance consultant and has never been employed by or has any connection with the Hertfordshire County Council.

2.5.2 Mary was formerly Chief Executive of Solace Women's Aid (2003-2019), a leading Violence against Women and Girls (VAWG) charity in London. Mary is a qualified solicitor (non-practising) with experience in both criminal and family law.

2.5.3 She has more than 30 years' experience in the women's, voluntary and legal sectors in supporting women and children affected by abuse. She has experience in strategic leadership and development; research about domestic abuse; planning and monitoring and evaluation of

programmes for Violence Against Women and Girls (VAWG). Mary has successfully adopted innovative solutions to ensure effective interventions which achieve results, increasing the quality of life of women and children.

2.6 Parallel Reviews

2.6.1 The criminal investigation was carried out by the Metropolitan Police, who were represented on this review panel and provided a full written report to the Panel.

2.6.2 The initial inquest was quashed and will be reconvened once this report is finalised.

2.7 Equality and Diversity

	Sex	Age*	Ethnicity	Disability	Religion	Marital status	Sexuality
Marie	Female	30	White British	None known	None	Single	Heterosexual
Christopher	Male	30	White British	None known	None known	Single	Heterosexual
Leo	-	Early teens	White British	None known	None	N/A	None known
Ella	-	Pre-teen	White British	None known	None	N/A	None known
Chloe	-	Under 4	African Caribbean and White British	None known	None	N/A	N/A

** At the time of Marie's death*

2.7.1 The perpetrator, Christopher, was a 30-year-old male at the time of the incident and the victim, Marie, a 30-year-old woman. Christopher met Marie when she was vulnerable, having survived at least three abusive intimate partner relationships, all of whom were with men. Christopher was violent and exercised power and control over her. From evidence given at his trial, his criminal history, history of domestic abuse and evidence from an army friend, he was violent and abusive to women he was in intimate partner relationships with and exhibited misogyny towards women generally.

2.7.2 This violence and abuse fits into a pattern of male violence against women. Whereas both men and women may experience incidents of inter-personal violence and abuse, women are considerably more likely to experience repeated and severe forms of abuse, including sexual

violence. They are also more likely to have experienced sustained physical, psychological, or emotional abuse, or violence which results in injury or death.

2.7.3 The important differences between male violence against women and female violence against men - namely the amount, severity, and impact of the violence and abuse - is well researched. Women experience higher rates of repeat victimisation and are much more likely to be seriously hurt (Walby & Towers, 2017; Walby & Allen, 2004) or killed than male victims of domestic abuse (ONS, 2019). Further to this, women are more likely to experience higher levels of fear and are more likely to be subjected to coercive and controlling behaviours (Dobash & Dobash, 2004; Hester, 2013; Myhill, 2015; Myhill, 2017).

2.7.4 The focus of attention of services was on Marie as a mother rather than the fathers of the children, all of whom were abusive to Marie. The perpetrator was therefore missing from assessments, and the extent of the abuse Marie was experiencing also partially hidden.

2.7.5 The marital status of Marie was considered alongside her status as a single mother. All agencies were asked if this led to any bias in the way in which Marie was treated as a young single mother. All reported this was not the case, but it should be noted that unconscious bias can impact negatively on interpersonal relations and agency treatment of different groups of people.

2.7.6 Marie had her first child at 15. The father of her first child was abusive, and Marie experienced verbal and physical abuse and controlling behaviour. Being abused so young established a pattern for Marie, whereby men she was in a relationship with would abuse her, which impacted on both her and her children greatly. A Public Health England (PHE) report, entitled 'No Child Left Behind' (2020), highlights associated individual risk factors for pregnancy before the age of 18. The PHE and Local Government Association Framework for supporting teenage mothers and young fathers identifies and addresses risk factors which make children more vulnerable. It also describes the types of interventions and approaches which can mitigate these risk factors. It recommends a dedicated trusted adviser for young parents, who identifies and coordinates additional support to meet individual needs.

2.7.7 Although Marie suffered from postnatal depression, panic attacks and depression, these were intermittent and did not fall within the scope of disability. Christopher served in the army in a tank unit for five years and served in Iraq and Afghanistan. The Police and his friend and colleague suggested he might have post-traumatic stress disorder following his term in the army. His friend thought that his use of cocaine had a negative impact on his mental health and his behaviour. There is no record of a mental health diagnosis.

2.7.8 There is evidence that Marie was self-medicating with alcohol and that Christopher was using cocaine which he shared with Marie. There is no evidence that Marie used cocaine independently of Christopher, but the post-mortem shows she had used cocaine heavily prior to her death.

2.7.9 Marie received state benefits and did not work after her youngest child was born. She had previously worked as a cleaner. She found school attendance for her children intimidating. The question of whether local services are tailored to meet the needs of young, working class,

single mothers should be considered as part of the Public Equality Duty as set out in the Equality Act, 2010.

2.7.10 Equality and diversity, as set out in The Equalities Act 2010, was considered throughout the review process including age, disability, race, sex, and religion.

2.8 Dissemination

In addition to the organisations contributing to this review, the following will receive copies of this report for learning within their organisations.

Name	Agency	Position/ Title
Mary Moroney	Hertfordshire County Council	Safeguarding Boards Manager
Kay Lancaster	Hertfordshire Constabulary	Head of Serious Crime and Safeguarding Command and Chair of the Hertfordshire Domestic Abuse Partnership Board
Jenny Coles	Hertfordshire County Council, Children's Services	Director of Children's Services
Chris Brace	Office of the Police and Crime Commissioner	Chief Executive
Kevin McGetrick	Office of the Police and Crime Commissioner	Head of Commissioning and Victim Services
Amanda McIntyre	For Baby's Sake Trust	(Domestic Abuse Executive Board's voluntary sector representative)
Jane Kinniburgh	Herts Valleys Clinical Commissioning Group	Director of Nursing and Quality
Jane Padmore	Hertfordshire Partnership University NHS Foundation Trust	Deputy Director of Nursing
Joanne Doggett	Hertfordshire County Council, Public Health	
Chris Badger	Hertfordshire County Council, Adult Care Services	Director of Adult Care Services
Neeve Bishop	National Probation Service	Head of Hertfordshire NPS
Mary Emson	East & North Herts CCG and Herts Valleys CCG	Designated Nurse for Safeguarding Children

Ka Ng	Welwyn Hatfield CSP	Chair
Sarah Browne	Hertfordshire Community NHS Trust	Director of Nursing and Quality

3.1 Background information

3.1.1 Marie lived in Hertfordshire with two of her three children and Christopher, the perpetrator, who was her partner of five months when she died in August 2017.

3.1.2 The ambulance service responded to a call from Christopher stating that he had found Marie hanging in the home, after returning from work. Marie was found to have a pulse, resuscitation was attempted at the scene and Marie was taken to the local hospital, where she was admitted to intensive care. She had suffered terminal hypoxic brain injury due to oxygen deprivation and three days later died after brain stem death was confirmed and ventilation withdrawn. Family members had been with her.

3.1.3 Marie was born in Hertfordshire in 1987 and was the youngest of two children. During their childhood, Marie and her brother spent much of their time with their maternal grandparents and their aunt as their parents were busy working.

3.1.4 Marie had three children and her youngest was aged under four when Marie died. She was 15 years old when her first child was born - she was abused by the child's father. Marie had two further children and, in both cases, she was abused by the children's respective fathers.

3.1.5 Christopher was not the father of any of her children and did not have children of his own. Her middle child, Ella, was living with her paternal grandmother and her step-grandfather at the time of Marie's death and Leo and Chloe were staying with Chloe's father in London for two weeks.

3.1.6 Christopher was charged and in March 2018, found guilty of five offences of engaging in coercive or controlling behaviour in an intimate relationship under the Serious Crime Act 2015, assault by beating and assault occasioning actual bodily harm. He was sentenced to four years and three months imprisonment which included three months of a suspended sentence for cocaine possession in 2017.

3.1.7 The Judge also imposed a Criminal Behaviour Order, lasting ten years, requiring Christopher to inform police of any sexual relationship he has in future lasting more than 14 days, and to notify police within 21 days of the start of the relationship.

3.1.8 A DHR was agreed in this case based on the Judge's finding in the Criminal Court trial that Christopher had exerted considerable influence on Marie, and that his coercive and controlling behaviour led to her death.

3.9 Chronology

Christopher: History of perpetrating domestic abuse obtained from police and A&E records

DATE	Victim	Agency	Risk/crime?
May 14	A	Police	Non-crime domestic
June 14	A	Police	Common assault – no injury. NFA
Dec 14	B	Police	NFA
March 15	B	Police	Non-crime
March 15	B	Police	Non-crime – low risk
March 15	B	Police	Non-crime
June 15	A	Police	Common assault – no injury
June 16	C	Police	Charged. Then NFA.
June 17	Marie	A&E	No crime reported
July 17	Marie	Police	Non crime – standard risk
Aug 17	Marie	Police	Coercive and controlling behaviour

Marie: History as victim of domestic abuse obtained from police and A&E records

Date	Marie's age	Perpetrator	Police	Detail	Children present
April 03	15	-	-	Leo Born	-
June 03	15	Marie's Father	Attend	Non-crime.	Leo and Chloe
Feb 04	16	Jake	Charged affray.	Charges dropped	-
Feb 04	16	Jake	Threats to kill	NFA	Leo
June 04	16	Jake	Threats to harm	NFA	Leo

June 04	16	Jake	Criminal damage	NFA	?
April 06	18	L	Attend	Non-crime	?
June 06	18	-	-	S born	-
April 10	22	Andy	Medium risk domestic abuse	Caution	No
April 10	22	Andy	Domestic Abuse - physical	Targeted advice	?
Nov 10	22	Andy	Case closed	Non-crime	Leo – concern raised
Nov 13	26	-	-	M born	-
Dec 14	27	Marie	CS Assessment	Incident with Marie and S	Ella
May 15	27	Tom	Standard risk Domestic Abuse	NFA	Chloe
June 17	29	Christopher	A&E	Marie head injury	No
Aug 17	30	Christopher	Police attend and later charge Christopher	Marie taken to hospital and dies on 26.8.17.	Children with relatives

3.3 The Facts

2003 – 2006

3.3.1 Marie had her first child, Leo, in 2003, when she was 15 years old and living at home with her mother. She was in a relationship with Jake (aged 17), Leo's father, who moved into live with

Marie before Leo was born. A non-crime domestic incident is recorded by the police in June 2003, involving Marie's father who had left the family home the previous year and had returned to collect his belongings. There are no Children's Services referrals for this family prior to 2002 when Marie became pregnant.

3.3.2 Marie suffered postnatal depression after the birth of Leo. She also had a difficult relationship with her mother and struggled with the baby's care. She received support from the Health Visiting Service during this period with frequent home visits in the two months following his premature birth at thirty-two weeks. Records show that Marie was not always meeting Leo's needs in a timely manner (for example, immunisation). However, there were no concerns that Leo was at risk of significant harm. She moved into her own Housing Association house with Jake and Leo early in 2004.

3.3.3 Jake was abusive to Marie with four recorded incidents by the Police of domestic abuse in four months in the first half of 2004.

3.3.4 Following the first incident, Jake was charged with affray, but the case was later withdrawn. Two months later, he threatened Marie in the presence of their 14-month-old child, and in front of the police saying: *'I'm going to burn you and crucify you*'. He was arrested, bound over to keep the peace and a referral was made to Children's Services. The following day, he was arrested for threats to kill after neighbours reported a disturbance, No Further Action (NFA) was taken. By 2004, Jake was no longer living in the property and police were called when he was attempting to gain entry. NFA was taken.

3.3.5 In October 2004, the Health Visiting Team received its first communication from Hertfordshire Children's Services (CS) about this family. The records about what action was taken are not available.

3.3.6 In November 2004, Leo's speech development was investigated, linked to possible developmental delay. Marie did not attend an initial appointment, resulting in his speech being monitored by the Health Visitor (HV).

3.3.7 The Children's Services referral in April 2004 resulted in a core assessment being carried out with the case being closed in July 2005. There are no records of any referrals to support services, but an anonymous referral to the NSPCC, alleging safeguarding concerns, was forwarded to Children's Services in June 2005. Leo's nursery were informed so they could monitor his progress and the Health Visitor was informed so she could support the family. It should be noted that Marie was only seventeen at the time.

3.3.8 In 2005, the family were under the care of HV4. Two different concerns were raised about Leo in relation to possible neglect and bruising. HV4 supported Marie and undertook two home visits during 2005. Full details are not available. Health Visitors reported that Leo was not always taken to his appointments in a timely manner.

3.3.9 By June 2006, Marie was in a relationship with Andy and gave birth to Ella, her second child. It was routine practice to enquire about domestic abuse at the booking appointment at the time of both this and her previous pregnancy but there is no record of domestic abuse being disclosed and it is not certain from the records whether the questions were asked. Andy was 19 years old.

2007-2010

3.3.10 Between 2007 and the end of 2009, there were four reports to the police involving Marie. None involved domestic abuse or a serious incident but two concerned the care of the children. A referral was made to Children's Services, who also received an anonymous referral in April 2009, raising concerns about Leo and his care. An initial assessment was completed in August 2009 -this included a home visit which had possibly been planned. No professional concerns were found, and the case was closed to Children's Services.

3.3.11 An anonymous report was made to the police in Oct 2009, raising concerns about Andy selling drugs and Marie drinking. This is the first referral to Children's Services which mentions Marie's use of alcohol. A referral was made to Children's Services was logged for information only as there had been a recent initial assessment.

3.3.12 In April 2010, Marie called the police and reported that Andy had punched her in the head and smashed a window. She said that this had happened before, but she had not reported incidents to the police. The children were at their grandparents at the time and Andy was arrested and cautioned. The incident was logged as medium risk by the police.

3.3.13 A further incident took place later the same month when Andy pushed her face into the sofa and smashed a window. Andy was not arrested, and advice and information was given. Although not recorded, it is likely that the children were present, and a referral was made to Children's Services who recorded this referral as 'for information only'. No rationale for this was given.

3.3.14 Another referral was made to Children's Services in June 2010 from a neighbour reporting verbal and physical fights late into the night and distressed children. An initial assessment was undertaken, and the file note states that the concerns were not substantiated. Marie reported she was no longer in a relationship with Andy, and she was referred to the Sunflower Centre. This was a domestic abuse drop-in centre in Hertfordshire at the time and so we can assume this was signposting rather than an actual referral. There are no records to confirm whether or not she followed this up.

3.3.15 A third-party investigation by the police in July 2010 notes that Marie was a possible witness to an assault but was too intoxicated to respond to their query.

3.3.16 The Health Visiting team were now using SystemOne and record keeping improved. HV4 knew Marie and had worked with her since 2005. She discussed the above incident with Marie at a child health clinic in April 2010. It was recorded that Marie had separated from the perpetrator, but no details were given of any exploration of domestic abuse to explore the context and also whether there would be continued child contact with Ella's father.

2011-2012

3.3.17 There are no records of domestic abuse or drug or alcohol use during this period. Marie's relationship with Andy had ended by mid-2010 and by January 2013 she was in a relationship with Tom. It is significant that there are no concerns raised or reports about Marie or her care for her children for over three years (June 2010 to November 2013), when was not in a relationship and not experiencing domestic abuse.

2013-2015

3.3.18 Marie had a child, Chloe, with Tom, in November 2013. Marie received maternity care during her pregnancy. Domestic abuse enquiry in maternity services had changed to reflect a more effective process of recording and evidence that domestic abuse enquiry had taken place. However, there is no recorded evidence that routine domestic abuse enquiry took place and Marie was discharged with no safeguarding concerns raised. The Trust recognises that there was a missed opportunity to open up a dialogue about domestic abuse with Marie during this pregnancy. Thereafter, Marie and Chloe were seen by professionals on four different occasions, once at home and once with a paediatrician. There was no mention of domestic abuse. These appointments related to concerns about Chloe's speech and her development. She was referred to a special needs HV in February 2017. The HV was to liaise with the nursery and suggested a 'Team Around the Family' was put in place. This had not happened, and Chloe was waiting for speech and language therapy when her mother died.

3.3.19 Shortly before this, an NSPCC referral was passed to Children's Services with concerns about the two children regarding Marie's alcohol use. These were passed to the Targeted Advice Service (which has since been replaced by a Multi-Agency Safeguarding Hub - MASH – and Families First Triage), who were unable to make contact by phone. A letter was sent to Marie. The Police also received a report in November 2013 from Marie's uncle, who raised issues about the paternal grandparents of Ella. The police record states that Hampshire Social Services were involved and were treating the calls from the grandparents as malicious. It is not clear from the files why this was the case.

3.3.20 In late 2013, Ella's paternal grandparents made an application to the Family Court for contact with both Leo and Ella, who they had not seen regularly for several months. Previously, they had seen both children very regularly for weekends and had taken them away on holidays abroad. The relationship between Marie and the grandparents had become difficult due to what Marie felt was undermining criticism about her parenting and reports to Children's Services with concerns about the children. The Court ordered an interim contact order.

3.3.21 In November 2013, a home visit took place with HV5. The files do not document any discussion about domestic abuse within current or past relationships. Postnatal depression was noted as a risk and a follow up review of Marie's emotional health and wellbeing was due to take place at three months. Unfortunately, this visit did not occur. This is recognised as a missed opportunity by the HV team.

3.3.22 In December 2013, Marie was diagnosed with postnatal depression by her GP and prescribed medication. In March 2014, she reported panic attacks to her GP. The medical records do not show that domestic abuse was explored, or questions asked about domestic abuse by the GP.

3.3.23 Marie's Housing Association (Clarion) referred to four reports of anti-social behaviour (associated with parties, loud music, cannabis use and drinking) during 2014 and although letters were written to Marie, there was no follow up and the case was closed after each report, with the pattern of antisocial behaviour not being recognised by Clarion.

3.3.24 In October 2014, HV6 had contact with the family for Chloe's one year development review; Tom also attended. Marie said she was well, and no questions were asked about domestic abuse as her partner was present.

3.3.25 In November 2014, Ella disclosed an incident to her grandmother. She said her mother had been drinking and pulled her downstairs by the hair. As a result, Ella's grandparents applied to the Family Court for a Child Arrangement Order that Ella live with them. Marie was not represented at hearings but was supported by her mother.

3.3.26 The Court ordered that Marie had a hair strand and liver function test. This did not happen as the Family Courts Fact Finding Hearing (February 2015) found that, on the balance of probabilities, the incident reported by Ella did take place and that Marie did assault Ella while under the influence of alcohol or illegal drugs. A Child Arrangement Order for Ella was made by consent for Ella to reside with her grandparents and to have regular contact with her mother. The Court also ordered the Social Worker in the case to explain why she failed to appear at the Dispute Resolution Hearing despite a Court Order to attend.

3.3.27 HV7 provided information for the Section 17 assessment at the end of 2014, and she took part in a S47 strategy call. Domestic abuse was not noted as a risk factor but there were concerns about Marie's use of alcohol. A vulnerability icon was activated to highlight this risk, though it was not clear what steps were put in place to reduce any risk to Chloe, who was 13 months old.

3.3.28 In January 2015, Marie and Andy separated.

3.3.29 A Children's Services assessment was completed in March 2015. During the assessment, Marie said that Andy was violent and used drugs. She denied assaulting Ella and that she had any alcohol issues. It is noted that the grandparents had been granted a Child Arrangement Order with residency of Ella. The assessment concluded that there was no proof of safeguarding concerns for Chloe and good observations of Chloe and Marie together but that there were some supervision concerns.

3.3.30 The case was stepped down to universal services with the Oak Tree Children's Centre outreach worker taking responsibility for the plan. A home visit took place in April 2015 and a centre visit in June 2015. Advice was given about centre activities although Marie did not take these up. There are no further records of contact with Marie until September 2016, when Chloe was offered a place in Ludwick Nursery.

3.3.31 The Nursery had no record of any family involvement with Children's Services, and no record of domestic abuse or substance misuse linked to the family. Their records showed that the family were not known to the onsite Children's centre and there was no Family Worker involvement. Oak Tree Children's Centre had been involved with the family, a Child in Need meeting on 24 March 2015 showed the Outreach workers' involvement both at the meeting and for case work follow-up. Although records were available, this information was not passed to the Nursery School.

3.3.32 Between May and October 2015, there were in total four reports to the police raising concerns about Marie being intoxicated while caring for a child (two anonymous reports, one by Ella's grandmother and one by Leo's school). One of the reports was forwarded to Children's

Services. During the same period, there were two reports to Children's Services, including one anonymous referral in June 2015 and one from NSPCC in September 2015. Both raised concerns about Marie being intoxicated while caring for a child.

3.33 The Police carried out a welfare check of Marie and children on 07 May, following an anonymous report that Marie was intoxicated while caring for her child. The police log references a non-crime domestic abuse report following a verbal argument with Chloe's father, Tom. He had removed Chloe from the home as he said Marie was drunk. The Police log shows attendance and no issues at the house. The incident was referred to Children's Services.

3.34 On 13 May, a second referral from an anonymous source was received by Children's Services, outlining concerns regarding Marie's heavy drinking of alcohol when she had the children in her care, and also concerns relating to her care for Chloe and conditions in the home.

3.35 HV7 attempted to contact Marie on two occasions following the domestic abuse incident in May 2015 but was unable to get a response so left her details asking Marie to call her back. The family were not discussed in supervision, possibly due to incidents being considered separately. It is not clear that Marie's history was ever reviewed as a whole by the Health Visitor service.

3.36 A Children's Services Assessment was completed in July 2015 and concluded that the family were not engaged with community support activities to assist Marie with her parenting. Alcohol and wellbeing scale checks were carried out with no concerns in either area. Leo raised issues about missing his sister and his worry that the assessment might lead to his and Chloe's removal from the family home. It was explained that this would not happen as long as he was safe with his mum.

3.37 The report was very thorough and concluded that there was no evidence to substantiate the concerns raised, although issues were raised about Marie not engaging with services. Advice was given to her about community support activities, but no plan or strategy was put in place to help her engage with these or other support.

3.38 A further Children's Services assessment was carried out in November 2015, following a referral from NSPCC alleging Marie was intoxicated while caring for her children. The assessment was about alcohol use and Marie's ability to care for her children. Marie denied the allegations and said she felt they were malicious and from Debra (Ella's grandmother). Concerns about alcohol use were raised as well as Marie's wellbeing. The Children's Services social worker's assessment noted that Marie was of low mood, and linked this to her alcohol use, but did not feel that the health or development of Leo or Chloe were at risk of significant harm. It was noted that Marie was not engaged with community support, and advice was again given to her about activities open to her and the children.

3.39 Concerns about the number of referrals were raised with Marie, and the report noted that both Leo and Ella had been worried about their mother's alcohol use. Leo also spoke fondly about his mother and sisters and laughed about things they had discussed and done together. Chloe showed an emotional bond towards her mother by hugging and kissing her and was comforted by her when she has been unhappy during home visits. The report notes emotional warmth in the home.

3.40 The assessment report acknowledges the impact of Ella moving to live with her grandparents which undoubtedly caused Marie additional stress, but also upset Leo a great deal as he was close to his half-sister. Marie told the social workers she would like Ella to return to her care and was looking into how best to do this. The report also notes the impact on the children of alcohol use but does not explore the reasons for Marie's alcohol use and does not link this to domestic abuse.

3.41 No evidence was found to substantiate the concerns raised in the referral and the case was closed. The outcome of the assessment was shared with the GP, HV and Leo's school.

3.42 The HV team received various communications from Children's Services between August and December 2015, but it is noted that there was minimal liaison between Children's Services and the HV team and a lack of professional curiosity by HV9 in regard to understanding the social worker's input with the family and any safeguarding concerns.

3.43 HV10 assessed that as Children's Services had closed the case, Chloe was no longer vulnerable and so deactivated the vulnerable icon on Marie's file. It was noted that given Marie's history and the difficulty the HV team had in establishing contact with Marie, it would have been preferable to leave on the icon at least until after Chloe's two-year development review.

2016

3.44 Chloe was seen by the community physician towards the end of 2016 and was referred for speech and language and hearing assessments and to the Specialist Health Visitor service. She was added to the waiting list for speech and language therapy. The Specialist HV visited Marie and Chloe in February 2017, liaised with the nursery, and suggested a 'Team Around the Family' meeting. There are no records to suggest this took place and no further contact is recorded. The Specialist HV records are not shared with the Health Visitors team who use different recording systems.

3.45 The HV team attempted contact with Marie to arrange the two-year development review between March and June 2016. A Nursery Nurse (NN2) visited the home in June and saw Leo when he returned home from school. He said his mother was sleeping but it was not clear where Chloe was and NN2 did not enquire any further. She did, however, see Marie on 14 June 2016 and referred Chloe to the Speech and Language team.

3.46 A further report was made to the police in August 2016 by Ella's grandmother, who had received a text from Ella saying her mother was drinking and a neighbour was bullying her. Ella had been dropped at her mother's house by an aunt who collected her and took her to her great-grandparents house. Welfare checks were made. The police reported no concerns for Ella's welfare. There was no referral to Children's Services, but the Police noted that given Marie's history, a referral could have been made to Children's Services.

3.47 During 2016, Chloe was seen by the Community Paediatrician as her speech and language were not age appropriate and there were concerns about her social and emotional development. Following a finding of mild 'glue ear', she was referred to the special needs HV in late 2016. The HV carried out a home assessment in early 2017 (before Marie started a relationship with Christopher) and liaised with Chloe's nursery. She suggested a possible 'Team Around the Family' meeting, but this did not take place and it was unclear from the

notes who was responsible for this. There is also no record of routine domestic enquiry in the HV notes.

2017 (including Christopher's background)

Christopher

3.48 From November 2013, Christopher was known to Hertfordshire Constabulary in respect of several minor criminal matters as well as for domestic abuse. In November 2013, he was arrested for driving a car without insurance and deception. He was cautioned and told the police he had debts of £10,000 and was a casual cocaine user. In June 2016, he was arrested and in February 2017, he was sentenced to nine months imprisonment suspended for 18 months, for possession of a stun gun, and a 12-month conditional discharge for drug possession.

3.49 Probation interviewed Christopher for the Pre-Sentencing Report (PSR). He stated that he had no children and was not in a relationship at that time. A probation report was prepared proposing a Community Order with requirements, but the Court did not follow this recommendation and no supervision by Probation was ordered. The report did not include Christopher's domestic abuse history, as probation do not receive reports of domestic abuse from the police as matter of routine. If the PSR had included his domestic abuse history, the Court may have put a Community Order in place with requirements, and domestic abuse/safeguarding checks would have been completed on an ongoing basis as part of his risk management.

3.50 Christopher is one of three children. His father died several years ago, and he is understood to have sporadic contact with his mother. He served in the army between 2005 and 2010. Since leaving the army, he has worked in scaffolding and labouring jobs. His was employed as a driver with a local company when he was arrested in August 2017.

3.51 Christopher was known to Hertfordshire Constabulary as a perpetrator of domestic abuse in three different relationships with women during 2014/15:

a) In 2014 -15, he was involved with AN, who called the police three times: twice for common assault and once for a non-crime incident. They were all marked as NFA. A DASH risk assessment was carried out (2 ticks) and concluded that the abuse was getting worse, and Christopher may have unresolved mental health: '*possibly PTSD issues, male party was in the army in a tank unit for 5 years, in Iraq and Afghanistan has told female party that he has killed before'.* The incident was referred to Victim Support and although the crime enquiry screen is endorsed as '*fully signposted all safeguarding third-party agencies' and 'there is concern raised for mental health'*, there are no records as to which third-party agencies were being referred to. Victim Support records do not refer to Christopher's mental health and only state '*no consent to contact and so case closed*'.

b) He had a relationship with two other women during 2014/15. One called the police when he made threats, verbally abused, and intimidated her. Another called the police three times – all were recorded as non-crime verbal abuse with threats.

3.52 In total, seven domestic abuse reports were made to the police over a 12-month period.

3.53 A previous relationship of Christopher from around 2012 was also identified by police following Marie's death. Christopher had physically and emotionally abused her and told her

to '*go and hang herself*'. An ex-army colleague and friend of Christopher gave an account of his history, describing him as an emotional bully towards women. He spoke about a second relationship where Christopher made threats. He felt that due to Christopher's abuse of alcohol and cocaine, he became paranoid and suspected him of having an affair with his girlfriend. As a result, their friendship ended, and Christopher moved to Welwyn. He describes Christopher's abuse of drugs and alcohol as worsening, and he lost contact with him for about a year.

3.53 In February 2016, Christopher contacted this friend. He believed Christopher had just come out of a relationship and states they got on initially, but again Christopher's behaviour deteriorated as his cocaine abuse grew. In 2017, he and Christopher reconnected, and he said he had met a girl called Marie. He recalls an incident when Christopher called him and said he and Marie had been play fighting and he had to take her to hospital. Later the same day Christopher called again asking to meet for a beer. He said he felt *'like s**t'*, and that he had bust Marie's head open out of temper, and there was no play fight.

3.54 A few weeks after this incident, Christopher called again, crying, and saying he was living in his car as Marie had kicked him out. The friend told Christopher that he did not want to know him.

3.55 Victim Support received two referrals for Christopher, and both were not actioned and recorded for information only.

2017

3.56 Sometime in March 2017, Marie met Christopher in a pub. He moved in to live with her and the children a short time later.

3.57 Christopher was intimidating and bullying from the beginning. Neighbours reported that he was *'normal and friendly'* to begin with and they were surprised when it became apparent how he was actually behaving. Marie told friends that he was controlling her, was violent and she wanted to end the relationship.

3.58 After her death, the Hertfordshire Constabulary investigation revealed, through reports from friends and neighbours, that Christopher had physical assaulted her during their relationship. We are aware of at least four different assaults on her by Christopher, which resulted in bruising, and in August 2017, a black eye.

3.59 His controlling and coercive behaviour had included taking charge of her bank card, accusing her of being unfaithful, disapproving of her having friends and checking up on her. He also displayed sexually provocative behaviour by standing naked in full view of neighbours, which upset and angered Marie. Under Christopher's control, Marie quickly became isolated and frightened.

3.60 The police investigation revealed that Marie had told friends that Christopher had strangled her and hit her. The picture we have is of a violent, threatening and controlling man, particularly in relation to intimate partners.

3.61 Police evidence describes text messages which show *'a repeated theme whereby Marie is expressing feeling worthless, being put down and feeling like a controlled prisoner. She disclosed to her friend's violence within the relationship and feeling trapped.'*

3.62 Christopher also isolated Marie – her mother reports that she saw little of her after she met Christopher, despite them meeting very regularly before this.

3.63 The impact on the children, who were living in the house with him, was profound. They disliked him intensely and were scared for their mother as well as being worried about being separated from her. On an infrequent visit to Ella, due to the physical distance between them, Christopher insisted he and Marie left quickly. Despite travelling over 100 miles to see Ella for her birthday, and not having seen her for over a year they left, they left after only an hour at Christopher's insistence. Ella described her mum and Christopher of '*stinking of alcohol*' and that '*you could tell she was scared to stand-up to him*.'

3.64 A friend from Chloe's nursery recalled Marie as friendly and having casual chats before and after nursery. This ceased around June 2017, when Marie became more distant.

June 2017

3.65 Marie attended the Urgent Care Centre in the QEII Hospital with Christopher. She had a cut on her head which was cleaned and glued. She explained that they had been '*messing about'* and she had hit her head on the wooden patio door. They stayed together throughout the consultation and Marie was not asked about domestic abuse. The staff member did not suspect domestic abuse and when asked, reported that they appeared to be at ease in each other's company.

3.67 In the police investigation into Marie's death, evidence was given that this was a non-accidental injury. Christopher's friend (see above) informed the police that Christopher told him he had *'bust her head open'* and '*there was no play fight'.*

9 July 2017

3.68 A neighbour's visiting sister called Hertfordshire Police and gave an incorrect name, as she wished to remain anonymous. The log was endorsed and said:

> *'Informant can hear a lot of shouting and banging – 2 children – 1 child has gone to in (sic) but not saying much as autistic.'*

3.69 The police attended, by which time only Marie and Christopher were in the house. The police confirmed that records for both parties would have shown that Christopher was a serial perpetrator of domestic abuse, and that Marie was a repeat victim, although there had not been a recent call out. Both parties' records would have been checked before the police attended the scene.

3.70 Two officers attended and questioned both parties separately but one of the body cameras did not work; the officers therefore shared one camera which resulted in some of the informal discussion not being recorded. Marie was spoken with alone. Marie said there had been a verbal argument and that she did not want to provide details of the children as she was fearful that social services might remove them. The officer encouraged her to complete the DASH and

reassured Marie that Children's Services would offer support to her. The significance of this remark for Marie, reflecting her fear of social services involvement, was missed by the officer who did not go on to speak to the children.

3.71 The officer described Marie as visibly very upset, but that she did answer the DASH questions. The Police have not been able to find the DASH record itself, but as there were only six ticks on the DASH Risk Assessment, the case was marked by the Police as standard risk. Please note there was some discrepancy in the documentation, but Hertfordshire Police have confirmed this record:

> *Q2: Are you very frightened:*
> *A: Yes*
>
> *Q3: What are you afraid of? Is it further injury or violence?*
> *A: He is a very angry person*
>
> *Q5: Are you depressed or having suicidal thoughts:*
> *A: Yes 'depression'*
>
> *Q15: Does xxx try to control everything you do and/or are they excessively jealous?*
> *A: Yes, gets angry when I'm not at home or answering the phone*
>
> *Q21: Has xx had problems in the past year with drugs, alcohol or mental health leading to problems in leading a normal life?*
> *A: He has been in loads of fights.*
>
> *Q24: Do you know if he has been in trouble with the police or has a criminal history?*
> *A: He has been arrested before*

3.72 One of the officers present was trained as a DVERO officer (domestic violence emergency response officer) and so would have been trained to use his professional judgement to override the tick box process. The answers to the assessment show a high level of control by Christopher and Marie's fear and depression. It is significant that the officers do not appear aware of the implications of this, particularly given Christopher's history. The result was that the officers did not make a MARAC referral nor a referral to the specialist Domestic Abuse Investigation and Safeguarding team (DAISU) and did not use Clare's Law to inform Marie of Christopher's history. Knowing about Christopher's history of violence to women, this may have helped her to understand her level of risk from him.

3.73 A Family Front Sheet (Child Referral Form) was completed by the officer in the case and endorsed *'criteria for automatic Police referral to Children's Services are met, in that there has been previous involvement within the agreed time parameters'* and '*child under 5 highlighted for health'*. A check box is completed for both children but is clearly incorrect as it shows that the children were not seen by the officers but that they were in the house at the time of the incident but did not witness it.

3.74 Records also show that the police were called away to a robbery, but that there was not a police resource issue at the time.

3.75 Hertfordshire Police have accepted that there should have been a house-to-house enquiry and that further checks should have been made to establish that the children were safe and well.

3.76 The police investigation following Marie's death revealed further information, which is recorded here, as it brings to light the actual events on the 9 July 2017 and the extent of the missed opportunity.

July 2017:

3.77 The HV team received police notification of the incident on 9 July, detailing a verbal argument between Marie and Christopher. HV11 reviewed the files and attempted to contact Marie. She noted that the domestic abuse notification was at standard risk, that there had not been other recent domestic abuse incidents and therefore a home visit was not required. HV11 also noted that Chloe was accessing speech and language therapy appropriately and making progress.

August 2017

3.78 On the morning of 23 August, Christopher and Marie argued before Christopher left for work. There followed a series of texts between them, made between 7 and 8am, where Marie tells Christopher how bad he made her feel, that she could take her own life, and that he had already told her she would be "doing everyone a favour".

3.79 It is important to note that Marie's friend and her uncle had taken their life by hanging, a matter referred to below. A record of the communication between Marie and Christopher ended as follows at 7.50am:

> *Everything I tell you you throw back in my face, my xxx and xxx hanging themselves. You throw it in my face so maybe it's my time now as well as you keep saying, do everyone a favour*
>
> *You no I would as well cos tried before. You keep saying I will do everyone a favour so why not just do it like xxxx and xxxx did. They did there loved ones a favour didn't they as they kept getting told like I do by you*
>
> *you told me to do everyone a favour so that's what I shall do. Hope your lifes better without me*
>
> *you hurt me inside so much, you don't even know*

3.80 Christopher then attempted to call and text Marie and did not get an answer. He then left work (at 08.06) and returned to the house. He told police that he found her hanging and 'cut her down'. He then dialled 999 (at 08.15) and police report that he then deleted messages on their phones. On attendance, the ambulance crew found that Marie was still alive. She was taken to hospital, where she remained on a life support machine until she sadly died three days later.

3.81 Since Marie's death, Ella has remained living with her grandparents, whilst Leo and Chloe were initially living with Chloe's father in London. Leo went to live with his father in August 2020.

4. Overview

4.1 Marie was 30 years old when she took her own life in August 2017 in response to the coercively controlling behaviour of a serial domestic abuse perpetrator, Christopher. Marie had been in a relationship with Christopher for five months, during which time she had experienced multiple forms of abuse: physical, psychological, sexual, and financial.

4.2 Marie had three children, two of whom (Leo and Chloe) were living with her and Christopher at the time she died. They were not in the family home when Marie took her life but were staying with relatives. Her middle child, Ella, was living with her paternal grandparents.

4.3 Marie had her first child at 15 years old. The father of her first child abused her, as did the fathers of her other two children. There is a pattern of manipulative and abusive men targeting, controlling, and abusing her. She received support from Children's Services when she had her first child.

4.4 Four assessments carried out by Children's Services and reports from the school and health visitors showed a loving relationship between Marie, Leo, and Chloe. The assessments included a number of home visits. However, the children were all affected by the domestic abuse and their mother's use of alcohol, almost certainly related to an attempt to self-medicate to deal with the trauma she was experiencing.

4.5 Leo was 14 when his mother died. He had been in the home on 9 July 2017 when Christopher strangled and hit his mother and had rushed to a neighbour for help. He had previously witnessed domestic abuse in the home. He is a quiet boy who was protective of his mother, was settled in school and had a group of friends. When Leo was younger, there were concerns about his speech development which was monitored by the HV, but there are no records of ongoing issues. More recently, he has had some further health issues with hormonal development which are being treated.

4.6 Leo was aware of his mother's drinking and expressed concerns about this but also minimised it, possibly to protect himself and his mother. During a Children's Services assessment in 2015, he spoke about his sadness at the loss of his sister, who had left the family home to live with her grandmother when he was 11 years old, and of his fear that he might be removed from the home as well.

4.7 Ella's relationship with Marie was not an easy one and Ella reported a physical assault from her mother in 2014, as well as her mother's drinking. She left her mother's home in 2014 aged eight years following a Child Arrangement Order being agreed by consent in the Family Court for her to live with her paternal grandparents. A Fact-Finding Hearing in the Family Court found, on the balance of probabilities, that the incident of physical violence (pulling Ella by the hair down the stairs while intoxicated) did happen. Following this, Marie gave consent for Ella to live with her maternal grandparents.

4.8 Marie maintained phone and video link contact with Ella but rarely visited due to the distance and cost. She visited Ella for her birthday in June 2017 along with Christopher, a visit which lasted less than an hour due to Christopher's insistence that they return home.

4.9 Ella has had a number of difficulties since her mother died, including bullying at school, which impacted on her mental health. As well as the violence from her mother and her mother's death in 2017, she has recently lost her grandmother. She is now in her mid-teens, and her life has already been significantly impacted by trauma and loss. She is now living with her step-grandfather.

4.10 Chloe was three years old when her mother died. She had settled well into nursery and had a close bond with Marie. Chloe was under review by the paediatric consultant for social and emotional development and waiting for a course of speech and language therapy.

4.11 Chloe was in the home or close by at a neighbour's house on 9 July 2017 when Christopher attempted to strangle and hit Marie. There were 2 incidents we are aware of relating to her father and mother's separation and child contact when the police were called. We do not know how much of Christopher's violence towards Marie she witnessed, but as a small child this would have been very frightening for her.

4.12 Marie had experienced much trauma in her life. Christopher was her fourth significant intimate partner. All three previous partners had come to the attention of the police for domestic abuse. She had also experienced the loss of her daughter, Ella.

4.13 Marie struggled with her use of alcohol. Numerous concerns were raised with Children's Services and the Police about Marie's ability to care for the children while drinking. The Family Court found that she had on the balance of probabilities, Marie assaulted Ella while under the influence of alcohol. It is significant that for three years during 2010-2013, there were no concerns raised about Marie, and that during this time she was not in a relationship. It is likely that Marie was using alcohol to self-medicate to deal with the emotional pain of the trauma she experienced due to the abuse perpetrated against her. This, in turn, raised concerns about her parenting of her children, which in itself caused her distress and fear. The significance of the Consent Order was not fully considered by Children's Services. The social workers failure to attend the Court hearing, after being ordered to do so by the court, is perhaps another example of the lack of priority being given to this case by Children's Services and a failed opportunity to understand its significance.

4.14 There were seven reports of domestic abuse to the police about Christopher by three different women in a 12-month period in 2014-2015. Hertfordshire Police were also aware that he was arrested in June 2016 and convicted in January 2017 for possession of a firearm (a stun gun) and possession with intent to supply a Class A drug (cocaine). He received a suspended sentence. Probation's Pre-sentence Report (PSR) did not include Christopher's record as a domestic abuse perpetrator, as this information is not routinely included in case history, and they did not ask him about his previous relationships with women. Probation therefore had no ongoing contact with Christopher.

4.15 Victim Support received two referrals for Christopher, both were recorded for information only.

4.16 Police attended Marie's home 12 times between 2004 and 2017 for domestic abuse incidents involving four different perpetrators. The result of the attendances was one medium risk assessment and the rest either no DASH risk assessment was done, or standard risk was

assessed. Five different referrals were made by the police to Children's Services, but no referrals were made into specialist domestic abuse support services.

4.17 Children's Services carried out an assessment of the family in 2010 and then carried out three assessments in 2015. No significant concerns were found, and the files were closed with an agreed step- down plan in place, with the outreach worker at the Children's Centre acting as the lead. The outreach worker then unsuccessfully attempted to follow up actions with Marie, but as there was not requirement to report back to Children's Services, she took no further action.

4.18 The children's schools were unaware of the domestic abuse Marie experienced. Chloe's nursery was not informed about the Step-Down Plan or Marie's history of domestic abuse when Chloe started at the Nursery in September 2016.

4.19 Marie received support when she was pregnant and following the birth of her children. This was from maternity services, health care and health visitors but she clearly found it difficult to engage. Part of this may have been the frequent change of HV but also her general insecurity. She spoke of feeling stigmatised for being a single young parent, and this may have undermined her ability to engage with support. Marie had postnatal depression twice following the births of her first and third child and was treated for depression by her GP in 2014/15. By mid-2015, she said she felt better, and she did not return to the GP with further symptoms. She had several mild physical ailments and health concerns. There is no record of questions being asked about domestic abuse by the GP, nurses, HV or other health professionals.

4.20 Marie and Christopher visited A&E in June 2017, following what was later revealed as a non-accidental injury to her head which required gluing. They presented together and explained the injury as occurring when they were '*fooling about'*. This was accepted and no enquiries were made about domestic abuse.

4.21 Significantly, the police attended a call out on 09 July 2017, just over a month before Marie died. We now know that the attendance was a result of a call by a neighbour who had been alerted by Leo, who had witnessed Christopher attack his mother and attempt to strangle her.

4.22 Marie and Christopher told the officers that the altercation had been verbal. She also initially told the officer that she did not want to discuss what had happened and did not want to complete a DASH risk assessment as she was scared that her children might be removed by Children's Services. This may have led to her minimising the abuse she experienced from Christopher, having been through a Family Court case which resulted in a Consent Order for Ella to live with her paternal grandparents.

4.23 The officer explained to Marie that Children's Services would support her, and she agreed to answer questions. The officer then completed a DASH risk assessment with her which resulted in 6 positive ticks (a referral to MARAC is automatically made when there are 14 or more ticks or four incidents in 12 months). The officer positively ticked that Marie she was very frightened of Christopher, was depressed and that Christopher was very angry and had been arrested before. Professional judgement can be used when completing a DASH risk assessment (when there are fewer ticks) to make a referral to MARAC and the IDVA service,

but this was not exercised, and the officers showed a lack of awareness of indicators of coercive control.

4.24 The police were aware that there were children living in the house but did not make enquiries about whether they had been present at the time of the incident. They were aware of Christopher and Marie's history but did not carry out a door-to-door enquiry to find out who had made the call. If they had done so, they would have found Leo at the neighbours and been able to speak to both the neighbours and Leo about what had happened. If this had exposed the physical violence, which included strangulation in front of a child, then this would almost certainly have triggered a MARAC referral. Good practice would have been to:

a. Inform and warn Marie about Christopher's history of domestic abuse complaints by previous partners (under Clare's Law).
b. Follow up on the emergency call they had received from a neighbour by checking with neighbours.
c. Check on the whereabouts and well-being of the children, and.
d. Use their Professional Judgement to make a MARAC referral given the indications of coercive control, Christopher's history, and Marie's vulnerability as a repeat victim of Domestic Abuse.

4.25 A Child Referral Form was completed by the officer in attendance. The form states that the children were in the house at the time of the incident but that they had not witnessed the incident. This does not accord with other reports and is explained by the Police as an administrative error.

4.26 The Child referral form was sent to Children's Services and passed to the Family First Team, but as the DASH risk assessment was standard risk it was not treated with urgency and by the time Marie took her own life, six weeks later, there had been no follow up action. A referral was also made to the HV team who, based on the standard risk assessment, did not take follow up action. It appears that neither team reviewed Marie's whole history.

4.27 The significance of the Police attendance and their Risk Assessment on 9 July 2017 cannot be underestimated. We do not know what might have taken place, but if the Police had investigated further there may have been a different result on that day and by Children's Services and the HV team. There is significant learning for the Police and the other agencies from this incident.

4.28 Christopher was abusive to Marie from the start of their relationship. Friends, relatives, and neighbours reported her fear of him and changes to her personality during the months leading up to her death. On 23 August 2017, he left her at home to go to work, sending her distressing texts. He did not stop but continued to abuse her until she finally said:

You told me to do everyone a favour so that's what I shall do.

Hope your life's better without me.

4.29 When she failed to answer his calls, he rushed back to the house, finding that she had attempted to take her own life. He called an ambulance and deleted the messages from both their phones. Marie very sadly died in hospital three days later, not recovering consciousness.

4.30 The Police investigation following Marie's death was extremely thorough and was commended by the Judge and the family.

5. Analysis

5.1 Marie was 30 years old, and had three children, when she was driven to take her own life in August 2017 as a direct result of the coercive and controlling behaviour of Christopher. She had endured physical, emotional, and psychological abuse from him. She had been with the perpetrator, Christopher, for four months. This was her fourth significant relationship where domestic abuse was reported.

5.2 There is significant learning from this extremely sad case of a young woman, known to services, who took her own life while in a relationship with a highly controlling male perpetrator of domestic abuse who was known to the police.

5.3 Marie had three children, aged 14, 11 and three years at the time of her death. She had her first child at 15 years old and received support as a young parent. The father of her first child was abusive and this must have had a profound impact on her, increasing her vulnerability to manipulative men. There were numerous reports to the police and Children's Social Care, but she received little actual support during her short life, falling below the threshold at assessment stage for specialist services. The links between the trauma of the domestic abuses he experienced, her alcohol use and the loss of one of her children from her care in private family court proceedings, were not fully recognised by agencies. For Marie and her children, a targeted support package was needed to ensure she was able to recover from the negative impact of the trauma she had experienced.

5.4 Christopher was a serial perpetrator of abuse in intimate partner relationships. He also had a history of minor crime and a conviction in February 2017 of possession of a stun gun and possession of cocaine with intent to supply. Probation do not routinely receive reports of domestic abuse from police when preparing a court report. Probation do not regularly ask all offenders at court interview stage about their relationship status, previous relationships, and the quality of those relationships. It is their view that reports of domestic abuse in this case would have changed his risk assessment, and that this may have resulted in probation supervision rather than a Suspended Sentence Order (SSO) with no involvement. Probation supervision would mean domestic abuse/safeguarding checks on Marie would have been conducted on an ongoing basis as part of risk management on the order.

5.5 Christopher is clearly a danger to women in intimate partner relations and is under a ten-year Criminal Behaviour Order, with a duty to report to police if he starts a new sexual relationship. His motivation for selecting Marie as a partner appears to centre around her financial stability (she had secure accommodation and received welfare benefits) and her vulnerability, which he manipulated to control and abuse her to gain power over her. The responsibility for her death lies firmly on his shoulders.

5.6 This was the first case of a conviction of coercive control after the death of a victim, since the introduction of the offence under Section 76 of Serious Crime Act in 2015, and the police were

commended for their investigation following Marie's death. As the first conviction for coercive control, it is important to examine the history behind the relationship and its dynamic as well as the learning for the many agencies involved. There is learning for police, health services, schools, and nurseries as well as for Children's Services and in particular learning about professional curiosity, inter-agency communication, understanding of Marie's history of domestic abuse and trauma, including Marie as a repeat victim of multiple perpetrators. There is also learning about Christopher, his criminal behaviour, his misogyny, and the impact of this on women he had intimate relationships with.

5.7 Although the panel found no evidence of direct discrimination, the panel does consider that Marie's socio-economic status, her age, her position as a single mother on benefits with three children with three different fathers probably impacted on the support she received. At the very least, she did not receive support tailored to meet her needs although the various agencies were aware of her situation.

5.8 There is a need to develop services to respond to women in Marie's position, who have been subjected to domestic abuse over a long period and who find it difficult to access support services. In considering what else could be done to prevent this from happening again, considerable learning needs to take place about the difficulties Marie would have experienced about reporting to the authorities and her fear of having her children removed.

5.9 Several themes have emerged from this review:

a. Recognising that domestic abuse is most likely, in its severest forms, to be perpetrated by men against women:

Marie was subjected to abuse by all four male intimate partners who moved in to live with her. Domestic homicide statistics show that the prevalence of male perpetrators and female victims:

- For the year ending March 2016 to the year ending March 2018, 74% of victims of domestic homicide (homicide by an ex/partner or family member) were female. This contrasts with non-domestic homicides where the majority of victims were male (87%). (ONS, 2019).

- The overwhelming majority of female domestic homicide victims are killed by men; of the 270 female victims of domestic homicide for the year ending March 2016 to the year ending March 2018, the suspect was male in 260 cases and in 218 of the cases a partner or ex-partner. 43 male victims were killed by a partner or ex-partner in the same time period. (ONS, 2019)

- Over 80% (83%) of high frequency victims (more than 10 crimes) are women. (From a study of data from the Crime Survey for England and Wales, a nationally representative household survey). (Walby & Towers, 2018).

5.10 Evan Stark (2007), in writing of coercive control and domestic abuse, said:

'Domestic abuse is a form of gendered violence; as many scholars have argued, it is shaped, facilitated, understood and at times legitimated by socially constructed gender relations …. and, in various ways, by intersecting axes of power such as race, class and sexuality.'

b. Suicide associated with domestic abuse:

5.11 The State has a positive obligation under the Human Rights Act to protect citizens from inhuman and degrading treatment (Article 3) or from threats to life (Article 2). This obligation extends to the need for agencies (including the police) to have systems that allow serious violent crime to be investigated effectively and to ensure that such systems are applied appropriately in all cases, including those where, like for Marie, multiple victimisation, and coercive control, together with using alcohol to self-medicate, are key factors.

5.12 We know from research that one third of all female suicides in England and Wales are preceded by domestic abuse and that more women take their lives because of domestic abuse than are killed in domestic abuse situations (Walby, S., 2004).

- Research with Refuge, a specialist domestic abuse charity, by Aitken, R & Munro (2018) into domestic abuse and suicide amongst their client group showed that 83% confirmed feeling despairing and hopeless - a key determinant for suicidality. The chances of being suicidal were 3.5 times greater for those who were feeling depressed and 1.68 times greater for those with alcohol difficulties.

- The research showed that damaging gaps and delays were found by staff who referred clients to community services, with existing tools limited in assessing risk of harm from the client to herself particularly over a broad timescale. The research describes the need for a trauma informed approach to practice, for clients and for the workforce to be in place and available to respond to these needs, at the time of need.

5.13 Although there are a number of factors which may have increased Marie's susceptibility to suicide, the responsibility for her death lies with the coercively controlling behaviour of Christopher. Her vulnerability as a multiple victim of domestic abuse, her use of alcohol to self-medicate, her use of cocaine with Christopher and the loss of Ella from her immediate family were all factors which combined to undermine her confidence, increase her fear level and impact on her ability to fully reveal the extent of the domestic abuse she was experiencing. It was her eldest child who called for help from neighbours on 9 July 2017, and despite the severity of the attacks on her, she neither called the police nor told them about the extent of the abuse when they arrived. It is significant learning for the police to consider all elements of the history and current situation when dealing with domestic abuse and determining whether there is high risk for the victim and children from domestic abuse.

5.14 Aitkin, R & Munro (2018) identify having children as a frequent protective factor in preventing suicide and Marie loved her children. However, her fear of losing her children to care was strong and may have negated this protection for her. In commenting on this issue, Aitkin and Munro (2021) reflected on the research with domestic abuse charity, Refuge:

> *In the interviews we did with IDVAs (and this was a small-ish cohort), the concern that children could also act as a barrier to seeking help was certainly raised as a theme, with IDVAs indicating that precisely this concern about intervention by social services could make women disinclined either to seek help for suicidal thoughts or to report experiences of abuse (or both).*

Had the agencies been aware of these key factors and the potential for suicide, they may have been able to put together a plan with Marie to re-build her life, free from domestic abuse.

c. Importance of seeing the life story of the individual victim/survivor and not individual incidents.

5.15 Marie was the victim of domestic abuse in all four of her main intimate partner relationships with men. In '*Risk for Revictimization of Intimate Partner Violence by Multiple Partners: a Systematic Review*' (2018), Elisabeth Christie Ørke and colleagues showed that despite empirical research being scarce, with only limited recent development, there are significant differences between women with Intimate Partner Violence (IPV) in a single relationship and women with IPV by Multiple Perpetrators (MP).

5.16 Their research showed that IPV by MP was significantly associated with childhood trauma with some association with present drug abuse, IPV characteristics, and attachment style. Depression did not appear to be a salient risk factor for subsequent violent relationships. They reported that:

> *'Characteristics of IPV, such as frequency, severity, and mutual IPV, may increase the risk of revictimization. Cumulative lifetime victimization predicted partner violence by a new partner…. the group of women subjected to IPV by MP was found to have a significantly stronger tendency to have had a history of trauma (childhood emotional, physical, and sexual abuse and witnessing parents' physical abuse) than women with a single abusive relationship.'*

5.17 The factor with the strongest empirical evidence was women with a history of childhood trauma. For this group of women, there was a higher risk of revictimisation in multiple relationships even before their first intimate adult relationship.

5.18 The authors summarise the learning in the following way: *'instead of treating women victimised by IPV as a uniform group, it is important to attend to women with IPV by MP as a subgroup with special needs.'*

5.19 We do not have a history of Marie's early childhood, but she grew up initially with both parents who then separated when she was in her early teens. We know she was affected by their separation and that there was at least one domestic abuse incident involving the police when Marie was 15.

5.19 At 16 years, Marie was subjected to domestic abuse by Jake (Leo's father), with four police call outs in four months including for affray and threats to kill. Given that cumulative lifetime victimisation is predictive of partner violence by a new partner, this is an alert that all agencies should be aware of.

d. The link between multiple abuse, trauma, and alcohol use.

5.20 Evan Stark's '*Coercive Control'* (2007) describes domestic abuse as characterised by a pattern of 'coercive control', built by perpetrators over their partners through a range of strategies, often including physical, sexual, psychological, emotional, and financial abuse.

5.21 We now know that Marie experienced repeated physical, emotional, psychological, and financial abuse in her relationship with Christopher. In the four months they were together, Christopher caused Marie a head injury which needed A&E treatment. He also bruised her, gave her a black eye, and strangled her. His controlling and coercive behaviour included taking charge of her bank card, accusing her of being unfaithful, disapproving of her having friends and insisting on knowing where she was at all times. He also displayed sexually provocative behaviour by standing naked in full view of neighbours.

5.22 Marie was a repeat victim of domestic abuse from multiple perpetrators, struggling with alcohol and in addition, one of her children had been removed in private Family Court proceedings. Children's Services assessments described Leo's worry that he might be taken into care and Marie expressed this concern in the Children's Services assessment in July 2015 and to the Police in 2017. The impact of this traumatic event on the family (regardless of whether this was the right decision for Ella) was not fully recognised by services.

5.23 In '*Breaking Down the Barriers: Findings of the National Commission on Domestic and Sexual Violence and Multiple Disadvantage'* (2019), the fear many women have of losing their children is described as a huge barrier to seeking support. This is particularly true for women who use substances and/or who experience mental ill-health, who are often viewed as unable to parent and who describe a constant fear that their mental health or addiction will be used against them.

5.24 The trauma of domestic abuse and the link with emotional disturbance and post-traumatic stress disorder (PTSD) is well established (PTSD was first included in the Diagnostic and Statistical Manual of Mental Disorders in 1980). Judith Hermann (1992) speaks of the impact:

> *'People who have endured horrible events suffer predictable psychological harm. There is a spectrum of traumatic disorders, ranging from the effects of a single overwhelming event to the more complicated effect of prolonged and repeated abuse …… the likelihood of harm is increased when traumatic events include physical violation or injury, exposure to extreme violence…... the salient characteristic of the traumatic event is its power to inspire helplessness and terror.'*

5.25 For agencies, awareness of coercive control and how this is used by perpetrators as well as its impact on the victim/survivor, is an essential part of recognising and responding to domestic abuse. For Marie, opportunities to engage with her were missed, with the cumulative impact of domestic abuse and complex trauma not being fully recognised in relation to her ongoing support needs.

5.26 While Marie did not have an official diagnosis of trauma related difficulties, her use of alcohol was likely a result of attempts to self-medicate. This was first reported to agencies in November 2010 following two domestic abuse incidents she reported to the police. Thereafter, concerns about Marie's alcohol use were raised several times with agencies in

relation to her care for her children. Although for almost three years after her second abusive relationship, there were no concerns raised, suggesting a significant link between domestic abuse, trauma, and her alcohol use.

5.27 Research confirms this link between abuse and dependence on alcohol or other drugs. In '*Breaking Down the Barriers'* (2019), women who experience domestic and sexual abuse are reported to be three times more likely to be substance dependent than non- abused women. In discussing the use of alcohol to achieve a numbing effect from emotional pain, Herman (1992) observes:

> *'Traumatised people who cannot spontaneously dissociate may attempt to produce similar numbing effects by using alcohol or narcotics …..it seems clear that traumatised people run a high risk of compounding their difficulties by developing dependence on alcohol or other drugs'.*

5.28 Assessments by Children's Services noted Marie's experiences of domestic abuse, the impact of the court case with Ella going to live with her Grandparents and her use of alcohol, but they did not link these issues together with trauma. Marie was, throughout, attempting to continue to care for her children, who she loved and who loved her. Children's Services acknowledge and find no evidence that her children were not cared for, but agencies do not appear to have made the link between alcohol, domestic abuse, and trauma.

5.29 Marie also experienced economic abuse by Christopher, who took control of her bank card. Economic abuse usually occurs alongside other forms of domestic abuse. Surviving Economic Abuse is a relatively new organisation who successfully campaigned for economic abuse to be included in the new statutory definition of domestic abuse (Domestic Abuse Act, 2021). Their website (https://survivingeconomicabuse.org has links to research and additional resources.

e. Support for Marie

5.30 Although Marie was assessed regularly over a period of 13 years by health services, Children's Services and Police, support was not put in place to help her deal with the domestic abuse she experienced. She was once referred into a Sunflower Centre, but there is no record of her engaging with support. She otherwise did not meet the threshold for referral into the IDVA or MARAC services, based on the way risk assessments were conducted.

5.31 Marie was 15 years old when she had her first child and 17 when she had her second. The Children's Services assessment in June 2015 concluded that the concerns about alcohol use were not substantiated, and advice be given to her about engaging with community support. It was also noted that Marie had not accessed services as advised. An element of victim blaming, perhaps from frustration, crept into the report. It reflected a lack of understanding of the multiple impacts of the trauma Marie had experienced and the resulting impact on her self-confidence and self-worth and as with all victim blaming, masked the responsibilities of statutory services:

> *'The previous referrals and historical concerns regarding X's ability to care for her children appropriately cannot be ignored …… it can be wondered, if X had continued to*

access the support recommended to her, then she may not have ended up in situations where referrals were having to be made to Children's Services multiple times.'

5.33 In *'Breaking Down the Barriers'*, the report concludes that strength-based trauma informed practice is needed to respond to women who face multiple disadvantages and have experienced multiple traumas. Specially targeted services are needed to ensure survivors are supported to engage with services which are also trauma-informed. The use of targeted, assertive, and intensive outreach with a holistic and trauma informed approach and the aim of supporting women to access and engage with services is currently being evaluated by AVA in conjunction with Solace Women's Aid.

5.34 Other examples of missed opportunities to refer Marie into domestic abuse support include Marie's visit to the hospital with a cut on her head in June 2017 as well as the DASH assessment of July 2017, which contributed to Children's Services and Health Visitor Teams not expediting the case and not carrying out full case reviews.

f. Risk assessments were carried out which assessed risk but did not fully consider Marie's support needs and did not assess her partner/the father.

5.35 On 9 July 2017, the DASH risk assessment led to six ticks and a standard risk assessment of domestic abuse. It is important that the DASH is not used as a decision-making tool in itself, but rather as an influencer with some questions and answers carrying more significant than others, leading the officer to use their professional judgement in assessing whether a MARAC referral should be made.

5.36 Marie told the police she was very frightened, that she was depressed, and that Christopher had used violence before. However, there was no follow up enquiry and professional judgement was not used to refer the case to DAISU (Hertfordshire Police). She was also not referred into community-based domestic abuse support services.

5.37 It is significant that although the police were aware of Marie's history of domestic abuse, they did not escalate it, not recognising her as a multiple victim. This, sadly, is not uncommon, and often agencies do not 'see the history' of abuse but instead look at each incident separately.

5.38 Christopher was a multiple perpetrator of domestic abuse, and the police would have been aware of this when they were called out on 9 July 2017. They could and should have used Clare's Law to inform Marie of Christopher's history and inform her that she was not safe. Using Clare's Law may well have led to a recognition of the higher risk Marie was facing and a referral into MARAC, where the full history of both Marie and Christopher and the children could have been fully examined.

5.39 The Domestic Abuse Act 2021 has put the Domestic Violence Disclosure Scheme ("Clare's law") on a statutory footing.

5.40 Research by SafeLives (2015) shows that on average high-risk victims of domestic abuse live with domestic abuse for 2.3 years and medium risk victims for three years before getting help. Sylvia Walby and J Allen (2004) reported that, on average victims experience fifty incidents of abuse before getting effective help. We know that Marie did not call the police each time she

was abused but do not know how many different incidents she endured of physical and other types of abuse.

5.41 Children's Services carried out four different risk assessments for the children, which led to signposting and step-down but no consistent support as the children did not meet the threshold for services. The impact of abuse on children is also well documented with childhood trauma a significant indicator for post-traumatic stress disorder. Awareness of domestic abuse impacting on children as actual victims rather than by-stander, is now recognised in the Domestic Abuse Act, and is a major step forward in recognising the needs of children victims of domestic abuse.

5.42 Eleven different Health Visitors were involved with Marie, who visited her in the home several times over their 14-year involvement with the family. Marie could have benefitted from more consistent support from one HV who she could have built a relationship of trust with.

5.43 It is also relevant that all assessments appear to have been with Marie and her children. No assessments appear to have taken place with the fathers of the children (Children's Service and HV assessments all took place before Marie started her relationship with Christopher).

5.44 The NSPCC (2015) recognise the significance of men in children's lives, despite this, men can be ignored by professionals and the focus put on the care provided solely from the mother. Omitting men from assessments can prevent the assessment of their presenting risk to mother/child and not see the ongoing risk they present.

g. How information is recorded and shared between agencies (including specialist domestic abuse agencies) and how this is reviewed.

5.45 The Children's Services assessment in March 2015 resulted in a Step-Down plan to Universal Services with the outreach worker at the Children's Centre responsible for calling a meeting after two months. There is no record of this meeting taking place. When Chloe started nursery in September 2016, information about this referral and the domestic abuse was not passed from the Children's Centre or Children's Services to the nursery, who did not then keep an active check on the family. The Nursery School reported that they did not receive regular information from Children's Services on children as part of the intake.

5.46 The specialist Health Visitors from the local hospital were not in communication with the HV in the community, and they do not share common record keeping systems. The specialist HV was therefore unable to pass on information about Marie. The lack of integration of SystmOne across health services meant that this information was lost to the community and both services restricted in their ability to see the wider picture in relation to Marie and her children.

5.47 Although Marie experienced multiple incidents of domestic abuse, there was only one referral into the Sunflower Centre and no other attempts to encourage her to use domestic abuse support services in the area. Women's Aid, Refuge and Victim Support had no information about Marie or any of the children, and there are no records showing referrals into support for them. All agencies should inform all survivors of domestic abuse of support available to them and where necessary support referrals into services.

h. Children as victims of domestic abuse and impact of trauma

5.48 Although there were four different Children's Services assessments, they were of Marie and her ability to care for her children. Between 2004 and 2017, Marie lived with her children and a perpetrator for at least five years. The children were aware of the abuse and were interviewed but not recognised as victims of domestic abuse.

5.49 Referrals were made by the police into Children Services on some but not after all callouts. There were very thorough assessments of Marie and good interviews with the children by Children's Services, but if the children had been seen as victims of domestic abuse, we would expect their emotional and support needs to be considered and to have resulted in referrals for support for the children and liaison with the school.

5.50 The Children's Services Information and Advice Record following Marie taking her life recorded a 2015 assessment as 'not concerning DV' but did not outline her history of domestic abuse and notifications received earlier in the same year.

5.51 In the weeks following Marie's death, Hertfordshire Children's Services liaised well with Camden Children's Services and with Chloe's father and grandmother, who Leo and Chloe were staying with. In addition to liaison, references were made to a referral to CAMHS for Leo (but not for Chloe). It was also noted that Ella would receive support from school. It is not clear whether these were followed up as the case was closed to Children's Services two months after Marie died.

5.52 The children were now living in two different places (in 2020, Leo then moved in with his father). It is not clear what follow up work, if any, was done with the children. However, for children's needs and rights to be fully recognised as victims of domestic abuse, there needs to be support (counselling and other support) available when there is a death associated with domestic abuse.

5.53 The trauma associated with domestic abuse potentially has a lifetime impact, with children experiencing domestic and sexual abuse being most impacted. All three children experienced domestic abuse in their early childhood from their fathers to their mother, and from Christopher to their mother. For Baby's Sake (2020) provide a dedicated service in Hertfordshire, and stress the importance of intervention:

> *'One in five children in the UK experience domestic abuse. This can have a profound impact on the rest of their lives with babies particularly affected. Exposure to domestic abuse in the first 1001 days of life (from conception until age two), can physically alter a baby's brain chemistry and affect cognitive, emotional, and physical development.'*
>
> *'Left unresolved, trauma in infancy can lead to issues in later life that affect the whole of society, Adverse Childhood Experiences have gained recognition in relation to later issues, it is for our institutions and organisations to be aware of this and to make sure support and services are in place for the children impacted.'*

6. Conclusions

6.1 There are several issues identified in this report and conclusions drawn. Agencies have worked to identify and learn from the issues which were highlighted by the previous report writer and changes have been put in place since the last report in 2019.

6.2 The panel have particularly highlighted the learning in relation to domestic abuse and repeat victims by multiple perpetrators. By not reviewing the whole of Marie's record when there was an incident, agencies did not see the pattern of abuse. Although Marie's history was acknowledged in Children's Services assessments, the traumatic impact of domestic abuse was not investigated and professional curiosity around Marie's drinking was not used to understand what might be happening for her and by association, to her children.

6.3 Agencies have all been open and transparent about the improvements needed and reflected on the learning with many improvements identified and in place. There are improvements needed in recognising and assessing the impact of abuse on individuals, including children, and the trauma they have experienced as well as ensuring good and clear inter agency communication.

6.4 There was a lack of referrals to specialist domestic abuse services, perhaps because the DASH risk assessment was being used too literally as a determinant of risk rather than being used as a general indicator with other factors, such as a history of domestic abuse, level of fear and the perpetrator's history, guiding the investigation. However, we would expect the police to refer survivors into support in all incidents, having regard to research on the frequency and length of domestic abuse before survivors generally report to the police.

6.5 The outcome and impact of the police visit on 9 July 2017 is concerning. The Police have acknowledged several aspects of this which should not have happened and improvements to systems have been put in place. The failings include not investigating fully, particularly as the original callout informed them that two children were present, with one possibly autistic child who was therefore very vulnerable. This failure meant that the case was not escalated to DAISU, and the domestic abuse Child Referral Form registered the risk as standard.

6.6 This, in turn, had an impact on Children's Services, who did not fully access Marie's history, but noted that there was no Children's Services history in the past 12 months. The case was referred to Families First Team, but no actions had been completed prior to Marie death, six weeks later. If they had read her previous assessments, they would have seen that she was a repeat victim of domestic abuse, there were issues about alcohol use and that both she and the children had raised fears about the children being removed, following Ella leaving the family home. This may have alerted them to the increased risk to Marie.

6.7 The HV team similarly used the standard risk assessment to close their investigation after two failed attempts to contact Marie and did not escalate to a home visit.

6.8 Assessments by Children's Services were detailed and thorough but showed a lack of professional curiosity. They do not appear to have asked themselves key questions about why Marie was using alcohol, why she wasn't returning calls or keeping appointments and how her history of domestic abuse had impacted her. They noted that there was an impact on the

family of Ella moving to live with her grandparents but not how the family could be supported through this loss.

7. Lessons to be learnt

7.1 Lessons from the previous review in this case have been put in place by all agencies. There have, in addition, been key changes which have led to significant learning across services.

7.2 Learning has been identified in this report in eight key areas:

1. Information sharing between agencies, the need for the whole person/family to be visible.

2. To look at the history of abuse by the perpetrator and the impacts of abuse on the victim(s) over their life history.

3. To understand the support someone in Marie's position needs, recognising the different elements of domestic abuse she was experiencing including physical, emotional, controlling, or coercive and economic abuse and avoid victim blaming which prevents the professional from seeing the whole history of abuse.

4. The need for trauma-informed services and assertive outreach for those with multiple disadvantages with a pathway of support in place for repeat victims of multiple perpetrators.

5. Suicide and domestic abuse – recognising its frequency, the impact of coercive control and symptoms to recognise.

6. To include learning about attempted strangulation as an indicator of the escalation of domestic abuse.

7. The use of risk assessments as a tool to identify but not determine risk. The use of professional curiosity and asking questions such as: Why was Marie drinking? What was the impact on her of losing Ella? Why was she so resistant to referring herself and children into support?

8. The traumatic impact of domestic abuse on victims, survivors and children and the need for agencies to recognise this and support to be in place for children as victims and not bystanders.

8. Recommendations

Including implementation of Recommendations from DHR 1 and further recommendations from this DHR.

8.1 Recommendations from DHR 1 (2019)

8.1.1 The DHR panel identified several practice issues which gave rise to the following recommendations. In addition, each of the agencies which produced IMR's for the DHR made recommendations for their agencies, as set out below.

8.1.2 The following recommendations have been implemented:

Recommendation 2	Hertfordshire Constabulary should ensure officers use professional judgement to make decisions about whether or not to refer to MARAC or for specialist assistance (e.g. health or Constabulary Domestic Abuse Officer); and make a record of the reasons for decisions.
Recommendation 3	Hertfordshire Children's Services should ensure that the timeline set for evaluating and progressing cases assigned to Families First is implemented.
Recommendation 5	Hertfordshire Domestic Abuse Partnership should promote the use of the Domestic Abuse Disclosure Scheme in the area.

8.1.3 The following recommendations are partly implemented and so are included in the Action Plan going forward:

Recommendation 1	Hertfordshire Constabulary should review the process of notifying schools about domestic abuse incidents and extend the notification to nurseries if the review deems this appropriate:
Update:	Schools are currently notified of domestic abuse incidents. This has not yet been extended to under 5's. Recommendation included under Hertfordshire Police below.
Recommendation 4	Hertfordshire Domestic Abuse Partnership should raise awareness through publicity of the role friends can play in identifying domestic abuse and providing help to victims.
Update:	Recommendation included under Hertfordshire County Council below.

8.2 Recommendations from this DHR

8.2 (1) National:

The Quality Assurance Panel are asked to write to the Home Office requesting the following recommendations and for agreement that the Home Office response is shared with Hertfordshire County Council:

1. An allocated lead at the Home Office is responsible for establishing a national fund to enable a package of therapeutic and advocacy support to be put in place for child survivors of Domestic Homicide and suicide linked to domestic abuse. The Home Office to report back to Hertfordshire County Council on this recommendation and its implementation.

2 That the Home Office issue guidance that repeat victims of multiple perpetrators are treated as a special category of domestic abuse victim/survivor with automatic escalation to MARAC; that the DASH risk assessment is amended to reflect this change with guidance and training in place.

3 National Tier 1 training to include the importance of developing the professional curiosity skills of students, using domestic abuse case studies and national guidance to assist in improving this skill. This recommendation is linked to issues arising following the lack of professional curiosity used which impacted on decision making and professional judgement in this case.

8.2 (2) Hertfordshire County Council

Hertfordshire County Council have carried out a comprehensive review of domestic abuse in Hertfordshire in a report published in spring 2021, entitled '*A Review of the support needs of Victims and Survivors of Domestic Abuse in Hertfordshire'*.

The report provides '*an overview of the experiences of victims and survivors of domestic abuse in Hertfordshire with a view to understand the type of support services they may require, and any barriers that they may need to overcome to access them*.'

1. All Agencies involved with this review to report that they are now sharing information on a consistent basis with pathways and checks in place to ensure the right information is being shared. Agencies to confirm they are sharing historic as well as current information about domestic abuse.

2. Hertfordshire Domestic Abuse Partnership to roll out an agreed community awareness and training programme over the next 12 months with the aim of increasing awareness amongst all communities of domestic abuse and the role organisations, family and friends can play in tackling and reporting domestic abuse.

3. Hertfordshire Domestic Abuse Partnership to publish, publicise, and maintain updated lists of organisations who can offer help and support to victims and survivors, ensuring these are available to communities across the County.

4. Police, Health Services and Children's Social Care increase their awareness of the role of the different third sector and specialist organisations in Hertfordshire, including therapeutic trauma services and ensure they refer their clients/patients/service users appropriately into these services.

5. Statutory and voluntary sector agencies involved with this review to confirm that they include a trauma-informed approach to their work with victims/survivors and train and support their staff in this approach.

6. Hertfordshire Domestic Abuse Partnership to develop a policy which recognises the particular vulnerability of repeat victims of multiple perpetrators and ensures they are treated as a special category with referral into MARAC and specialist outreach support to ensure they can engage with services.

7. Children's and Adult Care Services to include in their safeguarding training an awareness of the link between domestic abuse, substance use, mental ill health and trauma and the services available for those impacted including counselling and therapeutic support.

7. Children's Services, CGL and the IDVA teams to work together to develop a joint understanding of alcohol dependency and domestic abuse which is reflected in policy, training, and support pathways.

8. Hertfordshire Domestic Abuse Partnership ensures all agencies are aware of their changed responsibility under the Domestic Abuse Act 2021

9. Hertfordshire Domestic Abuse Partnership considers establishing community-based support for domestic abuse perpetrators and that a report, outlining successes elsewhere and the cost of a programme, is presented to the CSP.

10. Agencies involved in this review to check their policies, communications, training, and records to ensure they avoid victim blaming which prevents the professional from seeing the whole history of abuse.

11. Hertfordshire Domestic Abuse Partnership facilitates training which includes learning about:
    a) Domestic abuse and suicide
    b) Attempted strangulation as an indicator of the escalation of domestic abuse with risk of homicide and suicide.

12. Hertfordshire Domestic Abuse Partnership to review services across the County with a view to ensuring therapeutic support is available to all survivors of domestic abuse, including children.

Single Agency Reports and Recommendations

The following agencies provided information about implementation of recommendations made in DHR 1 (2019) and changes in practice since that date:

8.3 Hertfordshire Police

Recommendations from DHR 2019
Completed:

1. Hertfordshire Constabulary to record Domestic Violence crime and non-crime cases in line with NCRS.

Domestic abuse incidents not closed off until a supervisor has reviewed the incident and checked the appropriate crime has been recorded.

2. All staff to ensure DASH risk assessments are completed accurately and the risk level is correctly recorded.

All risk assessments are now reviewed by the DAISU daily. Duty inspector has oversight of high-risk cases.

3. 'MARAC Case List Record' kept by DAISU to ensure MARAC and Safeguarding referrals are managed.

4. Any escalation in risk level as identified by professional judgement is considered for referral to MARAC if it does not fit the criteria.
Current DASH RA is referral for four incidents in 12 months or high risk. All officers and staff have been reminded of the use of their professional judgement if a case doesn't meet criteria.

Partly Implemented and to be included in Action Plan:

Recommendation 1	**Hertfordshire Constabulary** should review the process of notifying schools about domestic abuse incidents and extend the notification to nurseries if the review deems this appropriate:
Update:	Schools are currently notified of domestic abuse incidents. This has not yet been extended to under-fives. This recommendation to be implemented alongside safeguarding reorganisation plans.

Changes made since 2017:

Several changes made by the police to their response and recordings of safeguarding and domestic abuse, including training:

a) Training and developmental messaging are proactively delivered. Training is given to student officers along with a toolkit package including a power point presentation covering all aspects of safeguarding. Highlighted within this that any children present must be seen and that their voice is heard as well as completing child risk assessments.

b) Officers are encouraged to use their professional judgement above and beyond the DASH tick assessment. The training and presentation have significantly enhanced officers understanding and confidence when attending and reporting domestic abuse.

c) Since the original IMR was completed 'ATHENA' has come into operation which collates all previously reported crimes and domestic history for the Victim and the Perpetrator. This enables DAISU (Domestic Abuse Investigation and Safeguarding Unit) to make better informed decisions (please note Family Front Sheets have been superseded by Athena).

d) The learning from the incident on 09/07/2020 has been included in training days.

Further Recommendations:

a) Schools are currently notified of domestic abuse incidents. This has not yet been extended to under-fives. This recommendation to be implemented alongside safeguarding reorganisation plans.

b) Recommend that Officers discontinue the use of 'Domestics' and 'Domestic Disputes' and use the term 'Domestic Abuse'.

c) Children are seen by officers in domestic abuse call outs and where appropriate, spoken to individually and separately from the perpetrator.

d) Information shared with Children's Services and within MASH to include any domestic abuse and other violence, including abuse involving previous partners of both perpetrator and victim.

e) Information is passed to all victims of domestic abuse about domestic abuse support services and victims are encouraged to contact services for support.

f) Special consideration to be given to escalate repeat victims of multiple perpetrators to MARAC.

g) Training to include the danger of attempted strangulation as an indicator of escalation of abuse.

h) The Police provide Probation with domestic abuse history alongside other information for Court. Police and Probation to discuss and implement this recommendation.

8.4 Hertfordshire Children's Services

Recommendations completed:

a) Information shared by Hertfordshire Constabulary with Hertfordshire Children's Services (including Safeguarding, Specialist and Families First) and within the MASH to include any domestic abuse and other violence, including abuse involving previous partners of both perpetrator and victim.

b) Domestic Abuse Notifications provided by Hertfordshire Constabulary to include an assessment of the impact of the abuse on the victim and/or their children.

c) Information shared and analysed by Hertfordshire Children's Services (including Safeguarding, Specialist and Families First) and within the MASH to include any Children's Services current or historic involvement with the children of both the victim and perpetrator, and their previous or current partners.

d) Specific, risk and need based timescales for management decisions to be agreed, set, and monitored for all referrals to Children's Services, including Safeguarding, Specialist and Families First.

e) Specific risk and need based timescales for completion of actions and tasks following initial management decision to be agreed, set, and monitored for all new referrals to Children's Services, including Safeguarding, Specialist and Families First.

f) Manager's directions should be timed and dated and recorded on General Notes as well as Contacts within the Families First Triage electronic system (EHM)

Changes made since 2017:

a) Hertfordshire Schools are signed up to Operation Encompass and now receive domestic abuse notifications.

b) Families First Triage experienced particular pressures in 2017. Referrals received are now actioned within 5 working days.

c) Close and effective working relationships are in place between Children's Services and the DAISU and key police colleagues (including MARAC) and pathways are regularly reviewed.

d) There is increased awareness within Children's Services and across partner agencies of trauma informed practice and training is in place in relation to this.

e) There is good awareness within Children's Services of Coercive Control and training has taken place.

f) The Family Safeguarding model is in place in Hertfordshire which enables both victim and perpetrator intervention from specially trained workers.

Further Recommendations

a) To share the reflections gained in this IMR with the workforce (by way of a learning bulletin) and in particular the impact of repeat victimisation from multiple partners.

b) To consider additional ways of supporting victims/survivors including young parents who are experiencing substance use and domestic abuse to ensure they can access support.

c) Hertfordshire Children Services contacts the carers of the three children in this case and establishes whether they have access to the therapeutic resources needed to support the three children. If this is not the case that they establish a fund to enable the children to access the support, they need.

8.5 East and North Hertfordshire NHS Trust

Recommendations Completed

a) Domestic abuse training with staff in emergency department and urgent care centre:

(i) including awareness of tactics that an abuser may frequently adopt to prevent a victim from disclosing abuse when interacting with health care professionals.

(ii) consider if the presenting injury was inflicted by someone else and create an opportunity to be alone with the patient. Ask the patient if they want to be referred to an IDVA, or to arrange police involvement if the individual is in imminent danger.

b) The urgent care centre and emergency department now have a room where domestic abuse patients can be triaged into.

Further Recommendations

a) The need for a Trust-wide holistic and robust domestic abuse policy which examines the signs of domestic abuse, barriers to disclosure and gives clear guidance on safe and effective domestic abuse enquiry (including specific guidance on 'asking the question' and question framing).

b) Areas within the Trust, such as Adult ED, Maternity, Community Paediatrics, Gynaecology, Plastics & Orthopaedics to have an enhanced provision of domestic abuse training which supports the development & understanding of the purpose of routine domestic abuse enquiry within those areas and equips staff with knowledge and experience in the recognition, response, and risk assessment of domestic abuse. This training will also focus on case scenarios regarding how to create an environment to support safe enquiry.

c) Further review of the Specialist Health Visitor assessment tool; to incorporate domestic abuse routine enquiry as a standard for each initial assessment, to gather family functioning/dynamics and identification of men in children's lives.

d) The review supports the recommendation of community services employed by East & North Hertfordshire NHS Trust to have read access to community records (System one) to enhance communication and information sharing with universal services.

e) Information sharing between specialist HV service and community services – a review of current information sharing practices in place should take place.

f) Development of domestic abuse care bundles: domestic abuse care bundles are a bundle of information/documentation which will support a clinician where there is a suspicion of disclosure of domestic abuse. This will include the domestic abuse pathway, clinical photography prompts, body maps & literature for safety planning and onward referrals to IDVA and safeguarding services.

g) Trust-wide annual domestic abuse audit to be commenced, examining efficacy of domestic abuse enquiry, recognition, and responses to domestic abuse. This will be the foundation for future training and service improvements.

h) Development of domestic abuse champions within each department within the trust, who will receive additional local training on domestic abuse, risk assessment and safety planning, to help develop knowledge from the 'ground up'. The role of the domestic abuse champion will be to support the frontline staff on domestic abuse identification, domestic abuse enquiry and to ensure the victim & their children get the right and appropriate support in a timely manner.

i) Domestic Abuse awareness raising throughout the organisation (e.g., screensavers, active participation in awareness days and regular internal communications) alongside the above recommendations will provide a further reinforcement.

8.6 Hertfordshire Community NHS Trust

Recommendations Completed

a) Health Visitors must ensure that groups and relationships are up to date in all the SystmOne health records for the families open to them.

b) Father's details including parental responsibility must be included (including fathers not living in the family household) within the SystmOne health records. This is particularly important with blended families where children have different fathers.

c) To reinforce record keeping responsibilities in record keeping training and at safeguarding supervision.

d) Nursery nurses to undertake mandatory domestic abuse training and have management oversight when allocated to working with families with complex needs and vulnerabilities.

e) Where possible domestic abuse notifications to be allocated to the last health visitor involved and not managed by duty. This would ensure continuity of care and may enhance effective health visiting support.

f) Reinforce professional's responsibility to share the domestic abuse notification with the GP and school health nursing in training, team meetings and communication platforms as per current domestic abuse policy.

g) The follow up of domestic abuse notifications to be monitored through audit.

h) When 'asking the question to domestic abuse' cannot be undertaken, the reason for and plan of action must be documented within the health records. Consideration must be given as how the follow up to the domestic abuse question can be completed through the plan of action.

i) If records of alleged perpetrator are not able to be opened onto SystmOne then a note of this must be made in the victim's records.

j) To launch the new domestic abuse guidance and RAG rating risk assessment with HV and school nursing

Changes made since 2017.

a) Record keeping and documentation. There was limited information on records for this family. Record keeping has been addressed for Public Health Nurses.

b) The Domestic Abuse policy and RAG rating guidance has been updated to make sure documentation is recorded following a domestic abuse incident.

Further Recommendations

a) HCT policy review to be finalised and to ensure there is adequate response to domestic abuse victims who have been subject to abuse from different partners

b) HCT Domestic Abuse training to be updated to ensure that greater awareness is raised regarding coercive control and victim suicide.

8.7 Clarion housing

Changes made since 2017.

a) Clarion now deals with all ASB reports via their Tenancy Specialist (TS) Teams. They log domestic abuse cases onto their system. Having the TS teams dealing with both ASB cases and domestic abuse cases have led to better joined up working. All domestic abuse reports are followed up and if there is no response the tenant is followed up until contact is made.

b) All Clarion staff, including operatives, are trained in domestic abuse, including how to report.

c) All high-risk domestic abuse is accompanied by high level dedicated support to the victim with a specific point of contact with Clarion and link with the police.

d) Clarion will take legal action to further safeguard the victim and ensure their housing is maintained.

e) Domestic abuse enquiry has been introduced into two Clarion processes: the 6-week welcome call and the rent arrears process.

8.8 Probation Service

It is not standard practice to ask for DAISU checks on non-domestic abuse cases. Probation is therefore not given domestic abuse information for all cases going to Court regardless of the offence type.

Recommendation that:

a) The Police provide Probation with domestic abuse history alongside other information for Court. Police and Probation to discuss and implement this recommendation.

b) As a matter of good practice all offenders at Court interview stage are asked about their relationship status, previous relationships, and the quality of those relationships.

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