community safety partnership

A Review Overview Report DHR 007

Report into the death of a 33-year-old woman

'Louise'

in May 2018

Report produced by Malcolm Ross M.Sc.
Independent Chair and Author

Amended: August 2025

Contents

List of Abbreviations

AAFDA	Advocacy After Fatal Domestic Abuse
ALMHS	Acute Liaison Mental Health Service
AOM	Ambulance Operations Manager
ASC	Adult Social Care
A&E	Accident and Emergency
BBR	Build Better Relationships
BeNCH	Bedfordshire, Northamptonshire, Cambridgeshire, and Hertfordshire Community Rehabilitation Company
CATSS	Crisis and Telephone Support Services
CBT	Cognitive Behavioural Therapy
CCG	Clinical Commissioning Group
CCTV	Close Circuit Television
CFN	Children First Northamptonshire
CMHT	Community Mental Health Team
CPS	Crown Prosecution Service
CRC	Community Rehabilitation Company
CSC	Children's Social Care
DA	Domestic Abuse
DAPIT	Domestic Abuse Police Investigation Team
DNA	Did Not Attend
DASH	Domestic Abuse, Stalking and Harassment Risk Assessment form
DHR	Domestic Homicide Review
DOL	Deprivation of Liberty
DVPN	Domestic Violence Prevention Notice
DVPO	Domestic Violence Prevention Order
EMAS	East Midlands Ambulance Service
GP	General Practitioner
HACAA	Heroin and Crack Action Area
HOA	Housing Options Advisor
IDVA	Independent Domestic Violence Advisor
IMR	Individual Management Review

KBC	Kettering Borough Council
KBCSP	Kettering Borough Community Safety Partnership
KBCSPB	Kettering Borough Community Safety Partnership Board
KGH	Kettering General Hospital
MAPPA	Multi Agency Public Protection Arrangements
MARAC	Multi-agency Risk Assessment Conference
MASH	Multi Agency Safeguarding Hub
MDT	Multi-Disciplinary Team (Meeting)
MIND	A mental health charity in England and Wales.
NCMHT	Northampton Community Mental Health Trust
NHFT	Northamptonshire Health Foundation Trust
NPH	Northampton Partnership Homes
NPS	National Probation Service
OCG	Organised Crime Group
PCART	Planned Care and Recovery Team
PCLW	Primary Care Liaison Worker
RAR	Rehabilitation Activity Requirement
RO	Reporting Officer (Probation)
ROSH	Risk of Self Harm
S2S	Substance to Solutions
SIO	Senior Investigating Officer
SFC	Sunflower Centre
UCAT	Urgent Crisis and Treatment team

Introduction and Background

The members of this review panel offer their sincere condolences to the family of Louise for the sad loss in such tragic circumstances.

It is the wish of the Victim's mother that she is referred to by the pseudonym of 'Louise' throughout the report. As the boyfriend has not had any engagement with the review process, he will be referred to as 'Boyfriend' throughout the report, as the report author does not choose pseudonyms for those who decline to engage with the process.

1.1 Introduction

1.1.1 This Review concerns the death of Louise who was aged 33 at the time of her death in May 2018. She took her own life at her home address in Kettering, which she shared with her on/off boyfriend and their 9-year-old child. There is a history of domestic abuse between Louise and the boyfriend, who is 20 years older than Louise.

1.1.2 H.M. Coroner for Northamptonshire held an Inquest into Louise's death on 1st September 2020 and determined that the cause of death of Louise was 1a - Hypoxic Brian Injury and 1b - Hanging. HM Coroner concluded Louise's death was Suicide.

1.1.3 Northamptonshire Police conducted an investigation into Louise's death. There is no evidence of any third party being involved. No one faces prosecution over the death of Louise.

1.1.4 In accordance with Home Office Guidance[1] a Domestic Homicide Review had been commissioned.

1.2 1.2 Purpose of the Review

1.2.1 The Domestic Violence, Crimes and Victims Act 2004, establishes at Section 9(3), a statutory basis for a Domestic Homicide Review, which was implemented with due guidance[2] on 13th April 2011 and reviewed in December 2016[3]. Under this section, a domestic homicide review means a review "*of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by—*

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

1.2.2 Where the definition set out in this paragraph has been met, then a Domestic Homicide Review must be undertaken.

[1] Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews – Home Office 2016
[2] Multi-Agency Statutory Guidance for The Conduct of Domestic Homicide Reviews - Home Office 2011 *www.homeoffice.gov.uk/publications/crime/DHR-guidance*
[3] Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews – Home Office 2016

1.2.3 It should be noted that an intimate personal relationship includes relationships between adults who are or have been intimate partners or family members, regardless of gender or sexuality.

1.2.4 In March 2013, the Government introduced a new cross-government definition of domestic violence and abuse[4], which is designed to ensure a common approach to tackling domestic violence and abuse by different agencies. The new definition states that domestic violence and abuse is:

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

1.2.5 In December 2016, the Government again issued updated guidance on Domestic Homicide Reviews especially with regard to deaths resulting from suicide. The guidance[5] states:

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

1.2.6 The guidance[6] defines coercive and controlling behaviour as:

> 'Controlling behaviour is: a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.
>
> Coercive behaviour is: a continuing act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim."

1.2.7 The circumstances of Louise's death meet the criteria under this section of the guidance.

1.2.8 Such Reviews are not inquiries into how a victim died or who is to blame. These are matters for Coroners and Criminal Courts. Neither are they part of any disciplinary process. The purpose of a review is to:

[4] Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews Revised August 2013 Home Office now revised again by 2016 guidance.
[5] Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews Revised August 2013 Home Office revised again by 2016 guidance paragraph 18 page 8
[6] Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews Revised August 2013 Home Office revised again by 2016 guidance paragraph 15 page 8

- Establish what lessons are to be learned from the homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims.

- Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result.

- Apply these lessons to service responses including changes to the policies and procedures as appropriate.

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

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

- Highlight good practice.

1.3 Process of the Review

1.3.1 Kettering Borough Community Safety Partnership Board (KBCSPB) was notified of the death of Louise on 4th June 2018 by Northamptonshire Police. KBCPSB reviewed the circumstances of this case against the criteria set out in Government Guidance[7] and decided that a Review should be undertaken.

1.3.2 The Home Office was notified of the intention to conduct a Domestic Homicide Review (DHR) on 6th July 2018. An independent Chair and Author was commissioned and appointed and a DHR Panel was appointed. At the first review panel terms of reference were drafted. On the 26th June 2019 the Board approved the final version of the Overview Report and its recommendations.

1.3.3 Home Office Guidance[8] recommends that reviews should be completed within 6 months of the date of the decision to proceed with the review. The Home Office has been notified of the reason for a delay in the process.

1.4 Independent Chair and Author

1.4.1 Home Office Guidance[9] requires that:

"The Review Panel should appoint an independent Chair of the Panel who is responsible for managing and coordinating the review process and for producing the final Overview Report based on IMRS and any other evidence the Review Panel decides is relevant", and "…The Review Panel Chair should, where possible, be an experienced individual who is not directly associated with any of the agencies involved in the review."

1.4.2 Mr Malcolm Ross was appointed at an early stage of this review. He is a former Detective Superintendent with West Midlands Police where, as a Senior Investigating

[7] Home Office Guidance 2016 Page 9
[8] Home Office Guidance 2016 pages 16 and 35
[9] Home Office Guidance 2016 page 12

Officer, he was responsible for the investigation of around 85 murders many involving domestic abuse. Since retiring in 1999, he has 25 years' experience in writing over 80 Serious Case Reviews, and post 2011, performing both roles of Chair and Author on over 65 Domestic Homicide Reviews. He has also authored and chairs over 80 Child Protection Safeguarding Reviews and SARs. Prior to this review he was not involved either directly or indirectly with members of the family concerned or the delivery or management of services by any of the agencies. He has attended the meetings of the panel, the members of which have contributed to the process of the preparation of the report and recommendations and have helpfully commented on it.

1.4.3 Mr Ross attended the initial Home Office DHR training Course held in Bristol in 2011. He has since, of his own accord, attended two AAFDA (Advocacy After Fatal Domestic Abuse) DHR training courses to refresh his knowledge and keep updated. In 2024, Mr Ross attended the first of the new Home Office/AAFDA certified DHR training course and successfully passed and was accredited as a DHR Author and chair. He regularly attends AAFDA webinars and always attends AAFDA's annual conferences. He has an enhanced knowledge of domestic violence and abuse issues including so-called 'honour'-based violence, research, guidance and legislation relating to adults and children, including for example the Children Act 2004, the Care Act 2014 and the Equality Act 2010. He is completely independent of North Northamptonshire Community Safety Partnership and any other agency in Northamptonshire. He has attended the meetings of the panel, the members of which have contributed to the process of the preparation of the Report and have helpfully commented upon it.

1.5 Review Panel

1.5.1 In accordance with the statutory guidance, a Panel was established to oversee the process of the review. Mr Ross chaired the Panel and also attended as the author of the Overview Report. Other members of the panel and their professional responsibilities were:

- Malcolm Ross, Independent Chair and Author
- John Kinloch, Community Safety Lead Officer, Kettering Borough Council / Kettering Borough Community Safety Partnership
- Richard Tompkins, Detective Superintendent, Northamptonshire Police
- Lucy Westley, Manager, Sunflower Centre
- Rose Lovelock, Northamptonshire Healthcare Foundation Trust
- Diane Postle, Deputy Director of Nursing and Quality, Kettering General Hospital
- Ruth Sibbett, Head Safeguarding, Northamptonshire County Council Adult Social Care
- Georgette Fitzgerald, Designated Nurse Adult Safeguarding, Nene and Corby Clinical Commissioning Group
- Mikesh Kotak, IRO Manager Safeguarding & Quality Assurance Service, Children First Northamptonshire

1.5.2 The Panel members confirm they had no direct involvement in the case, nor had line management responsibility for any of those involved. Georgette Fitzgerald, Nene and Corby CCG, (Clinical Commissioning Group) was, some years ago, the manager of Louise's sister, but Georgette confirms that has no relevance to her position or independence as a panel member. Louise's family are satisfied that there is no conflict of interest. The Panel was supported by the DHR Administration Officer. The business of the Panel was conducted in an open and thorough manner. The meetings lacked

defensiveness and sought to identify lessons and recommended appropriate actions to ensure that better outcomes for vulnerable people in these circumstances are more likely to occur because of this review having been undertaken.

1.6 Parallel proceedings

1.6.1 The Panel were aware that the HM Coroner for Northamptonshire concluded the inquest on 1st September 2020.

1.7 Time Period

1.7.1 The time period for the review is from 1st December 2016 to the date of Louise's death in May 2018. However relevant information is included covering specific events prior to 1st December 2016 which add contents to the lifestyle of Louise.

1.8 Scoping the Review

1.8.1 The process began with an initial scoping exercise prior to the first panel meeting. The scoping exercise was completed by the KCSP to identify agencies that were involved with Louise prior to her death. Where there was no involvement or insignificant involvement, agencies were requested to inform the Review by a report. Where agencies had significant involvement Individual Management Report (IMRs) were requested.

1.9 Individual Management Reports – Contributors to the Review

1.9.1 An IMR and comprehensive chronology was received from the following organisations:

1.9.2 IMRs produced by:

- Nene and Corby Clinical Commissioning Group – GP (General Practitioner) Services
- Kettering General Hospital (KGH)
- Northamptonshire Health Foundation Trust (NHFT)
- Northamptonshire Police including the Sunflower Centre (SFC)
- Community Mental Health Team (CMHT)
- BeNCH[10] (Bedfordshire, Northamptonshire, Cambridgeshire, and Hertfordshire Community Rehabilitation Company)
- Education
- Housing
- Adult Social Care (ASC)
- Children's Social Care (CSC)

1.9.3 Statements of Information provided by

- East Midlands Ambulance Service (EMAS)

[10] BeNCH - Bedfordshire, Northamptonshire, Cambridgeshire, and Hertfordshire Community Rehabilitation Company

1.9.4 Guidance[11] was provided to IMR Authors through local and statutory guidance and through an author's briefing. Statutory guidance determines that the aim of an IMR is to:

- Allow agencies to look openly and critically at individual and organisational practice and the context within which professionals were working (culture, leadership, supervision, training, etc.) to see whether the homicide indicates that practice needs to be changed or improved to support professionals to carry out their work to the highest standard.
- To identify how those changes will be brought about.
- To identify examples of good practice within agencies.

1.9.5 Agencies were encouraged to make recommendations within their IMRs, and these were accepted and adopted by the agencies that commissioned the reports. The recommendations are supported by the Overview Author and the Panel.

1.9.6 The IMRs were of a high standard providing a full and comprehensive review of the agencies' involvement and the lessons to be learnt.

2. Terms of Reference for the Review

2.1 The aim of the Review is to:

- Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims.
- Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result.
- Apply these lessons to service responses including changes to the policies and procedures as appropriate.
- Prevent domestic homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working,
- Contribute to a better understanding of the nature of domestic violence and abuse.
- Highlight good practice.

2.2 **Scope of the review**
The Terms of Reference for this DHR are divided into two categories i.e.:

- the generic questions that must be clearly addressed in all IMRs; and
- specific questions which need only be answered by the agency to which they are directed.

2.3 The generic questions are as follows:

[11] Home Office Guidance 2016 Page 20

1. Were practitioners sensitive to the needs of the deceased, knowledgeable about potential indicators of domestic abuse and aware of what to do if they had concerns about a victim or perpetrator?
2. Was it reasonable to expect them, given their level of training and knowledge, to fulfil these expectations?
3. Did the agency have policies and procedures for risk assessment and risk management for domestic abuse victims (DASH) and were those assessments correctly used in the case of this victim / ex-partner?
4. Did the agency have policies and procedures in place for dealing with concerns about domestic abuse?
5. Were these assessments tools, procedures and policies professionally accepted as being effective? Was the deceased subject to a MARAC? (Multi Agency Risk Assessment Conference)
6. Did the agency comply with domestic abuse protocols agreed with other agencies, including any information sharing protocols?
7. What were the key points or opportunities for assessment and decision making in this case?
8. Do assessments and decisions appear to have been reached in an informed and professional way?
9. Did actions or risk management plans fit with the assessment and the decisions made?
10. Were appropriate services offered or provided, or relevant enquiries made in the light of the assessments, given what was known or what should have been known at the time?
11. When, and in what way, were the deceased's wishes and feelings ascertained and considered?
12. Is it reasonable to assume that the wishes of the deceased should have been known?
13. Was the deceased informed of options/choices to make informed decisions?
14. Were they signposted to other agencies?
15. Was anything known about the ex-partner? For example, were they being managed under MAPPA? (Multi Agency Public Protection Arrangement)
16. Had the deceased disclosed to anyone and if so, was the response appropriate?
17. Was this information recorded and shared, where appropriate?
18. Were procedures sensitive to the ethnic, cultural, linguistic and religious identities of the deceased, the perpetrator and their families?
19. Was consideration for vulnerability and disability necessary?
20. Were Senior Managers or agencies and professionals involved at the appropriate points?
21. Are there other questions that may be appropriate and could add to the content of the case? For example, was the domestic homicide the only one that had been committed in this area for a number of years?
22. Are there ways of working effectively that could be passed on to other organisations or individuals?
23. Are there lessons to be learnt from this case relating to the way in which this agency works to safeguard victims and promote their welfare, or the way it identifies, assesses and manages the risks posed by ex-partners? Where could practice be improved? Are there implications for ways of working, training, management and supervision, working in partnership with other agencies and resources?
24. How accessible were the services for the deceased and ex-partner?

2.4 In addition to the above, agencies would have been asked to respond specifically to individual questions in the event of any being identified.

Individual Needs

2.5 Home Office Guidance[12] requires consideration of individual needs and specifically:

> 'Address the nine protected characteristics under the Equality Act 2010 if relevant to the review. Include examining barriers to accessing services in addition to wider consideration as to whether service delivery was impacted'

2.6 Section 149 of the Equality Act 2010 introduced a public sector duty which is incumbent upon all organisations participating in this review, namely to:

- eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act.
- advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it.
- foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

2.7 The review gave due consideration to all the Protected Characteristics under the Act.

2.8 The Protected Characteristics are: age, disability, gender reassignment, marriage and civil partnerships, pregnancy and maternity, race, religion or belief, sex and sexual orientation

2.9 There was nothing to indicate that there was any discrimination in this case that was contrary to the Act. However, from April 2014 to March 2017, 73% of victims of domestic homicides (homicides by an ex/partner or family member) were women and from April 2014 to March 2017 four in five female victims of domestic homicide were killed by a partner or ex-partner (239, 82%); of which the vast majority of suspects were male (238).[13]

2.10 It is of interest to note however, that Louise's family stated that they felt that Louise was seen by agencies as just another drug user and this may have led to Louise not being given opportunities or consideration as a person in need.

Family Involvement

2.11 Home Office Guidance[14] requires that:

> "Consideration should also be given at an early stage to working with family liaison officers and senior investigating officers involved in any related police investigation to identify any existing advocates and the position of the family in relation to coming to terms with the homicide."

[12] Home Office Guidance 2016 page 36
[13] Office of National Statistics 2018
[14] Home Office Guidance 2016 page 18

2.12 The 2016 Guidance[15] illustrates the benefits of involving family members, friend and other support networks as:

a) assisting the deceased's family with the healing process which links in with Ministry of Justice objectives of supporting victims of crime to cope and recover for as long as they need after the homicide.

b) giving family members the opportunity to meet the review panel if they wish and be given the opportunity to influence the scope, content and impact of the review. Their contributions, whenever given in the review journey, must be afforded the same status as other contributions. Participation by the family also humanises the deceased helping the process to focus on Victims and perpetrator's perspectives rather than just agency views.

c) helping families satisfy the often expressed need to contribute to the prevention of other domestic homicides.

d) enabling families to inform the review constructively, by allowing the review panel to get a more complete view of the lives of the deceased and/or perpetrator to see the homicide through the eyes of the deceased and/or perpetrator. This approach can help the panel understand the decisions and choices the deceased and/or perpetrator made.

e) obtaining relevant information held by family members, friends and colleagues which is not recorded in official records. Although witness statements and evidence given in court can be useful sources of information for the review, separate and substantive interaction with families and friends may reveal different information to that set out in official documents. Families should be able to provide factual information as well as testimony to the emotional effect of the homicide. The review panel should also be aware of the risk of ascribing a 'hierarchy of testimony' regarding the weight they give to statutory sector, voluntary sector and family and friends contributions.

f) revealing different perspectives of the case, enabling agencies to improve service design and processes.

g) enabling families to choose, if they wish, a suitable pseudonym for the deceased to be used in the report. Choosing a name rather than the common practice of using initials, letters and numbers, nouns or symbols, humanises the review and allows the reader to more easily follow the narrative. It would be helpful if reports could outline where families have declined the use of a pseudonym.

2.13 Comments made by the family members have been included and referred to in this report. Please see section 'Views of the Family'.

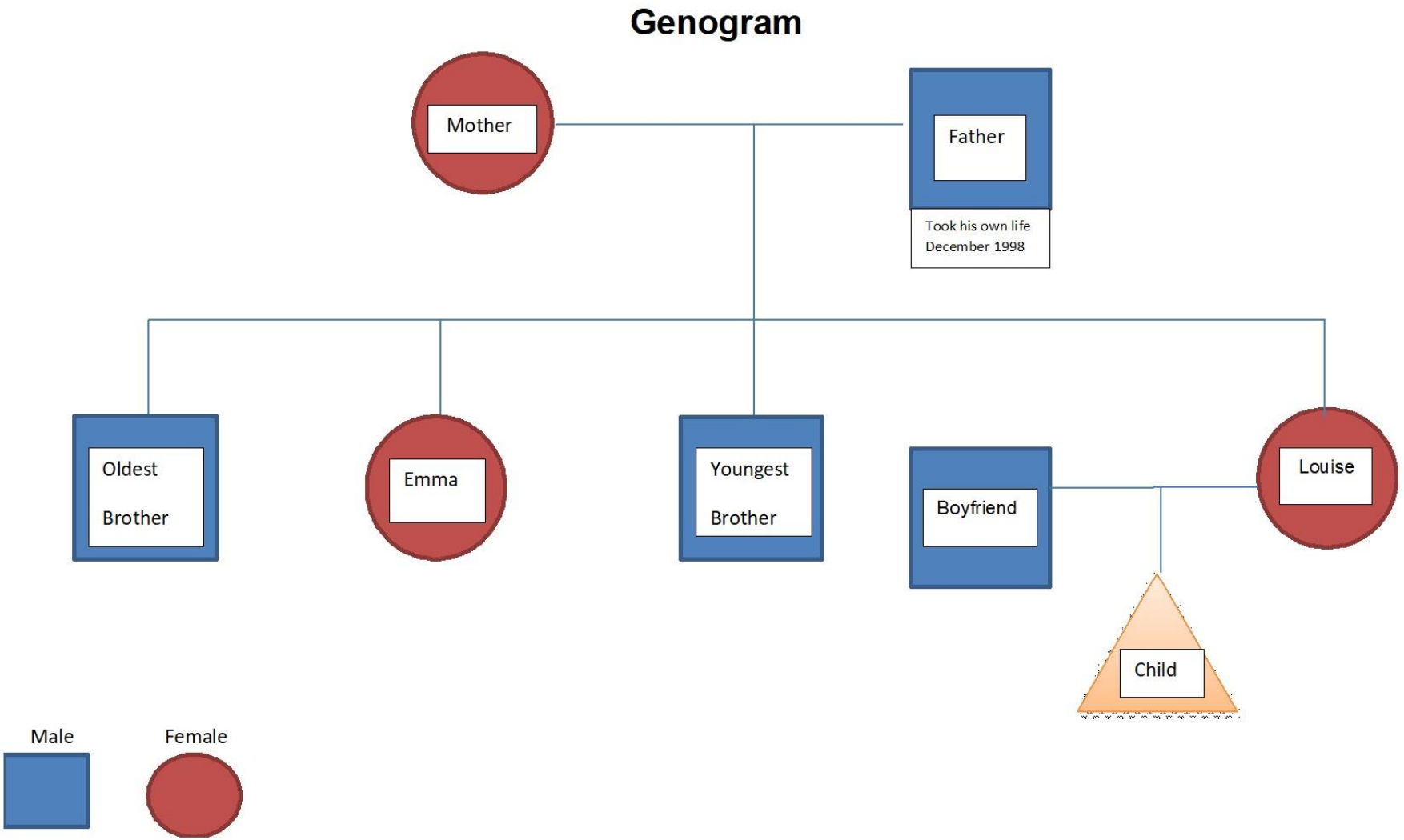
2.14 Family members have been supplied with a redacted copy of the Overview report and the Executive Summary of this report.

[15] Home Office Guidance 2016 Pages 17 - 18

Subjects of the Review

2.15 The following genogram identifies the family members in this case, as represented by the following key:

Louise	The deceased and mother of child
Boyfriend	Boyfriend of the deceased and father of child
Child	Child of Louise and boyfriend
Mother	Mother of Louise and Grandmother of child
Emma	Sister of Louise


Genogram
Mother
Father
Took his own life
December 1998
Oldest
Brother
Emma
Youngest
Brother
Boyfriend
Louise
Child
Male
Female

3. Summary of events

Relevant Information prior to the scoping date of this review

3.1 As stated earlier in this report, the boyfriend is 20 years older than Louise. In April 2008, Louise came to the notice of the police from intelligence suggesting that she was living with the boyfriend who was suspected of being a drug dealer. The police believed the boyfriend had intentions of bringing drugs into the Northamptonshire area. Later that month, more information came to the police that Louise and her boyfriend were living in a boarded-up property in Kettering, and they were both frequenting addresses believed to be used by drug dealers. According to Louise's family, the flat had no heating and no cooking facilities and was unfit for anyone to live there. At this time Louise was not known to Adult Social Care and there was no risk assessment conducted in relation to Louise.

3.2 In April 2010, Leicestershire Police intelligence system showed that a baby had been born to Louise and her boyfriend but there were concerns as both Louise and the boyfriend were known to be regular drug users. A Child Protection report was submitted. In October 2010, Louise was given the tenancy for a flat in Kettering. Although Louise had experimented in drug taking prior to her relationship with her boyfriend, she was not addicted at that point of time. The vulnerability was there, and it is the family's view that the boyfriend exploited drugs and Louise's vulnerability for his own personal gain.

3.3 In December 2011, Louise and two men were arrested for theft of a man's wallet in Kettering. During the investigation into this offence, Police attended and searched Louise's address where they found 'the boyfriend' with the young baby. The house was clean and tidy, and no concerns were raised about the baby. Louise received 20 weeks imprisonment in August 2012 for that offence.

3.4 In February 2012, Louise made a complaint to the police that the boyfriend had grabbed her around her throat and punched her in the face causing bruising[16]. Police attended and saw that there were no visible injuries to Louise. She stated that they had argued, and he had not hit her at all. This is the first recorded domestic incident between Louise and the boyfriend. There is no record of a referral being made to Adult Social Care, (perhaps due to the length of time that has passed). Although a DASH (Domestic Abuse, Stalking and Harassment) risk assessment was completed, she was assessed as medium risk, so she was not flagged to Sunflower Centre. There is no indication what, if any, signposting took place, and the Safety Plan read:

> "[Louise] and her child are at a friend's house out of harm's way. She has access to a mobile phone and a home line phone. She has been advised to stay with her friend which she is doing, and she has support in that house with her friend".

3.5 During the remainder of 2012, Louise was arrested on 10 occasions for stealing from stores, one of the occasions she was with the boyfriend. Louise received 4 weeks imprisonment and a conditional discharge for the offences. On two occasions Louise entered the houses of elderly people stating that she was a carer and stole property from their houses.

3.6 Also throughout 2012, Louise came to the notice of the police as she reported domestic abuse incidents involving the boyfriend as well as intelligence about their use of drugs.

[16] See footnote page 28 re: the significance of None-Fatal Strangulation

In November 2012 Louise was sentenced to 2 years imprisonment for a variety of theft offences. In April 2013 she was injured as she tried to kill herself by jumping over a balcony whilst inside HM Prison. She suffered relatively minor bruising and was treated within the Prison Medical Unit.

3.7 During 2014, numerous intelligence logs were submitted by police to the effect that both Louise and the boyfriend were using and dealing in drugs. Louise was seen to have black eyes and other injuries associated with domestic abuse. Each time the police responded to incident of domestic abuse a Child Concern Notification was submitted that would be shared with other agencies. The child had been present at the last incident in September 2014. The result of the Child Concern Notification was that there were two conferences held where CSC decided the involvement of the police was not required. In July 2015, another conference held that Louise was not at risk of significant harm being with her mother. The child's case was stepped down from a Child in Need case and effectively closed.

3.8 In August 2015, there was an allegation made that during an argument the boyfriend had threatened Louise with a knife. Police were called and the boyfriend denied using a knife and was released without charge. The child at that time was staying with Louise's mother. Another Child Concern Notification was submitted, and a DASH risk assessment completed but was not graded despite 11 positive answers being recorded which may have indicated a medium risk.

3.9 In December 2015, and Initial Case Conference was held regarding the child. It was decided that there was significant risk of harm to the child and the child was placed on a Child Protection Plan under the category of emotional abuse.

3.10 In June 2016, Louise presented at her GP saying she had been beaten up by a partner (who was not the boyfriend). The Family think it may have been the boyfriend as there was not anyone else and perhaps Louise was trying to protect him. She asked for sleeping tablets. There is nothing to suggest that she was given any Domestic Abuse advice or that a risk assessment was completed. Both Louise and her child were registered with the same GP's surgery.

3.11 In August 2016, Louise reported that she had been raped by a man in a local park but subsequently declined to assist in the investigation, make a statement or be examined. She refused to talk about the allegation. The report was subsequently filed.

3.12 Later that month, 27th August 2016, Louise reported the boyfriend had damaged her property. He was arrested and admitted the offence which was recorded on body worn camera. However, Louise declined to be involved with the investigation or make a statement. No further action was taken. A DASH Risk assessment was not completed due to Louise's level of intoxication, although the Police IMR Author considers that such an assessment ought to have been made. It may have been good practice to have returned the next day to try to engage Louise and do a risk assessment and signpost her to support.

3.13 In November 2016, the boyfriend was arrested for assaulting Louise and causing an injury to her eye. A DASH risk assessment was graded as high. Louise made a written statement of complaint. The boyfriend failed to answer to his bail but was arrested again in January 2017. CPS (Crown Prosecution Service) authorised a prosecution and the boyfriend received a Community Order in February 2017 after pleading guilty to the assault charge. During the investigation of this offence, Louise was referred to the Sunflower Centre and allocated an IDVA, (Independent Domestic Violence Advisor).

Information as per the time period 1st December 2016 – May 2018.

3.14 On 1st December 2016, GP Louise attended her GP's practice with her mother having left the boyfriend. Louise described him as being abusive. The record of this visit notes a recent assessment for suicidal ideations however she stated that she was not suicidal at that time. She asked for a repeat prescription which she could collect from her pharmacy where she went daily for her methadone.

3.15 Four days later Louise saw a consultant who was supporting her mother, and a risk assessment was completed, and it was noted that she was living with her mother who was supportive and Louise's child who was on a child protection plan. It is clear throughout this review that Louise's family, especially her mother, provided significant support to Louise and her child over a long period of time. Her mother was always there when Louise needed her. Her mother's constant support for the child continues.

3.16 Louise was due to attend S2S[17] the following day for a medical review but did not attend. Neither did she attend an out-patients appointment with NHFT. On 6th December 2016, Louise's case was heard at a MARAC for the first time.

3.17 On 7th December 2016, Louise explained to S2S that she had forgotten about her appointment the previous day and she was told that there would be no changes to her prescription until she engaged with a medical review. On the same day Police intelligence indicates that the boyfriend was staying with an acquaintance having fallen out with Louise after he had badly assaulted her.

3.18 On 12th December 2016, NHFT records indicate that the notes from the MARAC meeting state that Louise had retracted her statement about the assault, but CPS were to pursue a victimless prosecution.

3.19 The following day Louise was seen by S2S. Louise explained she'd missed the appointment with the mental health team and disclosed that at a party recently she had used crack and heroin. A drugs screen proved positive to opiate, methadone, benzodiazepines and cocaine.

3.20 On 22nd December 2016, Louise was seen by her GP. She was feeling low as this was the anniversary of her father's death and there had also been a gas explosion in the kitchen of the house she was living in at the time in Kettering. This was caused by Louise using a camping stove for cooking as she was without money for gas and electricity. The stove had not been set up correctly and had exploded. According to the family, Louise had broken into her old house at the time and had 'gone missing'. This was a regular occurrence.

3.21 On 30th December, S2S tried to contact Louise by telephone and spoke to Louise's mother who said she hadn't seen Louise since Christmas day and that she believed that she was back at her old address with the boyfriend. A message was left for Louise's S2S key worker to complete a welfare check on her return to work after the New Year break.

3.22 On 4th January 2017, S2S enquired with the pharmacy that Louise used, and it was confirmed that Louise had collected her medication on 3rd January. The pharmacy was asked not to dispense any more medication until Louise had contacted S2S. Louise was seen with her mother by S2S in the afternoon of the same day. She was reluctant

[17] S2S Kettering - offers tailored support and advice to individuals who misuse alcohol or drugs.

to give much detail of where she had been due to her mother's presence but did report using heroin and crack cocaine.

3.23 On 5th January 2017, Police intelligence indicated that Louise and the boyfriend were back in a relationship and living together in her old flat. This intelligence was correct.

3.24 On 9th January 2017, GP's practice notes indicate that Louise was panicking and feeling low, and she had not had her medication for two days. On the following day Louise attended S2S and disclosed smoking some substance once or twice a week. She did not indicate what the substance was. Another drugs screen proved positive for the same four drugs as on 13th December 2016. The GP's practice noted she was dependent upon benzodiazepine.

3.25 On 19th January 2017, Police intelligence indicated that the boyfriend was staying with Louise despite his bail conditions preventing that happening.

3.26 On 21st January 2017, a GP received a note from a Wellbeing practitioner that indicated that Louise was due for an assessment that morning, but her mother had answered the phone stating that Louise no longer lives with her. The note goes on to say that Louise attempted to take her life the previous Saturday. The note indicates that Wellbeing had decided that it was not appropriate for Louise to be dealt with by that service and that she should be referred to the crisis team or Primary Care Liaison Worker (PCLW). The Wellbeing service discharged Louise.

3.27 On 24th January 2017, Louise did not attend a S2S appointment. Her prescription was being held at the S2S office and not being held at the pharmacy as agreed at the medical review. She collected the prescription two days later. She reported feeling in a low mood and that her mental health had deteriorated. She had some suicidal thoughts but had not acted on them. However, this is contrary to the known facts as she attempted to take her life just days previously. Louise added that she had an appointment at her medical centre that day, but she had not attended. She was with the boyfriend and would contact a friend to take her to A&E (Accident and Emergency) if she needed to. Later that day Louise had a telephone conversation with her GP where she expressed that she felt low and was considering harming herself. She was with the boyfriend and stated she would attend the practice later that day, but she did not attend that appointment. S2S attempted to call Louise but there was no answer. The family stress that January 2017 was a real crisis point for the family. Louise was in the house with mum sporadically and because of her mental health, she was very unpredictable and abusive towards her mother. She would regularly try to manipulate the child and threaten to take the child away. Her Mother was feeling very vulnerable too, and she did phone the Police on numerous occasions asking for help, but the police said that as there was no order removing Parental Responsibility from the boyfriend, there was nothing that they could do. There was no open case for the child at risk. Police were therefore powerless as the boyfriend still has Parental Responsibility. It was considered that the child was not at any immediate risk of harm and therefore there was no safeguarding referral made.

3.28 On 1st February 2017, the boyfriend failed to attend the Magistrates Court to answer the charge for assaulting Louise on 7th December 2016 and a warrant was issued for his arrest.

3.29 On 3rd February 2017, a nurse from CMHT (PCART[18]) spoke to Louise in relation to her recent drug use and advised her to attend A&E for a physical and mental health checks which she said she would do but there is no record of her doing so.

3.30 On 6 February 2017, Louise did not attend her S2S appointment, nor did she attend on 14th February.

3.31 On 17th February 2017, Louise attended at her GP's practice. She admitted that she was a previous intravenous drug abuser but had stopped four nights previously. She had taken an overdose by intravenous injection into her forearm. She showed four injection marks which looked inflamed. She said she had spoken to the ambulance service via 111 and an ambulance had attended but had decided the arm was bruised rather than inflamed. She had said that she had wanted to 'end it all' because her child had been given to her mother. Louise was aware of the effects an overdose would have on her child. She said she wouldn't do it again.

3.32 On 23rd February 2017, S2S suggested that Louise needed to attend her appointments for her safety and gave assurances that she would attend. On the same day her GP received a letter from adult mental health saying that Louise had failed to attend an appointment with PCART. She was discharged from this team back to the care of the GP.

3.33 On 27th February 2017, the warrant in respect of the boyfriend was executed and he appeared before Northampton Magistrates court. The National Probation Service (NPS) confirmed with the MASH that Louise and the boyfriend's child were known to Social Services, but it had not been an open case since January 2017 and the child was living with Louise's mother.

3.34 During his court appearance a pre-sentence report heard that the boyfriend had no previous convictions for domestic abuse although Louise had alleged there had been previous abuse in her statement. His history is that he has 7 children from 7 different women. None of them have anything to do with him. The boyfriend was said to have used denial, minimisation and blame when discussing his offence. He blamed their relationship problems on Louise's drug use and claimed the assault on her was accidental. He denied any previous domestic abuse and stated that Louise was violent towards him. He refused to admit that his behaviour was problematic and demonstrated no awareness or empathy. He admitted breaching his bail conditions. The boyfriend's behaviour was deemed suitable for Building Better Relationships (BBR) but was assessed that he lacked motivation to complete the programme. Rehabilitation Activity Requirement (RAR) was recommended instead. He was sentenced to 24 months community order with a 60-day RAR and unpaid work of 200 hours, so he could be referred to a Safer Relationship Programme, a less intense programme dealing with minimisation and denial.

3.35 It appears during the court hearing a CPS lawyer contacted the Sunflower Centre asking if Louise could be contacted by phone to ascertain if she wanted a restraining order against the boyfriend, but she couldn't be contacted. There are no details of any messages being left for Louise.

3.36 The National Probation Service (NPS) assessed the boyfriend as posing a medium risk of serious harm (ROSH) to Louise, future partners and children and the nature of the serious harm was identified as physical, emotional and psychological harm as a result of being victims of and or witnesses to domestic abuse perpetrated by the boyfriend. This risk of serious harm was not assessed as being an imminent risk, despite the

[18] PCART – Planned Care and Recovery Team

boyfriend stating his intention to reconcile with Louise after the court hearing. For this reason, he was deemed suitable for management by CRC (Community Rehabilitation Company) and transferred to BeNCH. It is common following prosecution for couples to reconcile. The Family are of the view that there was a risk of serious harm to Louise irrespective of the NPS assessment.

3.37 On 3rd March 2017, the boyfriend failed to attend his induction appointment with his reporting officer from CRC.

3.38 On 4th March 2017, Louise contacted the Police from a neighbour's address. She had been out drinking and when she returned home the boyfriend was there, she alleged he shouldn't have been. An argument took place during which the boyfriend punched Louise in the face and head causing a large swelling and scratches. On arrival of the Police the boyfriend had already left the address. Louise was found to be very intoxicated and only able to give brief details. Louise was given safety advice and advised to see her GP. She declined medical treatment at the time. Due to Louise being intoxicated, a DASH risk assessment was not completed but she was given advice and arrangements were made for her to be seen once she was sober.

3.39 Despite attempts to contact Louise and arrest the boyfriend they both remained elusive until 9th March 2017, when the boyfriend was arrested at the home address. Louise was also present but declined to make an official complaint stating they were still in a relationship. In interview the boyfriend denied responsibility for causing the injuries and stated she had arrived home already injured. The investigation was reviewed by a supervisory officer who, considering Louise's intoxication and difficulties disproving the boyfriend's version, decided to take no further action. A DASH risk assessment was completed and graded as high risk. There are no details of any support being offered to Louise.

3.40 On 9th March 2017, Louise attended S2S appointment. She reported feeling suicidal and that she had attempted an overdose the previous week. She admitted intravenous drug use and stated she still had a naloxone kit[19] which was still in date. She was advised to see her GP later that afternoon which she did. She disclosed to the GP that she was struggling the previous week and had taken an overdose of heroin, but she denied any suicidal thoughts or thoughts of self-harm. She stated that the boyfriend was at home with her child and her mother. She was advised about the effects of Temazepam and to call for help if she felt worse of had thoughts of self-harm. There are no details of any other support being offered to Louise.

3.41 On 14th March 2017, the boyfriend attended an appointment with his Reporting Officer (RO) from BeNCH. Between them they agreed a sentence plan which consisted of having a stable and supportive relationship and being drug free. The RO agreed with the boyfriend that he would attend Safer Relationships Domestic Abuse Perpetrator Programme which is delivered by BeNCH CRC's operational partner Bold Moves. The boyfriend continued to work with S2S to address his drug issues. Consideration would also be given to delivering interventions targeting anger management and improving his parental skills.

3.42 The RO also contacted MASH regarding the child and to ensure there were no outstanding safeguarding concerns concerning the reconciliation between Louise and

[19] Opioid overdose–related deaths can be prevented when naloxone is administered in a timely manner. As a narcotic antagonist, naloxone displaces opiates from receptor sites in the brain and reverses respiratory depression that usually is the cause of overdose deaths. Naloxone rescue kits help reverse the drug overdose

the boyfriend post sentence, because pre-sentence Louise had stated that she wouldn't support a prosecution as their relationship was over for good.

3.43 On 15th March 2017, the boyfriend failed to keep an appointment with BeNCH and a warning letter was sent to him.

3.44 On 18th March 2017, Louise again called the Police complaining that the boyfriend was being aggressive towards her and refusing to leave the address. Police attended and found Louise to be intoxicated and under the influence of drugs. The boyfriend was compliant with the Police and left when asked to do so, but he did express concern about Louise's mental health. Louise was given safety advice and a DASH risk assessment was graded as medium. It is the family's view that Louise could have been taken to a place of safety and question if she should have been left her alone. The family consider Louise may not have been seen as a 'proper person', but just another drug addict. Agencies tend to see alcohol or drugs as the core issue whereas in this case, it was the abuse and coercion that had led to addiction and lack of wellbeing

3.45 On 21st March 2017, Louise attended S2S for a medical review. She admitted daily use of crack, smoking heroin 2-3 times a week, drinking up to ten units of alcohol three times a week and it was noticed that she was scratched under her eye, and she said that the boyfriend was responsible. Her physeptone was increased to 50mgs daily diazepam reduced to 20mgs daily. On the same day she attended her GP with a drug overdose by taking the boyfriend's pregabalin medication and had slept for two days. Louise disclosed experiencing major suicidal thoughts. Louise was assessed as experiencing low moods and the doctor from substance misuse unit suggested a referral to CMHT Planned Care and recovery Team (PCART). He increased her methadone.

3.46 On the same day the boyfriend failed again to an appointment with his RO, but he did contact the RO saying he had problems with his foot. He also failed to attend his Un-Paid Work appointment the following day.

3.47 On 24th March 2017, BeNCH prepared a report for Magistrates Court in respect of the boyfriend breaching his Court Order. The RO also prepared a report for a MARAC meeting which was to be held on 4th April.

3.48 On 31st March 2017, the boyfriend was sent a breach summons to appear before the Magistrates on 18th April.

3.49 On 2nd April 2017, Louise was seen in A&E for a mental health assessment. The boyfriend was with her and stated that he follows her around because she is unsafe, and he had witnessed her tying a ligature around her neck and he had to intervene. He explained that Louise had recently been on a crack/heroin binge that had lasted a week. Louise agreed to work with Urgent Crisis and Treatment (UCAT) team rather than being admitted to hospital. There is nothing to suggest that Louise was seen on her own, and the hospital notes indicate that the boyfriend was to be telephoned regarding Louise's appointment. This was a missed opportunity to see Louise on her own and to consider that there was to be a MARAC meeting in 2 days-time. There was a lack of professional curiosity in recognising that this was domestic abuse.

3.50 On 4th April 2017, the case was heard at MARAC following a referral from the Sunflower Centre. Notes from the meeting were sent to the GP and to NHFT. The notes recorded the boyfriend as being the perpetrator and mentions Louise was not engaging with services.

3.51 On 6th April 2017, NHFT notes indicate that Louise was seen with her partner who reported that Louise had made another attempt on her life, and he had only got there just in time. That may refer to the incident on 2nd April 2017.

3.52 On 10th April 2017, the boyfriend failed to attend the Safer Relationships session.

3.53 On 11th April 2017, Northamptonshire Police intelligence log indicated that dealing of class A drugs was being conducted from Louise's home address. The following day Louise was admitted to hospital due to her suicidal ideations. The doctor there confirmed his intention to conduct an assessment which would inform the appropriate action to be taken.

3.54 On 14th April 2017, NHFT records indicate that the boyfriend together with Louise's mother, visited Louise whilst she was in hospital and records indicate that the boyfriend was observed to be swearing at Louise and being demanding. There was a missed opportunity to see Louise in her own whilst she was in hospital and whilst there was no IDVA available at the time in hospital there were links to Domestic Abuse Services available which were not offered to Louise.

3.55 The following day Louise was granted leave from hospital to see her child and when she returned to the ward she was seen receiving a package from another patient. She then quickly left the ward again with the package and did not return until 22.20 hours the following day. When challenged she said she had been to the railway station to take her own life, but a member of the public had stopped her. She said she had been taken to hospital. There is no evidence that staff debriefed her or checked with KGH that she had attended that hospital. There was no discussion of a safety plan or about updating the risk assessment.

3.56 On 17th April 2017, NHFT records indicate that staff raised safeguarding concerns with Louise when she disclosed that the boyfriend had physically assaulted her at the weekend whilst she was on leave from the hospital. Staff encouraged her to report the matter to the Police which she promised to do. Staff should have made a referral as the obligation on Adult Social Care is now to report such incidents to the police.

3.57 On 18th April 2017, Louise was seen by a consultant, and she expressed her fears of being discharged as she alleged the boyfriend was violent towards her. It was decided that discharge would happen only when support services were in place. It was noted that Louise had still not reported the assault by the boyfriend to the Police. The Family note that Louise saw the hospital as a real protective factor and wanted to stay in the hospital. It made her feel safe. Her mother and sister had asked that the boyfriend was not to be allowed into the hospital and to their knowledge, he wasn't. The family feel this demonstrated that when Louise was away from him, she was getting stronger.

3.58 On the same day the boyfriend failed to attend the breach hearing at the Magistrates Court and a warrant was issued for his arrest.

3.59 On 19th April 2017, Louise was discharged from hospital.

3.60 On 20th April 2017, S2S report that although Louise admitted the continued use of crack and heroin, she stated that she felt better, and she had no thoughts of self- harm or suicide. Her safety plan would be to call her mother if she needed to. The family stress that her mother must not have known she was using drugs at this time because, is she had have known, she would have had no other choice, due to lack of support her mother had at the time, to have asked her to leave in order try to safeguard the child.

3.61 On 21st April 2017, Louise did not attend an appointment with NHFT, and the Police were called to ascertain her whereabouts because despite calling her on numerous occasions there was no answer from the phone. One possibility would have been to call her mother to find out where she was.

3.62 On 24th April 2017, Louise was contacted by S2S following a Police call. Louise stated that she was staying at her mother's address, and the Police wanted her to make a statement regarding the domestic abuse involving the boyfriend. She however said she did not want to make a statement and wanted to continue her life without the boyfriend.

3.63 On 26th April 2017, S2S had a telephone conversation with Louise who said she had missed group sessions earlier and she was up all-night smoking crack with the boyfriend. She was advised to attend S2S that day to discuss why this had happened and to discuss how to move forward.

3.64 On 28th April 2017, Louise reported to NHFT that she did not feel mentally well, and she had been using cocaine. There were no further concerns raised and there would be no further nurse contact.

3.65 On 8th May 2017, the boyfriend attended a Safer Relationships session, but he was sent away by facilitators as they had learned that the boyfriend was wanted on warrant. He was advised to hand himself in.

3.66 On 11th May 2017, Louise's mother had told S2S that Louise no longer lived with her as Louise had been regularly under the influence of substance and she had been concerned for the safeguarding of the child. Her mother had asked her to leave, and Louise had returned to the boyfriend.

3.67 On 13th June 2017, Louise contacted the Police following a verbal argument with the boyfriend who was refusing to leave their home. The boyfriend had gone before the Police arrived and no offences were disclosed. A DASH risk assessment graded the risk as standard.

3.68 On 4th July 2017, Louise was seen by S2S and reported intravenously using heroin and crack cocaine by 'snowballing[20]' three times a week as well as smoking heroin and using crack cocaine three times a week. A health screen detected the use of the same four drugs and an assessment of the long-term risk of fatal self-harm was put at high.

3.69 On 25th July 2017, Louise was seen by S2S and reported a reduction in her drug use of 1-2 times a week and that she no longer injects due to the increased risk of an overdose. She was taking her mental health medication and had no plans to harm herself.

3.70 On 26th July 2017, Louise saw her GP complaining of panic attacks for the previous two months. She stated they were getting more frequent. It was noted she was using prescribed methadone and denied taking any street drugs. She had no suicidal ideations. She was prescribed beta blocker medication, and the GP was to consider Cognitive Behavioural Therapy (CBT) if things didn't improve. Five days later she called the surgery stating she had lost her tablets, and a medication review was conducted over the telephone. There does not appear to have been any questions asked about Louise's child. Both Louise and the child were registered at the same surgery.

[20] Snowballing – taking a cocktail of drugs at the same time to maximise their effect.

3.71 On 1st August 2017, Louise failed to attend a nursing assessment at S2S.

3.72 On 7th August 2017, Louise's mother contacted S2S saying that Louise had been told the news of a close friend passing away and that she was staying back with her mother for a period of time. The news of her friend had led to her using five bags of heroin intravenously, which is excessive and dangerous. Her mother was provided with contact telephone numbers for bereavement counselling and also reminded of the Crisis and Telephone Support Services (CATSS) line should Louise require it. The following day Louise attended an appointment with S2S and stated she had not used any drugs for two days which had helped improve her mental health. She was then living with her brother's girlfriend and chose not to be in a relationship with the boyfriend as she wanted to concentrate on her recovery. On the same day Louise received a letter from Kettering Borough Council (KBC) housing services she was £133.00 in arrears with her rent.

3.73 On 9th August 2017, Louise attended the GP practice with her mother with a necrotic area on the inside of her right wrist. This was dressed and an appointment was made to see the nurse on 11th August 2017 which she did not attend.

3.74 On 16th August 2017, Police attended a shop in Kettering town centre where Close Circuit Television (CCTV) had shown Louise struggling with staff from the shop. On arrival the shop's management refused to make any complaint, but Louise was advised not to return to the store. The staff at the shop thought that she was stealing or attempting to steal from the shop.

3.75 On 20th August 2017, Louise contacted the Police complaining she had been assaulted by the boyfriend during an argument about his use of crack cocaine and heroin. During the argument he had grabbed her around the throat causing a red mark. When officers attended the boyfriend had left and Louise refused to make a complaint. A DASH risk assessment was completed and graded as medium. She was given appropriate safety advice. She was signposted to the Sunflower Centre.

3.76 The following day the Police were contacted by Louise's mother saying that it appeared that Louise had relapsed, and she was making verbal threats over the telephone to remove her child from her mother's care. The mother was concerned that Louise and the boyfriend may try to remove Louise's child. It appears that the police were not informed and because of this Louise's mother reported the matter to Children's Services and she was advised to contact Coram Children's Legal Advice Centre regarding obtaining a Guardianship Order. Just before midnight on that day EMAS attended to Louise who had taken an overdose of tramadol tablets in conjunction of heroin. It was reported that Louise felt suicidal and depressed. She was taken to KGH where she was treated for her overdose and admitted. The family stress that for 2/3 days the hospital, Louise didn't know who she was. The pharmacy had contacted the family to say Louise hadn't been picking up her prescriptions and then her mother phoned the hospitals to try to find where she was. She was disturbed, mute and didn't know who anyone was. She couldn't even speak to say she was going through withdrawals. She appeared very afraid of men (doctors, and visitors), which was noted by nurses and the Family consider that could have been explored further.

3.77 On 22nd August 2017, the Sunflower Centre made another MARAC referral and attempts to contact Louise were unsuccessful since she was in hospital.

3.78 On 23rd August 2017, S2S enquired with the pharmacy and found that Louise had last collected her medication 18th August. The pharmacist was asked to void any prescriptions as it was thought that Louise was no longer safe in collecting her own prescriptions which was good practice.

3.79 During the afternoon of the 23rd August, Louise was reviewed in hospital by the Acute Liaison Mental Health Team (ALMHT) found Louise to be uncommunicative with a vacant expression. She needed assistance with personal hygiene and an investigation took place to determine if her symptoms had any organic cause which was later ruled out.

3.80 By midnight on 23rd August 2017, Louise was still in hospital in a poorly condition. The ALMHT made the decision after the advice from a consultant, to defer assessing her mental health due to physical her condition at that time. (However, this was completed on 29th August as her medical condition had improved). On the same day, 23rd August 2017, KBC Housing Services served a possession notice at Louise's address due to increasing rent arrears.

3.81 Following a medical review on the 24th August 2017, Louise was referred to the mental health team.

3.82 During the afternoon of 24th August 2017, KGH contacted Louise's mother to explain Louise's current health and care situation. The mother thought that her condition was unusual as Louise was a regular heroin user. Her mother explained that her partner was known to be violent, and that Louise's friend had recently died through using drugs and since then Louise had increased her drug intake. The mother described how Louise had been depressed since the death of her friend.

3.83 By the evening of the 25th August 2017, Louise's condition had deteriorated, and various samples were taken, and x-rays were conducted.

3.84 On 26th August 2017, there was an improvement in her condition, and she appeared to be more alert and orientated.

3.85 The following day just after 04.30 hours Louise was standing on her bed saying, 'I want to hurt myself'. By midnight she was noted to be wandering without purpose in an agitated condition requesting methadone.

3.86 During the afternoon of the 29th of August 2017, Louise was seen by an ALMHS Recovery worker. She reported that she could recall that whilst she was on the floor following her overdose, the boyfriend was hitting her and physically abusing her. She was in a low mood and expressed her wish to stop using illicit substances. Louise said she did not feel well enough to be discharged and there was concern that her current presentation was significantly different from her usual functioning when she had previously overdosed on heroin. An Adult Social Care Referral was made. The Family stress that no medication was given to help her come off the drugs. She was violent, incontinent and released to her mother's where her young child was living. There is nothing to indicate what happened to the Adult Social Care referral and it seems that there was a lack of professional curiosity regarding the ability of her mother to cope with a young child and a violent, incontinent daughter.

3.87 On 30th August 2017, Louise was again seen by ALMHS. Louise said that she had regretted her actions and at that time had no suicidal intent. Mention was made of the Sunflower Centre supporting her with the Freedom Programme and that on her discharge she will be staying initially with her sister and then moving back in with her mother. Louise realised that this overdose could have killed her, and she stated that she didn't want to die. KGH Safeguarding Lead advised the Sunflower Centre of her discharge. She was discharged just after midday on the 30th August.

3.88 On 31st August 2017, the ALMHS recovery worker attempted to speak to CSC to advise them about concerns around Louise's child, but CSC stated that data protection rules would not allow for this conversation. This is unfortunate considering the

discussion was about a safeguarding issue. A referral to the Multi Agency Safeguarding Hub (MASH) may have been a better option.

3.89 On 1st September 2017, Louise attended an S2S meeting where she reported being drug free and wished to go on to Naltrexone[21]. She explained she had been issued with Naloxone whilst in hospital and that she wasn't staying in Kettering which reduced her risk of using heroin.

3.90 On 3rd September 2017, on receiving information from the hospital, her GP added Louise's name to be discussed at the next MDT (Multi Discipline Team) meeting at the surgery. The following day Louise contacted S2S concerned about her mental health and stated she had not been taking her mental health medication. She was advised to seek an urgent appointment with her GP.

3.91 On 4th September 2017, Louise attended at her GP appointment with her mother. She told her GP she was not given methadone whilst in hospital and felt that there were conspiracies ongoing. She felt that people were out to kill her. She couldn't sleep and appeared very confused. According to her mother she had constantly been talking about killing herself and at times was agitated. The GP referred her to the Crisis Resolution Team/ Home Treatment Team who saw her on the evening of the same day and made a referral for her admission or accommodation out of the county. Louise described how she was taking her own life in the same way as her father did, and if she had any tablets, she would take them. She saw her only future was in a coffin and that she would take another overdose as she doesn't want to 'be here anymore'. Louise was offered home treatment by UCAT team, but she declined this. She wanted hospital admission or out of area admission if no local bed was available. Her mother stated she was willing to take Louise home while an inpatient bed was sorted.

3.92 During the morning of 5th September 2017, S2S received an urgent telephone call from Louise's mother saying that Louise intended to leave home within the hour to use heroin and get admitted to hospital that way if a bed was not found for her quickly. Her mother stated she had been up all-night preventing Louise from leaving and the mother was convinced that if she did leave, she would attempt to end her life. Meanwhile, efforts were being made to find an inpatient bed but not before her mother made another call to say that Louise had left. She was advised to ring the Police. However, not long after Louise returned home and was told that a bed had been found out of the area and an escort to convey Louise was being arranged. Louise was transported and admitted to a hospital in London (determined to be Essex) until a local bed was made available.

3.93 On 11th September 2017, KBC Housing Services managed to contact Louise's mother about the rent arrears that Louise had incurred. The mother explained that the arrears were nothing to do with her and that Louise had been in a coma in hospital for several weeks and was still in hospital. She advised Housing Services to take the property back, but Housing Services explained that this was a legal process that could take some time. The mother tried to explain that she was elderly, looking after her grand-child and couldn't get involved in anything else. When asked if there was anybody else in the family, the mother advised that there wasn't and there was no Social Services involvement either. Housing Services tried to locate Louise in hospital to check on her welfare and to enquire if an advocate had been appointed to deal with her affairs.

[21] Naltrexone - a synthetic drug, similar to morphine, which blocks opiate receptors in the nervous system and is used chiefly in the treatment of heroin addiction

3.94 On 15th September 2017, Louise was discussed at the GP's Practice Adult Safeguarding Meeting where it was noted that she may be being abused by the boyfriend. Following the discussion Louise was removed from the safeguarding list but there are no details as to the rationale behind this decision.

3.95 On 18th September 2017, the Sunflower Centre contacted the hospital in Essex to confirm that Louise was still receiving support and there were no plans for her imminent discharge. The following day a MARAC meeting was held that decided that should Louise be discharged from hospital a referral would be made to CSC if she approached her mother's home. On the same day KBC Housing Services contacted KGH still trying to locate Louise so that she could be visited to complete the relevant documentation about her house.

3.96 On 21st September 2017, S2S called CSC with concerns about Louise being discharged to her mother's address where her child was residing. The duty social worker agreed to refer the child to the Early Help Team. On the same day a doctor from the hospital in Essex contacted S2S requesting an urgent prescription for Louise as she was returning home following bad news regarding a family members health. The doctor was told this would not be possible. It appeared that Louise was due for discharge home on 29th September 2017. This was confirmed to Louise by a doctor at the Essex hospital who told her that she would be discharged on that day with sufficient medication for the weekend, but she would have to get ongoing medication by a prescription from S2S. The doctor requested that S2S inform Louise's mother that her next appointment with S2S in Kettering would be the 2nd October 2017.

3.97 On 2nd October 2017, Louise attended her appointment with S2S. She stated that she had no intention to commit suicide or self-harm. Her urine proved positive for methadone and diazepam. She said the methadone had been prescribed.

3.98 By 6th October 2017, she admitted to her GP that she had relapsed by smoking and injecting heroin. She appeared to be still under the influence when she was seen by NHFT nurse later that day.

3.99 Towards the end of October, KBC Housing Services eventually contacted Louise to discuss her arrears. She was encouraged to try to make some sort of payment if possible and an email was sent to credit union on Louise's behalf seeking assistance with arrears on gas, electricity, water and council tax.

3.100 On 2nd November 2017, at a GP's appointment Louise described feeling down and not going out since she was discharged from hospital two months earlier. She also stated that she had taken no drugs for those two months which is contrary to what she told the GP on 6th October.

3.101 On 6th November 2017, Louise attended S2S where she admitted smoking crack cocaine and heroin a few days prior. She was no longer an open case to mental health services but did have contact details for them should the need arise.

3.102 On 10th November 2017, Louise's S2S worker made a referral for her to MIND[22]. She'd also been referred to the Wellbeing Service.

3.103 On 13th November 2017, Louise attended S2S to collect her prescription and reported that her mother had asked her to leave her home because she was using substances, and her mother didn't want that around the child. Louise stated that she had returned to her previous address but was not in a relationship with the boyfriend and a

[22] MIND - A mental health charity in England and Wales

discussion around a safety plan took place. Louise admitted smoking substances but not using intravenous injections.

3.104 Later that day Louise's mother contacted S2S and reported that Louise had gone to school where her child attends and had been involved in an altercation with her sister-in-law. Louise had dragged her sister-in-law across the road and hit her. Louise's mother was concerned about the child and the risk that Louise might try to take the child away. She was advised to ring the Police. On the same day Louise failed to attend a GP appointment.

3.105 Police intelligence log dated 14th November 2017 indicate information had been received to the effect that Louise was associating with drug dealers in Kettering who were also known shop lifters. Louise had visited an address in Kettering and told the occupant (presumably known to Louise) that she was being followed. The occupant left Louise alone in the address to conduct a search and on their return, Louise was asking to borrow money. Her request was refused, and Louise left the premises. A short time later the occupant discovered their wallet missing but it was found later minus £30 cash.

3.106 Louise was seen by the Police, admitted going to the address but denied stealing the wallet and money saying the occupant had lent her the money although she had no intention of paying the money back. Louise inferred that the occupant would lend money to girls for sexual favours. The investigation was reviewed by a supervisory officer who decided that there was no realistic prospect of conviction, and the matter was filed.

3.107 On 17th November 2017, more information was received by the Police that Louise was associating with another known drug user, and on that day, she did not attend a hospital appointment with the neurology team.

3.108 The following day, 18th November 2017, the boyfriend called the Police as Louise was banging on his front door. The boyfriend would not let her in. The police attended two days later. No offences were disclosed, and a DASH risk assessment was completed and graded as standard.

3.109 On 20th November 2017, Louise attended S2S drop-in service stating she had relapsed into both heroin and crack cocaine use and wanted an increase in methadone instead of going with the plan to swop methadone for buprenorphine. She felt suicidal following an assault from the boyfriend at the weekend where she had attended A&E but had not waited to be treated. She said she wanted to remain in a relationship with the boyfriend. Safety plans were discussed and contact numbers given to her to contact S2S should she feel that she needed further support.

3.110 On the same day, Louise's GP records show that a telephone conversation took place between Louise and her GP when she said she had tried to hang herself on the previous Saturday, 18th November 2017. She was in need of medication. That incident is not recorded by any other agency.

3.111 On 22nd November 2017, a Safeguarding Meeting was held at S2S where the risks with regards to Louise and her child were discussed including Louise's mental health and domestic abuse. A plan was made for S2S to write to Louise's GP raising concerns about her mental health and for S2S to liaise with CSC as the Early Help had not yet contacted Louise. Louise was also to be referred to MARAC via a DASH Risk Assessment.

3.112 On 23th November 2017, police intelligence showed that Louise was now living with another man in Kettering, and it was alleged that she was using a pedal cycle to collect

drugs to fund her heroin and crack cocaine addiction. She was associating with several known drug dealers who were dealing from Louise's home address.

3.113 On 1st December 2017, KBC Housing note that they had finally caught up with Louise about her rent arrears. Louise offered to pay at the rate of £20 per fortnight. She paid the first instalment but failed to pay the second.

3.114 As Louise collected her medication from S2S on 4th December 2017, she disclosed that the boyfriend had tried to strangle[23] her and punched her but she did not wish to leave the relationship or report the matter to the police. A DASH Risk assessment was completed and submitted. She told S2S that she had not taken heroin or crack cocaine for two days and that she was not injecting but smoking the drugs. She recognised the link between drug taking and her low moods and an appointment for her to attend MIND on 7th December 2017 was made. She said that she would attend MIND but there is no record of her doing so.

3.115 On 10th December 2017, the Sunflower Centre attempted to make contact with Louise but was unsuccessful. Contact was made with S2S asking for a visit to Louise offering additional support.

3.116 On 13th December 2017, a neighbour living near to Louise's flat contacted KBC Housing saying that Louise's flat was being sub-let and used to run a business.

3.117 On 18th December 2017, Louise did not keep an appointment with S2S. Two days later a man contacted the police stating that Louise had been bothering him requesting to borrow money. He knew Louise as he had paid her £250 and £300 but denied that this was for sex, although he admitted having sex with Louise in three occasions in the last 8 weeks. He was given advice and a DASH Risk Assessment was completed which was graded as standard.

3.118 On 9th January 2018, Louise was discussed at MARAC for the third time. The decisions from that meeting were both Louise and the boyfriend were to be considered as victims and perpetrators and neither of them will report matter to the police or the Sunflower Centre. Another action was for S2S to complete a DASH Risk Assessment for the boyfriend and support him to find his own accommodation to allow him to break away from Louise. NHFT notes of the meeting record that a MARAC Social Worker was to contact MASH for a single assessment for Louise's child as no one appears to have parental responsibility for the child. There was a suggestion that Louise had assaulted her mother and her sister when picking up the child from school. There was also an action for S2S to complete a DASH for the boyfriend and help him to find his own housing to allow his to break away from Louise.

3.119 Louise did not pay her rent in January 2018 and was in more arrears with KBC Housing.

3.120 On 15th January 2018, Louise collected her prescription from S2S. She was in a low mood and stated that she was spending £30 per day on crack and heroin. She had no plans to harm herself but understood the risk drug abuse was having on her physical and mental health. Louise thought she may need an increase in her methadone.

[23] A Red Flag for Homicide 3rd October 2018 Prof. Heather Douglas University of Queensland Australia. 'Non-fatal strangulation is a significant risk factor for a women being killed by her partner. Three quarters of women in domestic violence shelters report non-fatal strangulation from their previous partner. It is a gendered crime. Most victims are women and most Perpetrators are men.'

3.121 On 23rd and 24th January 2018, KBC Housing called at Louise's flat to offer her support but there was no response on both occasions.

3.122 On 30th January 2018, Louise did not attend for a S2S appointment, although she did collect her prescription. She was seen to have mud over her clothes, and she stated that she had been on a three-day crack cocaine 'binge' and had not eaten for three days. She stated that she was living at home and had no contact with the boyfriend. She said that she was smoking heroin every day and that she had been referred to counselling regarding the death of her father. She had no intention of harming herself.

3.123 On 4th February 2018, police received information that Louise and another man were using Louise's address to deal drugs. It was stated that there was a constant stream of people arriving at the address by day and by night and that an Organised Crime Group (OCG) was operating between her address and another address close by. As a result, and 6 days later, police visited Louise's address. Officers found signs of drug usage and Louise admitted that the house was due for re-possession in the near future. There was no gas or electricity, and the house was due to be taken back by the council due to rent arrears. Louise appeared depressed and admitted prostituting herself for money to fund her drug addiction. Officers submitted an Adult Safeguarding referral and informed housing of what they had found. Adult Safeguarding informed Louise's GP and housing on 20th February 2018.

3.124 On 12th February 2018, Louise missed her appointment with S2S but did attend the following day for her prescription. She reported that she had been smoking heroin and crack cocaine most days.

3.125 The following day the police received disturbing information that the drugs ring had been robbed of a quantity of drugs which had put the 'ring' out of action. The OCG were seeking retribution, and they had access to firearms.

3.126 On 23rd February 2018, Louise attended for a medical review and admitted using two to three bags of heroin daily, but she had reduced her crack intake. She stated she felt that her mental health had improved. This was confirmed by S2S on 26th February 2018, where she was described as being much more mentally stable.

3.127 Louise did not attend to a S2S appointment on 6th March 2018, but attended a week later. She admitted using drugs most days. The importance of attending at her appointment with S2S was stressed to her.

3.128 On 13th March 2018, a hand delivered letter for Louise from Housing Services was given to a man at who was at her address. The letter informed her of a court appearance on 21st March for rent arrears. The following day Housing Services discovered that her electricity meter had been tampered with. There was no heat or hot water in the flat.

3.129 On 17th March 2018, the boyfriend was arrested for the assault on Louise 4 months previously when he had tried to strangle her to a point where she nearly passed out. He had to be restrained by officers. He refused to make any comment when interviewed. An initial DASH Risk Assessment measured Standard, but this was subsequently altered to High Risk by a supervisor. An Adult at Risk referral was submitted and shared with Louise's GP and Children's Services.

3.130 On 18th March 2018, the warrant was executed at Northampton Magistrates Court and the boyfriend was arrested for breaching his conditions. His Community Order was revoked, and he was re-sentenced to a suspended sentence order (6 weeks custody suspended for 12 months) with a Rehabilitation Activity Requirement (RAR) for 60 days.

3.131 Later that night, the boyfriend went to Louise's address, but she refused him entry. He gained access to the house however by climbing through a broken rear window. An argument ensued and Louise left to walk to a friend's house. The boyfriend followed her there, but he was again refused entry and the police called. He had left by the time the police arrived. Police located him at Louise's address, and he was removed to a different address. A DASH Risk Assessment was completed as a Standard, but this time upgraded by a supervisor to medium, having consideration of the history of domestic abuse between Louise and the boyfriend. Louise stated that her boyfriend had tried to strangle to the point where she had passed out. This had happened some 4 moths previously. The matter was examined by a supervisor and filed as no offences were recorded. The police submitted a child referral report and made a referral to MASH. On receipt of the referral on 23rd March 2018, Social Services informed Louise's GP. No social care concerns where identified.

3.132 On 20th March 2018, the National Probation Service (NPS) contacted Adult Social Care to see if Louise was known to them. They were told that her case had been closed in April 2017. NPS expressed concerns that Louise was still living with the boyfriend. NPS said that they would pass the concerns to BeNCH CRC to follow up. NPS also contacted MASH to ascertain if the child was known to Social Services, but this was also a closed case as the child lived with Louise's mother.

3.133 The following day Housing was contacted by a neighbour of Louise complaining that Louise was regularly fighting outside her flat and that there was a group of men from Wellingborough staying at the flat believed to be drug dealing. It was reported that Louise often knocks on neighbour's doors asking to use mobile telephones. The neighbour said that they had been reluctant to complain in the past but now felt that something had to be done about the behaviour and that the neighbour was now willing to speak to the police. On the same day Louise did not attend a pre-court interview with housing.

3.134 Later that day, 21st March 2018, the boyfriend attended an appointment with his RO (Reporting Officer). He stated that he had become depressed and that was why he had not completed his Community Order. He said that he was the carer for Louise's mental health, and he had been trying to sort out her rent arrears, He stated that he had been clear from drugs for 2 years and he got angry when Louise spent her money and wasted it on drugs. He reported that he had to bite his tongue sometimes to avoid an argument and he would often go out to stop thing between him and Louise escalating. He said that he wanted to live a crime free life.

3.135 On 22nd March 2018, Louise reported at her nursing appointment that she had been smoking crack all night and that she owed a drug dealer money for drugs.

3.136 On 23rd March 2018, a referral sent by Social Services to Louise's GP was not seen by the GP due to an administrative error. The referral contained information to the effect that Louise had allowed the boyfriend back into her flat. A SI (Serious Incident enquiry) has been conducted into this matter details of which will be referred to later in this report.

3.137 On the same day Housing conducted a letter-drop in the area around Louise's flat, asking residents if they had any complaints about the behaviour, fighting and drug usage. None of the residents replied. The Family have views on the letter drop. They feel that the immediate neighbours of Louise and some of the wider community had issues with drug and social problems, so this was perhaps not helpful to Louise's recovery. In addition, asking neighbours if they had any complaints about Louise's behaviour could have escalated her risk by raising awareness of her within the community.

3.138 On 26th March 2018, the boyfriend was considered by BeNCH for a Safer Relationship Programme to start on 21st May 2018. BeNCH also made an Adult Safeguarding referral as requested by Social Services regarding the vulnerability of Louise whilst she continued to live with the boyfriend and the ongoing risk of physical, emotional and psychological abuse. Louise was not open to Social Service at this stage.

3.139 On 29th March 2018, Adult Social Care Manager contacted the boyfriend's RO at BeNCH asking why a referral had been submitted on 26th March and that no record could be found of contact between Adult Social Care and NPS. In any event it appeared that Louise did not meet the threshold for ASC involvement.

3.140 On the same day, 29th March 2018, Social Services Care Manager deemed that this was not a safeguarding issue. The Probation Officer was contacted, and he told Social Services that he had been advised to submit a referral form to Social Services, but he was unsure why and he was unsure of who instructed a referral to be submitted. The Care Manager undertook to follow up the drug abuse and mental health concerns. It was discovered that Louise had an ad hoc engagement with S2S and no recent engagement with the mental health team. As far as the GP was concerned, Louise last had telephone contact in February when she reported feeling low, but there were no concerns recorded on the system and Louise was logged as being a victim of domestic abuse.

3.141 However on 4th April 2018, ASC contacted the RO at BeNCH saying that the referral had been found and reviewed by a Principal Care Manager who confirmed that it did not reach the threshold for intervention, however the circumstances of the notification would be looked into and any necessary action taken.

3.142 On the same day, 4th April 2018, the police confirmed to the Domestic Abuse Unit that Louise had been spoken to on 20th March and there had been no concerns for her welfare. This was in conflict of the information on 22nd March when she admitted smoking crack cocaine, she was in rent arrears and owed money to drug dealers and information from 26th March when concerns were raised about physical abuse, emotional abuse and psychological abuse if she continued to live with the boyfriend.

3.143 On 5th April 2018, concerns were raised via the boyfriend's Probation Officer that Louise was not engaging with S2S, she had recently increased her methadone, and she was currently using heroin and crack which was possibly impairing her mental health. She had recently had a hospital admission for her mental health.

3.144 On 8th April 2018, Louise and another woman stole £25 worth of food from a local shop. They were seen on CCTV and this offence was being investigated at the time of Louise's death.

3.145 On 12th April 2018, the boyfriend was seen by his Probation Officer. He started that he had no problem with his anger management and was still abstinent from heroin and although he had tested positive for Cocaine use that was not recent. He had been clear from Cocaine for some time. He agreed to some Victim Focussed work whilst he was waiting for his Safer Relationship Programme to start.

3.146 On 26th April 2018, the boyfriend attended an appointment with his RO, after failing to keep a telephone appointment on 19th April. He explained that he had been drinking again but he was trying to keep off drugs. He was no longer engaging with S2S because he wanted to try and reduce his drug intake on his own without help from S2S.

3.147 Housing obtained a warrant to enter Louise's house regarding a gas safety check on 1st May 2018, but this was not executed on that day.

3.148 In May 2018, at a MARAC meeting, information was heard to the effect that Louise's address was being used as a base for 'cuckooing[24]'. A plan was made for services to encourage Louise to attend Kettering Borough Council to re-engage in treatment. Social Care was also to complete a single assessment. Later that day Louise attended a drop-in centre requesting a prescription for her medication. She was seen briefly, and arrangements were made to see her again at 1300 hours the same day. Louise stated that she was no longer on prescribed treatment as she had not been collecting her prescription. Louise did not attend at 1300 hours and attempts to contact her failed. A letter giving details of another appointment was sent to her.

3.149 In May 2018, the boyfriend failed to attend an appointment with his RO and a breach warning letter was sent to him. The breach prosecution was not pursued due to the subsequent death of Louise

3.150 At 01.24 hours a few days later police were notified by EMAS that they attended Louise's flat where a female had hung herself. The boyfriend was being aggressive and EMAS requested the attendance of the police. On arrival the police found EMAS working on Louise. The boyfriend was there and stated that both he and Louise had been using drugs throughout the day. He had used heroin, and Louise had used heroin and crack Cocaine. An argument had occurred over Louise using crack Cocaine and the boyfriend had left the room to avoid the argument escalating. He heard banging noises from the room that Louise was in and when he went to investigate 10 to 15 minutes later, he found the door locked. He forced the door and found Louise hanging from the back of a cupboard door with a red scarf around her neck. He cut her down and ran to a neighbour for help. Police Officers spoke to the neighbour who stated that they were aware of Louise attempting to take her life on several occasions since the beginning of 2018.

3.151 At 0900 on a few days later, a Housing Officer made a Home Visit to Louise's address. There was no response so a visit to her mother was made. Louise's mother stated that the previous day Louise had attempted suicide and had been admitted to hospital. Housing stated that Louise's address would be secured to protect her property whilst she was in hospital. On arrival at Louise's address the Housing Officer found the boyfriend there. He was asked to collect his belongings and leave which he did. Housing Officers found a note on the sofa that appeared to be written by Louise shortly before her attempt to take her life.

3.152 Subsequent examination of the note by the police showed that it contained information apparently written by Louise to the effect that she was lonely and expressing her love for her family. The note also mentioned that the boyfriend showed his 'true colours' watching her attempt to take her life and doing nothing about it. It was believed that this note may have been written following previous suicide attempts.

3.153 Louise was taken to hospital and medical staff worked on her in the Emergency Department. She was transferred to Intensive Care. It was though she may have suffered a cardiac arrest in the process of attempting to take her life.

3.154 Louise's mother and sister were consulted when the condition of Louise deteriorated the following day. Louise died at 16.09 hours during the following days.

[24] Cuckooing – when drug dealers take over a property to deal in drugs and provide drugs to the tenant in order to deal. If the tenant refuses, they are usually subjected to violence (there is no suggestion that the 'cuckooing' involved sexual exploitation in this case).

3.155 A police investigation commenced during which there was no evidence to suggest any criminal actions by a third party. H.M. Coroner for Northamptonshire has yet to hold an inquest into Louise's death.

4. Views of the family

4.1 Family members were written to by the Author of this report at an early stage in the review process, explaining the procedure, purpose and scope of the review including the details of the terms of reference.

4.2 In due course the mother of Louise contacted the CSP indicating that she would be willing to engage with the review process. Subsequently to the sister of Louise also indicated that she would like to contribute to the review.

4.3 Arrangements were made for the Author and the Community Safety Manager from Kettering Borough Council to visit Louise's mother in Northampton on 4th January 2019.

4.4 The meeting was very productive, and Louise's mother was very open and honest in her views of Louise, her struggle with her drug dependency, the boyfriend, and agency involvement with Louise, the boyfriend and the child.

4.5 In detailing some history and context to the family life the mother explained that Louise grew up as a happy 'normal' girl until she was about 13 years of age. Whilst at school, Louise had stated that she wished her father was dead. She did not repeat this at home but not long afterwards her father took his own life. He had mental health problems, and her comment played on Louise's mind after his death. This caused a sudden change in her behaviour and the mother thinks that this was the catalyst to the deterioration in her well-being Louise had experienced after that.

4.6 Louise's grandfather was one of 14 children, and he died when her father was born. All 14 children were brought up in children's homers and most of them were abused in their early lives.

4.7 Louise was the youngest of four children. Her siblings are all adults, male, female and male respectively.

4.8 Having been very good at school prior to her father's death, Louise changed. She rebelled, failed to take her exams and got involved in problems at school. One incident in particular recounted by the mother, involved Louise being blamed for smoking at school and she was grabbed by the teacher as she tried to escape. Apparently, there was an investigation into that matter, but the outcome is not known.

4.9 Louise's mother thinks that Louise started to take drugs at the age of 14 years. The mother found some silver paper in Louise's pocket. She and the older sibling confronted her about it, but she refused to say where she had got the drugs from. It is thought that Louise was also using alcohol at this time.

4.10 Louise's mother said that Louise had known the boyfriend for about 10 years. Louise did have other boyfriends in the past, but this boyfriend was supplying Louise with drugs. The mother said that she never liked the boyfriend and would avoid him where possible, although after the birth of their child, Louise, the boyfriend and the baby stayed at the mother's house for a while. The boyfriend had accommodation in Leicester and would call Louise over to Leicester to see him and to give her drugs.

4.11 Louise's sister did not have anything to do with the boyfriend. She didn't like him. Her sister was never told anything about the abuse Louise was being subjected to by the boyfriend.

4.12 Louise's mother said that the boyfriend has 6 daughters from various other women, but he never sees them.

4.13 According to Louise's mother, Louise was 'over the moon' when she found out that she was pregnant but when the child was born Louise visited her mother in a terrible state because of drugs she had taken. Louise's mother told Louise to go to S2S to get some treatment and that the mother would support her through it all.

4.14 Louise's mother said that Louise was fearful that in a strange way, the boyfriend was the only person she felt was supporting her and that is why she wouldn't press charges when the police responded to calls about the violence. Louise's mother felt that Louise was so coercively controlled by the boyfriend that she believed he was the only one who supported her. (This is common for lots of domestic abuse victims).

4.15 Louise told her mother about the violence she was being subjected to at the hands of the boyfriend, so her mother went to see him and told him that she thought they were in a toxic relationship. She said that Louise would leave him, go home but she always returned to him because he promised all of the drugs she wanted. Louise's mother said that she thought that Louise did not tell her everything about what was going on with the boyfriend as Louise knew that her mother would go and confront him.

4.16 Louise's mother kept saying that she couldn't believe that Louise was let down by agencies so badly. She quoted the incident in prison when Louise threw herself over the balcony and was seriously injured. Louise's mother said that when Louise was discharged from hospital she was returned to prison without any support from any agency. Louise took an overdose of Tramadol and was taken to KGH but again sent home with no support. She said that whenever Louise went to KGH she was told that there was nothing that could be done for her because she (Louise) was on drugs. Louise's mother would get really annoyed when she heard this comment being made.

4.17 When the conversation turned to the degree of support Louise had been offered and the number of times Louise had missed appointments and had not attended, Louise's mother was surprised and stated that she was unaware of this.

4.18 In relation to the boyfriend, Louise's mother said that she didn't like him and did not encourage him to come to her house, but she appreciated that he had supervised contact with the child, especially now that Louise has died. The supervision is by an independent Social Worker. Louise's mother has nothing to do with supervising the boyfriend with the child. Presently the boyfriend does not see much of the child.

4.19 Louise's mother described how she has looked after the child on a full-time basis for 3 years with no support from any agency. The common thread that ran through the visit was the support Louise's mother considered was lacking not only for Louise whilst she was alive but also for herself now, she has the child to look after. She stressed to say that she was a pensioner looking after a young child.

4.20 Louise's mother is very concerned about comments made by the boyfriend during the investigation. She understands that the boyfriend stated in interview that he had left Louise only for five minutes whilst he went upstairs to avoid an ongoing argument, yet she was told by a medical professional (unknown who) that Louise had been without oxygen for some 30 – 45 minutes. She is also concerned that whilst Louise was in the Chapel of Rest, the boyfriend apparently asked a friend of his to visit Louise's body and cut a lock of her hair for the boyfriend to keep.

4.21 Louise's mother decided on the pseudonym Louise to be used throughout the report.

4.22 Louise's mother also mentioned that she thought that her other daughter would have information that was additional to that she had given to the review, and she would like to see the Author.

4.23 On the evening of Thursday 17th January 2019, the Author travelled to South Wales to see Louise's sister, known in this report as Emma. Emma gave a history of the family dynamics. The father was a Roman Catholic who was a strict father and husband, who ruled the family with a 'rod of iron'. Emma and her older brother were subject to considerable physical abuse from the father as was her mother. Emma described how her father injured her mother on occasions so badly her mother was hospitalised. Emma, however, describes how the son, was treated even worse by the father. Much of this was to do with the father's excessive drinking. According to Emma, in total contrast, when Louise was born, the father curbed his drinking somewhat and treated Louise totally differently. He thought Louise was his 'Princess'.

4.24 Emma stated that her father, being a Roman Catholic, had lots of demons in his life and feared 'facing his maker' and what the consequences were going to be after living his life that way he had.

4.25 Emma described Louise as being the 'salt of the earth', a very pretty young girl with a happy go lucky outlook on life when she was young. Emma and Louise were very close. However, Emma states that Louise never believed in herself, and her lack of confidence made her vulnerable. Emma stated that when Louise took drugs, she was a different person.

4.26 Emma found her father when he took his own life. That had a profound impact on all of the family but especially Louise, who was only 13 when this happened. From then on, she changed. Louise met the boyfriend through a social group that Louise was part of. She had been taking drugs since she was 14 years if age and this continued when she started a relationship with the boyfriend. Louise seemed unable to find friends unless they were from a group that were already known to her. She seemed unable to communicate with people that were strangers to her. This demonstrated her lack of confidence.

4.27 Emma met the boyfriend when he and Louise started their relationship. She knew that he was considerably older than Louise and she was also aware of the boyfriend's previous children by various mothers. Emma did not like the boyfriend, and she felt that the boyfriend did not like Emma, because Emma would ask questions and challenge him. Emma once chastised the boyfriend about hitting and harming Louise and he did not like being challenged.

4.28 Emma said that Louise was easily led and would do anything that the boyfriend asked her to do. When she became pregnant by the boyfriend and had the child, she lived with her mother who looked after both Louise and the baby. However, the boyfriend was contacting her from his home in Leicester and he persuaded her to go to him and live there. The baby stayed with Louise's mother, and no sooner had she arrived in Leicester, Louise was taking drugs again. The baby was affected by Louise's use of drugs whilst pregnant and was in the Special Care Unit for quite some time. Louise always regretted that and felt guilty that her child was affected by her drug use.

4.29 In an attempt to get Louise off drugs, Emma, who owned a house opposite her mother's house, took Louise into her home and helped to look after her there for several months until she could manage without drugs. However, the boyfriend eventually persuaded her to go to him in Leicester, and again, she was immediately back on drugs. Emma

described that Louise was ruled by drugs and the boyfriend ruled her drugs. Louise hated the boyfriend, but she couldn't get away from him.

4.30 Emma's thoughts are that the boyfriend manipulated Louise. He would tell the mother when Louise was taking drugs and tell her different tales about Louise behind Louise's back. He would try to distance himself from the consequences of what he told the mother Louise was doing.

4.31 The Panel has considered information from Emma that Louise was often short of money; this could have been because her boyfriend took her money which left her unable to access support and to achieve her potential. It is possible that perhaps Louise was sometimes restricted from attending meetings with professionals as she had no money or means to travel to them. It is poignant that Louise was at times living in a property with no appropriate cooking facilities and the family have suggested that there were times that the property had no electricity or heating. This could be seen as further examples of how the boyfriend possibly restricted Louise's funds, leaving her dependant on him and trapped in a cycle of abuse and deprivation. The charity, Surviving Economic Abuse[25] states that:

> 'Many women experience economic abuse within the context of intimate partner violence. It limits their choices and ability to access safety'.

4.32 Louise was also in arrears with her rent. All this may have been Louise's reality. Financial and economic abuse can be an invisible form of abuse so is often hard to pinpoint particularly if there are a lot of other complex factors obscuring it but certainly for Louise it is clear that her financial means were minimal. Her lack of financial stability added to her overall vulnerability, and she found it difficult to access sufficient financial support.

4.33 It is relevant to highlight that Surviving Economic Abuse states:

> 'Women who can't find £100 at short notice are 3.5x more likely to experience domestic abuse'.

4.34 Emma often saw the consequences of the domestic abuse inflicted on Louise by the boyfriend. She saw black and bruised eyes, cuts and carpet burns on her face as the boyfriend dragged her across the carpet. She is also aware that neighbours reported that the witnessed the boyfriend dragging Louise along the street by her hair.

4.35 Louise told Emma that she knew she ought to leave the boyfriend, but he had told her that if she did, he would take the child away from her and he would kill Louise and anyone else that went near her.

4.36 When Louise took her life, the family were shocked. Emma stated that Louise had told her that she would never do anything like her father because she knew how much upset her father had caused by killing himself. Louise had said, 'I'll never hurt you like Dad hurt you all'.

4.37 Like Louise's mother, Emma is concerned about the contradiction in what the boyfriend said about only being away from the room for 5 minutes to remove himself from an argumentative situation, when the medical opinion was that Louise had been without oxygen for much longer. She is also concerned about the delay in finding of the suicide note. She confirms that the handwriting on the note is that of Louise. She also

[25] Surviving Economic Abuse Registered charity, No 1173256 survivingeconomicabuse.org

expresses concerns about the children and women the boyfriend had access to at the present time and also in the future.

4.38 Emma considers that Mental Health Services saw Louise as a drug user and that influenced medical opinion about her. She thinks that efforts to curb her drug taking missed the underlying problems that Louise had, which in her opinion, ought to have been addressed first whilst controlling her drug abuse. She does not think that problems stemming from her younger life, were addressed sufficiently enough. She said that Louise once told the Mental Health Team that 'It's my mental health that needs attention first'.

4.39 Emma expressed concern over Louise being discharged from hospital following an overdose about a year before she died. The effects of the overdose resulted in Louise being incontinent and she was discharged wearing nappies with no other support. Emma made the point that Louise was discharged in that condition, to her elderly mother's care with a very young child to also look after and there was no support offered. Within days she was readmitted to hospital, this time to a London hospital and eventually discharged without any sort of care plan. It is the family's view that Louise should have received detoxification treatment whilst she was in hospital and not discharged until she had shown signs of improvement. They see this an opportunity missed.

4.40 The Family feel that Louise was not considered appropriately under the Mental Capacity Act due to her drug abuse. They feel perhaps this was seen as 'lifestyle issue'. The Family believe Section 3 Mental Health Act could have considered her vulnerability more holistically rather than seeing her drug abuse as an 'informed choice'. They feel Louise was not capable of making an informed decision. She was too controlled, addicted, vulnerable and chaotic. Her mental health made her chaotic, not the drugs. The Family feel that it was mental health at route cause, not drugs.

4.41 Through their AAFDA representative, the family question how agencies tried to contact both Louise and her mother. The combined chronology of information from all agencies indicates that there was contact between S2S, Housing and Kettering General Hospital with Louise's mother especially during the summer of 2017. Often calls would be made to the mother's house from professionals trying to contact Louise about her treatment and appointments. Often messages were left for Louise. The family question whether Louise was aware of the times and dates of her appointments. The chronology indicates that on occasions Louise did not attend her appointments, but on other occasions she did. Whether there was lack of communication between agencies and Louise is difficult to be certain.

5. Analysis and recommendations

5.1 It has to be remembered that no one has been charged with any criminal offence in relation to the death of Louise. Northamptonshire Police carried out of full investigation and could not determine that Louise's death was as a result of a criminal act.

5.2 However, from information obtained by the Review Process from agency records, Louise's mother and sister, and from other associates who have engaged with the review process. There is clear evidence that Louise's boyfriend was often coercive, controlling and violent. Louise was seen on numerous occasions with injuries that she stated had been caused by the boyfriend.

5.3 Home Office Guidance[26] defines coercive and controlling behaviour as:

- 'Controlling behaviour is a range of acts designed to make a person subordinate and/or dependant by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.
- Coercive behaviour is a continuing act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim'.

5.4 The Serious Crime Act 2015, defines this behaviour as:

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

5.5 Research by Dr. Jane Monckton-Smith,[27] shows that control was seen in 92% of domestic killings, obsession in 94% and isolation from family and friends in 78%. Dr. Monkton-Smith considers that these types of behaviour can lead to a victim having no life of their own, and no privacy from their abusers, who will frequently monitor them by day and by night.

5.6 Lisa Arson Fontes[28] describes coercive control as:

> 'a situation in which one partner is usually isolated and afraid to anger her partner because of the punishment that might ensue. One member of the couple, usually the female, is deprived of the resources she needs – such as money, friends and transportation – to have autonomy. She loses her own perspective. Over time many victims feel like they cannot 'think straight'. People's lives are ruined by coercive control. They often lose their jobs, their self-esteem and freedom to make even the most minute choices in their lives'.

5.7 The narrative of this review report illustrates that every element of the Home Office controlling behaviour definition is present and can be identified in the boyfriend's behaviour towards Louise.

5.8 '*To make a person subordinate and/or dependant by isolating them from sources of support'* – this is illustrated by the way the boyfriend 'persuaded' Louise to go to him in Leicester when she was living with Emma and was being steered away from her drug habit. On another occasion, the boyfriend told her to go to him in Leicester not long after the child was born, and Louise was being supported by her mother.

5.9 '*Exploiting their resources and capacities for personal gain'* demonstrated by the boyfriend controlling Louise's drug habit and him supplying the drugs for her to take.

[26] Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews Home Office December 2016 page 8

[27] Coercion and Control: fighting against the abuse hidden in relationships. Dr Jane Monckton-Smith Gloucestershire University 2017 Guardian Society

[28] Invisible Chains: Overcoming Coercive Control in Your Intimate Relationship Lisa Aronson Fontes 2015

There is also evidence of the boyfriend using Louise's flat as a 'drugs den' from where drugs would be sold and used.

5.10 '*Depriving them of the means needed for independence, resistance, and escape and regulating their everyday behaviour'* – there is plenty of evidence of how the boyfriend manipulated Louise to live with him, thereby removing her from the support of her family and her independence. He regulated her everyday behaviour by fear and Louise told her sister that she hated him but could not get away from him. He dissuaded her from having a social life of her own and needed to know her every movement. Stark[29] states:

> 'This sort of power is somewhat contingent on social position because persons with money or political influence are better situated to produce effects congruent with their intentions than persons without these advantages'.

This is particularly relevant to the supply of drugs the boyfriend provided to Louise.

5.11 In relation to controlling, Bancroft[30] states:

> 'Control usually begins in subtle ways. He drops comments about your clothes or your looks, is a little negative about your family or one of your good friends, starts to pressure you to spend more time with him or quit your job, starts to give too much advice about how you should manage your own life and is impatient when you resist his recommendations'.

5.12 With respect to coercive behaviour – '*a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten'* can be amply illustrated by the times Louise was assaulted. There is also Emma witnessing injuries and, according to Emma, neighbours seeing her being dragged along the street by the boyfriend. She told Emma she was scared of the boyfriend.

5.13 Bancroft[31] describes abusive men:

> 'Abusive are men are masters of excuse making. In this respect they are like substance abusers who believe that everyone and everything except them are responsible for their actions. When they aren't blaming their partners, they blame stress, alcohol, their childhood, their children, their bosses or their insecurities. More important they feel *entitled* to make these excuses.

5.14 It is clear from the description of the boyfriend given by Louise's mother and sister; he is a controlling and coercive person who used violence against Louise. What is not known are any details of his relationships with his previous partners and the mothers of his other children.

5.15 One of the issues that arise from the IMRs that have been submitted is the frequency that Louise did not attend for appointments with various agencies or declined treatment or offers of support. What is clear is that Louise had numerous offers of help and at no time was it considered that she did not have capacity to make decisions for herself, resulting in her not attending for help and/or treatment.

[29] Coercive Control: How Men Entrap Women in Personal Life. Evan Stark 2007
[30] Why Does He Do That? Inside the minds of angry and controlling men. Lundy Bancroft 2002 page 117

[31] Why Does He Do That? Inside the minds of angry and controlling men. Lundy Bancroft 2002 page 71.

5.16 Her perceived reluctance to accept help may have been due to the influence of the boyfriend. There is ample evidence to suggest that she made decisions around her association with him, and it is obvious to see that he had a powerful control over her and her decisions. According to Emma, Louise told her that he threatened to kill her and anyone that went near her if she left him and that he would take the child away from her.

5.17 Stark[32] maintains

> 'Threats violate the person's right to physical and psychic security and tranquillity,'

and in a study, he found that 44% of 207 women experiencing domestic abuse reported their partners threatened to hurt or remove the children, treating the children as an extension of the mother and as a way to hurt or control her, often when she is less accessible, during separation or divorce of has stopped responding to direct threats or violence.

5.18 De Becker[33] is of the opinion that:

> 'Because most people have had little experience with death threats, and because they mistakenly believe that the death threat is inherently different from all other threats, the words usually cause undue fear.

5.19 De Becker makes an important distinction between threats and intimidation and quotes threats that are conditional, usually containing the words, *if, unless, until or else,* are intimidation, meaning that at least for now the perpetrator favours words over actions that harm. He does however acknowledge that both direct threats of immediate action and intimidation as described are aimed to reduce the victim's defences and self-worth. Both are behaviour that constitutes coercive and controlling behaviour and are criminal actions.

5.20 As far as agencies are concerned, it is appreciated that it is very difficult to manage the DNA's (Did Not Attend) when the patient/person chooses not to attend for whatever reason. The same applied to the boyfriend regarding him not attending at his BeNCH commitments. BeNCH have no power other than to submit papers to National Probation Service for the NPS to consider court action.

5.21 The policy is that if a service user supervised by the CRC fails to comply with the sentence of the court Bench CRC will complete paperwork which is passed to NPS who then prosecute a breach. Thus, NPS are the prosecuting agency. If a service user, then fails to turn up for the hearing date the NPS will apply to the court for a warrant not backed for bail. The court can either grant or refuse the application. In this case the application was granted. Once granted it is the court that has responsibility for ensuring the details of the warrant are passed to the police for uploading onto the PNC. Bench CRC does not have the power or authority to either issue a warrant or require a warrant to be circulated.

5.22 There appeared to be some confusion regarding the warrant that was issued by the Magistrates for the arrest of the boyfriend having failed to appear for a breach of his conditions on 18th April 2017. He attended the Safer Relationships Programme on 8th May 2017 but was turned away because the staff there realised, he was wanted on warrant. He was advised to surrender to the courts.

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[32] Coercive Control: How Men Entrap Women in Personal Life. Evan Stark 2007

[33] The Gift of Fear - Survival signals that protect us from violence Gavin De Becker 1997

5.23 On 9th January 2018, being still wanted on the April 2017 warrant, the boyfriend was discussed at a MARAC meeting where S2S were actioned to help him with finding alternative housing in order that he would keep away from Louise.

5.24 On 17th March 2018, the boyfriend was arrested for assaulting Louise. The following day the warrant from April 2017 was executed at Court. It is the CRC's viewpoint that once a Court issues a warrant for breaching conditions, the police should have been aware of the existence of a warrant as all warrants are entered onto the Police National Computer (PNC). It therefore appears that the boyfriend was at large, wanted on warrant from April 2017 until March 2018, during which time, whilst he was at large and could have been arrested, he did not come into direct contact with the police, although on 20th August 2017, Louise called the police stating she had been assaulted by the boyfriend who had left the address. On arrival of the police, Louise chose not to engage with the officers and declined to make a complaint against him. Although a DASH Risk Assessment was completed no further action was taken and the boyfriend was not traced or seen by the police due to the lack of a complaint. It is well documented that victims often are reluctant to pursue a complaint for fear that to do so will make the situation worse in terms of potential violence towards them.

5.25 Louise attended for treatment at S2S but was inconsistent and she did the same with Mental Health Services. The fact is that drugs and domestic abuse may influenced her choices and affected her ability to make rational decisions. She was also vulnerable due to her mental health, which her family members consider significant.

5.26 Another frequent occurrence upon their contact with agencies was that both Louise and the boyfriend were very adept at telling agencies what they thought the agencies would want to hear. Agencies did not recognise this disguised compliance from both Louise and the boyfriend. The number of times Louise apparently intoxicated, declined medical treatment when she had called the police for assistance illustrates another common difficulty the police, in particular, face in these circumstances. That is whether the complainant is intoxicated or suffering from a head injury, the symptoms of which, often appear similar. There were a number of occasions when Louise reported being punched to the head by the boyfriend but also intoxicated. These set of circumstances are a dilemma for officers who have to decide the best way to ensure the safety of the complainant.

5.27 **Northamptonshire Police** had significant contact with Louise, the boyfriend and their associates dating back to 1998, 235 incidents in total involving thefts, drugs, alcohol and domestic abuse. Only the relevant incidents have been mentioned in this report.

5.28 The Police IMR Author considers that the vast majority of occasions the police were called to incidents, the incidents were dealt with and recorded in accordance with policy and procedures. There is an exception in August 2016, when Louise reported that the boyfriend had caused damage to her property. There was a missed opportunity to complete a DASH Risk Assessment form. The records stated that was not done due to the level of intoxication of Louise at the time, but the Police IMR Author rightly considers that professional judgement ought to have been used in the circumstances and given the background of both Louise and the boyfriend, and a Risk Assessment form should have been completed.

5.29 The Police also make comment in their IMR about the frustration in responding to incidents after being called by Louise and she then declined to assist, refused to make statements or was reticent to follow through with a prosecution against the boyfriend. On two occasions consideration was given to a 'Victimless Prosecution' for offences that he had committed against Louise, meaning that Louise would not have to go to court and give evidence. On the first occasion on 16th June 2012, a police supervisor

examined the report submitted by the officers and decided that a victimless prosecution would not be appropriate. The second occasion, following the incident on 13th November 2016, Louise made an initial statement but later withdrew her support for the investigation in another statement. The papers went to Crown Prosecution Service which authorised prosecution. The boyfriend was charged but failed to appear at court. A warrant was issued for his arrest. Some months passed by while the boyfriend evaded arrest. He was arrested in January 2017 but absconded again. He was eventually arrested and pleaded guilty to the offences he had committed against Louise.

5.30 The Police IMR Author comments about the missed opportunity to consider a Domestic Violence Prevention Notice (DVPN) or a Domestic Violence Prevention Order (DVPO), which would have given Louise some space and respite between her and the boyfriend. Either could have been pursued by the police without Louise's consent or indeed in direct contradiction of her consent. DVPO's[34] are now daily business for the police via the Domestic Abuse proactive Team. In addition, all front-line police officers are now being trained on a 'Domestic Abuse Matters' course designed to make all officers aware of the victim's perspective, show how perpetrators operate and increase the awareness of controlling and coercive behaviour.

5.31 With regard to the MARAC process in this case, the Police IMR Author is of the view that actions emanating from the MARAC were vague and it is not clear if the actions were completed. The actions were created to offer further support to Louise.

5.32 The Police IMR makes 8 IMR recommendations:

- Northamptonshire Police to remind officers of the importance of considering the use of DVPN's or DVPO's even when the victim is refusing to engage with the investigation.

- Northamptonshire Police to remind officers of the importance of completing a DASH risk assessment even if the victim refuses to cooperate.

- Northamptonshire Police should remind officers of the importance of maintaining contact with the victims of domestic abuse especially following referrals from the SFC.

- The Northamptonshire Police Domestic Abuse procedures should be regularly reviewed and updated to ensure that they remain fit for purpose.

- Northamptonshire Police should continue to promote the roles of the DAPIT (Domestic Abuse Police Investigation Team) and SFC to ensure that officers and staff are aware of the additional support that exists.

- Northamptonshire Police should remind supervisors the importance of actively managing investigations where the victim(s) are vulnerable and reluctant to engage with the police beyond the initial report. A more lateral problem-solving approach and awareness of previous incidents may assist with the successful resolution of the particular issue.

  (The Family wish it to be highlighted that perhaps better supervision for officers to debrief about the cases and risk assessments should be encouraged).

[34] Regarding DVPOs and DVPNs significant amendments to the process are suggested in the Domestic Abuse Bill currently being considered by Parliament.

- Northamptonshire Police to remind officers to consider evidence lead prosecutions, in conjunction with the CPS, in cases where the victim is refusing or reluctant to support a prosecution.

- Consideration should be given to reviewing the quantity and effectiveness of the actions generated from MARAC and to establishing processes to ensure those actions are completed in a timely manner.

5.33 It should be noted that the family members consider that Louise was vulnerable with regard to the influence of 'County Lines' drug dealing across the county and that whilst that was being investigated, no cognisance of Louise's potential involvement via her boyfriend was appreciated by agencies. Enquiries show that there was no intelligence to suggest that Louise was connected with any of the known County Lines at that time. Since this period of time Northamptonshire, Kettering in particular, have introduced a version of HACAA, (Heroine and Crack Action Area), a multi-agency initiative aimed at tackling drug class A use and distribution across the county. This is based on the successful Bedfordshire HACAA pilot operation of recent months. All intelligence is now considered within the 4 P's plan of intelligence gathering and dissemination, Prevent, Pursue, Prepare and Protect. This involves training and awareness for all officers.

5.33 **Kettering General Hospital NHS Foundation Trust** indicates that they had been involved with Louise for most of her life and on four occasions during the period of this review. The first involvement was in November 2016 when she attended following an alleged assault. The first indication that there was a domestic abuse concern was when it was logged on the KGH system on 28th November 2016. Her case had apparently been discussed at MARAC and that Louise was attending the Sunflower Centre and a hospital IDVA had been informed. Written notes of this attendance are not available and therefore it is not possible to review the information or action taken.

5.34 When Louise was admitted to hospital on 21st August 2017 following an overdose it does not appear to the KGH IMR Author that staff were aware of the alert on the system from November 2016. That may have enabled staff to support Louise better by sourcing information from the Sunflower Centre and IDVA.

5.35 Louise did disclose to the ALMHS that she had been subject to physical abuse by her partner but there were no further details of who the partner was or the circumstances of the abuse. The ALMHS requested KGH to submit a referral to safeguarding but the KGH IMR Author finds it unclear why KGH staff were requested to make a referral by another agency.

5.36 In respect of Louise's perceived lack of communication with agencies the KGH IMR Author indicates that little consideration was given to her ability to consent to care interventions, procedures or remaining in hospital and there is no evidence that the question regarding her capacity to consent was considered until she indicated her wish to leave hospital and stated she wanted to harm herself. A Deprivation of Liberty (DoL)[35] authorisation was commenced but not completed and there is nothing to suggest a mental capacity assessment took place or if required, a best interest decision made. The DoL remained incomplete and not processed appropriately

[35] When a Managing Authority (either care home or hospital) has a reasonable belief they may be depriving a person in their care of their liberty, they make an application to the Supervisory Body at the Local Authority responsible for the person's care for a Standard Authorisation; they may also grant themselves an Urgent Authorisation which allows the Managing Authority to legally deprive the person for 7 days whilst assessments take place.

however it appears that staff may have believed that the DoL may have been completed and authorised.

5.37 There is good evidence of escalation to other services such as the mental health team when Louise did not attend KGH. The escalation was appropriate and timely.

5.38 Other positive areas identified in KGH IMR are the positive inter agency working to support Louise's mental health and substance misuse issues, good family involvement when her medical condition deteriorated and evidence of good consultation with the family and the effective processes in place to make alerts regarding domestic abuse.

5.39 The lessons learned in this IMR include inadequate review/consideration of the DA alerts which may have provided for further escalation to appropriate services and enable staff to support Louise in a different manner. There was also no consideration to Louise's ability to make decisions or consent to interventions and inadequate evidence of the use of the Mental Capacity Act 2005 in relation to the DoL authorisation.

5.40 The KGH IMR makes three recommendations:

- To review the electronic patient alert system and ascertain if any changes would support forced reading of alerts and implement changes that are possible
- Utilise the findings regarding the Mental Capacity Act issues within this report as a learning opportunity within training specifically related to documentation regarding consent
- Review of the Mental Capacity Act audit tool to include audit of review of Deprivation of Liberty Safeguards authorisations and implement any actions from findings to ensure compliance with the Mental Capacity Act.

5.41 **Northamptonshire Healthcare Foundation Trust (NHFT)** first had contact with Louise in December 2016 and her presentation to the Secondary Mental Health Services is described as sporadic. She often presented after an episode of deliberate self-harm (DSH). NHFT commissioned the AMLHS (Acute Mental Health Liaison Service) which provides psychiatric treatment to patients attending general hospitals.

5.42 The NHFT IMR indicates that in January 2017 the Community Mental Health Team at Kettering sent a standard letter to Louise asking her to contact the team within 14 days or she would be discharged back to the care of her GP. Louise contacted the Community Health Team on 3rd February 2017 and stated that she had self-harmed by taking an overdose of medication three days earlier. She was advised to attend the A&E but there is no record to suggest that she did. There is an entry on her clinical records stating that a Duty Mental Health worker tried to telephone Louise on 6th February 2017 but there was no reply. Another attempt was made to contact her on 16th February 2017, but the caller was informed that she no longer lived at that address. There is no record of the name of the person who was spoken to. There is no evidence that Louise's mother was contacted which may have led to the whereabouts of Louise being ascertained.

5.43 On 6th April 2017 Louise was reviewed by the UCAT Team at home. Records indicate that the boyfriend disclosed that Louise had recently tied a ligature around her neck and the boyfriend stated that he had to 'cut her down'. A duty psychiatrist was contacted and suggested Louise should be admitted to hospital to which she agreed. The NHFT IMR considers that there was good evidence that Louise's immediate safety

was discussed, and action taken to protect her. However, the IMR points out that there was no consideration that the boyfriend could have been a perpetrator in this scenario.

5.44 During her stay in hospital records indicate that on 15th April 2017 having returned to hospital after an agreed period of leave she was seen to be handed something from another patient and to leave the ward immediately. She did not return until late in the evening. She was not challenged by any staff. On her returns she had stated that she had gone to the railway station with the intent to end her life but was stopped by a member of the public and had been taken to KGH. There are no records to indicate that KGH was contacted to corroborate her account and there was no risk assessment completed.

5.45 On 17th April 2017 records indicate that Louise again had leave from the ward but there was no evidence to suggest that there was a discussion about her intention to end her life two days previously. However, the ward staff did raise an adult safeguarding concern but only in relation to a disclosure Louise made about domestic abuse from her boyfriend whilst she was on leave the previous weekend and there was no mention in the safeguarding referral of the incident at the railway station.

5.46 On the 19th April 2017 a discharge plan was discussed for Louise and records indicate that the plan describes that Louise should not have contact with the child if she uses illicit substances, but she was discharged to her mother's address who was caring for her child. There was no referral or contact made to Children's Social Care because Louise's mother had told the hospital that the child was no longer subject of care. She was discharged on this day. She was removed from the GP's list due to her being in hospital. Once she was discharged from hospital she was placed back on the GP's list. There is a problem with patients being admitted to hospital for short periods and then being discharged. The letter from hospital to the GP telling the GP the patient has been discharged are often not immediate and there is a time delay.

5.47 Records indicate that on 28th April 2017 Louise told UCAT that she had taken illicit drugs two days previously. It is recorded that there should have been a follow up contact within the next seven days but there is nothing to suggest that this happened. The IMR states:

> 'There appears to be a lack of professional curiosity in the relation to her safety, whereabouts, and general engagement with substance misuse services. As a result, risk assessments and considerations of therapies that could be offered to someone with [Louise's] diagnoses did not occur'

5.48 The NHFT IMR makes three recommendations:

- Domestic abuse notifications should be considered as part of any risk assessment by mental health teams.

- The inpatient teams should be made aware of the importance of contemporaneous record keeping and risk assessments. This should be shared learning at team meetings in relation to this case.

- Professional curiosity should be part of everyday practice, to ensure that patient's accounts of events can be corroborated thus aiding a more accurate risk assessment and safety planning. NHFT staff to continue work within the boundaries of Information Governance and Information Sharing agreements to ensure best practice and care to our patients.

5.49 **S2S**'s involvement with Louise commenced February 2013, supporting her with her crack and heroin use. S2S also supported the boyfriend between 2013 and 2018. The S2S IMR indicates that Louise was assessed as having capacity to make decisions about her life and understood the consequences of those decisions in relation to her substance use and her ongoing treatment.

5.50 S2S was aware of the domestic abuse in Louise's life and S2S attended the MARAC meetings and shared information. One of those meetings was held on 1st May 2018 when a team leader from S2S attended. An action from the meeting was to engage Louise back into treatment and encourage her to contact Kettering Borough Council regarding the concerns that others were using her property to use or deal in drugs, known as 'cuckooing'. It appears that the MARAC meeting put the onus on Louise to report this activity which may have placed her at some risk.

5.51 The S2S IMR considers that risk assessments that were completed in relation to Louise were appropriate, identifying domestic abuse by the boyfriend. It considers that Louise's treatment was responsive to her needs and followed best practise guidance. Louise stated that she did not wish to engage with the Police or leave her relationship with the boyfriend and this was respected by S2S while information was provided to support her keeping herself safe. However, there is little evidence of Louise being empowered to help herself to leave the relationship or enquiring if she thought he would ever change.

5.52 The IMR goes onto explain that Louise disengaged from treatment, did not attend planned appointments and stopped attending the pharmacy for her medication. Whilst attempts were made to contact Louise the services reengagement protocol was not followed consistently in attempting to reengage her in treatment. The S2S IMR makes three recommendations:

- S2S to create a service pathway which will outline end to end MARAC procedures including a template for how MARAC information is recorded in case management systems.

- S2S 'missed appointments check list' will be audited regularly by designated county safeguarding leads to support all managers to monitor service users' engagement, identify appropriate actions for case managers and reduce risk.

- S2S to introduce a new protocol regarding discharge planning processes for all service users exiting the service to ensure that discharge planning is linked to wider governance arrangements.

5.53 **Nene & Corby CCG GP Practice IMR** indicates that the first contact with Louise was when she was 15 years of age and had been taken to the GP by her mother as Louise was sniffing glue. She had been present at the time of her father's death and was presenting with emotional health issues. At the age of 16 years, she is recorded to have been dependent on Heroin.

5.54 Louise's GP records indicate numerous referrals to mental health services which include several missed appointments and non-engagement with services. It is recorded that during her pregnancy in 2009 Louise abstained from the use of alcohol and illicit drugs and only took prescribed medication. There is evidence of liaison between the GP, Social Services and the midwifery team regarding the safety of the newborn child.

5.55 The CCG IMR indicates that there were 31 episodes of DNA (Did Not Attend) at GP appointments and 5 DNAs to secondary services such as CMHT. The GPs practice wrote to Louise about this, and Louise was also discussed at a Safeguarding Multidisciplinary Team meeting (MDT) in 2016 but removed from the MDT list not long afterwards as she started to improve her attendance, and it was considered that there were no longer any safeguarding concerns about her.

5.56 Louise reported domestic abuse by the boyfriend on a number of occasions but there are no indications of any further enquiries or referrals being made as to who the boyfriend was or the circumstances of the abuse, considering there was a child in the household. The IMR states:

> 'There is no evidence of professional curiosity in relation to the incident'

5.57 On 29th November 2016, there is an entry on the SystmOne community tab noting Louise was being discussed at MARAC. There is no evidence the practice was informed of this meeting or were aware of the high-risk nature of that domestic abuse Louise was experiencing, perhaps indicating a lack of information sharing.

5.58 In March 2017, the GPs practice received a letter from CMHT to the effect that Louise had attempted suicide. The letter also stated that Louise had a scratch under her eye caused by the boyfriend. The IMR states.

> 'There is no evidence in the medical records of the CMHT referral being sent at this time although there is evidence the practice tried to engage with [Louise] by arranging a face-to-face meeting but medical records evidence Louise DNA'd a pre-booked appointment with GP on 29th March 2017'.

5.59 Louise was added to the Safeguarding list at the GPs surgery again in September 2017 due to her disclosure that she was being abused by her boyfriend. However, the notes record:

> 'Discussed – removed from safeguarding list'.

There is no rationale for removing her from the list recorded, although on further enquiry by the IMR author it was explained that she was an inpatient at this time and would have been added back to the list once she was discharged. There are issues when a patient is briefly admitted to hospital, removed from the GP's list, and then discharged from hospital. Sometimes the discharge notification from hospital is delayed in arriving at the GP's surgery so the information may be slightly out of date.

5.60 The IMR records that Louise was seen by 10 different GPs at the surgery and states:

> 'She was vulnerable due to her ongoing mental health problems and her substance abuse. This was further complicated by ongoing domestic abuse. If Louise had remained on the practice safeguarding register the practice may have maintained enhanced oversight which may have afforded them a clearer picture of the ongoing risks to her physical and mental health. This may also have led the practice to consider a referral to the adult safeguarding team when risks escalated'.

5.61 With regard to the domestic abuse inflicted upon Louise by the boyfriend, the IMR considers that there was no professional curiosity with regard to her disclosure of domestic abuse when she visited the GP with her mother in 2016. Equally the GPs practice was not informed of the intention to discuss Louise at a MARAC meeting in

December 2016, resulting in the practice not being aware of the High-Risk relationship she was in at the time. The IMR author considers that this is aggravated by the fact that the IT system used by GPs means that they are able to access the 'community tab'' giving access to information held by NHFT. The IMR stated:

> 'Information regarding domestic abuse may be present within the SystmOne records in the community tab however GPs may not routinely view information contained in this field unless they are aware of concerns.

5.62 Louise informed the GPs practice in December 2016 that she had left her abusive partner. The IMR author rightly considers that there was no professional curiosity or signposting to specialist support services given the risk that leaving a relationship poses to a victim of domestic abuse.

5.63 Louise was added to the practice Safeguarding Multidisciplinary Team meeting again in April 2017 as a result of her being discussed again at a MARAC meeting but removed from the list at the same meeting as no concerns were raised and that she was sunder the care of CMHT. The same process occurred again in September 2017, and again no evidence of the decisions made at the MDT.

5.64 Further MARAC meetings were held in January and May 2018 but again the practice was not informed of the meetings or the actions and outcomes of the meetings. The IMR comments:

> 'If the practice had been sent correspondence in respect of these meetings it may have informed their decision making and response to the continued presence of DA in Louise's life and the risks it placed her under. This may have resulted in a more robust response when [Louise] presented to the practice and the issue of obtaining specialist DA support reinforced'.

5.65 The CCG IMR makes three recommendations that adequately deal with the issues raised in the IMR:

5.66 The practice is shown to use appropriate coding in response to information they receive from external sources and their interactions with [Louise]. Although coding took place there could have been enhanced identification of risk if the practice were able to view all safeguarding incidents and the escalation of risk viewed collectively.

- **CCG Recommendation No 1**
  General Practice should utilise the IT tools available on their practice system to view all safeguarding codes collectively so that vulnerability and increasing risk can be identified in a timely manner and appropriate action taken to safeguard.

5.67 The practice is evidenced as recognising safeguarding concerns when [Louise] was subject to MARAC and added her to the practice Safeguarding MDT meeting. There were times when [Louise] was discussed at MARAC, but the practice was unaware of this and of the nature of the high-risk DA she was exposed to and to the additional risks she faced in order to fund her substance misuse. Practices would gain important insights into the risk DA victims are exposed to if they received information regarding the discussions and decisions at MARAC meetings.

- **CCG Recommendation No 2**
  The development of an information sharing agreement between MARAC and practices would greatly enhance information sharing and

allow practices to accurately code and have oversight for victims of DA in order to be able to assess risk and respond appropriately.

5.68 There is evidence in the medical records that when DA was disclosed opportunities to discuss its nature, and occurrence may have been missed. If general practice clinicians were seen to employ professional curiosity around DA, they may have been able to assess the risk [Louise] was exposed to and consider signposting her to specialist support services.

- **CCG Recommendation No 3**
  General practice clinicians should ensure that when DA is disclosed by an individual, a risk assessment is carried out. This will inform their management and enable victims to be signposted to the appropriate service.

5.69 **Housing** first had contact with Louise in 2010, and she resided in housing accommodation without concerns for a number of years. Following a report that she was not living at the house, a Neighbourhood Manager visited her in November 2015 and found the property clean and tidy. Louise disclosed that her child was not living there all of the time, so she became subject of a housing benefit reduction through which, she fell into arrears with her rent. She was given advice to apply for a Discretionary Housing Payment. She did not make an application and fell further behind with her rent resulting in her being served with a Notice of Seeking Possession.

5.70 A Housing Options missing appointment with the HOA (Housing Options Advisor) meant that it was sometime before Louise could be seen. When she was seen in December 2017, she made an offer of payment but was not seen again. Calling cards were left by the HOA and finally a letter was sent to Louise stating an intention to issue possession proceedings. In May 2018, a letter was hand delivered to Louise advising that officers would be attending at her property to execute a warrant to carry out a gas service.

5.71 The Housing IMR, in analysis of its involvement with Louise, suggests that neighbours when spoken to, admitted that they were not proactive in making their concerns about activity at Louise's home known to Kettering Borough Council and if they had been more proactive it may have triggered more efforts to make face to face contact with Louise and hopefully meet with her.

5.72 The Overview Author is of the view that there were sufficient concerns within Housing in terms of drug dealing, and Louise regularly calling on neighbours to borrow money, to make the decision to instigate face to face contact with Louise. Housing was asked to make a visit to Louise as a result of a decision emanating from a MARAC meeting.

Overview Recommendation No 1

Kettering Borough Council Housing Department to review its procedures regarding being proactive in taking steps to recover outstanding rent arrears.

Overview Recommendation No 2

Kettering Borough Council Housing Department to review its procedures regarding being proactive in responding to neighbour's complaints and not relying on the community to identify problem area especially where incidents of domestic abuse are evident.

5.73 **Kettering Borough Council Housing Department** make two IMR recommendations:

- Recommendation No 1

  Place flags on various KBC systems to contact relevant officer when we are actively trying to engage with victims of domestic abuse.

- Recommendation No 2

  Make more persistent attempts to contact victims of domestic abuse.

5.74 **East Midlands Ambulance Service** has attended to Louise five occasions since 2014 and each of the attendances have been examined by the EMAS IMR Author. In summary the IMR author details:

13th August 2014

5.75 EMAS were called by Louise's boyfriend saying that she had taken an overdose. She was taken to hospital. It was noted by the despatcher that there was a child on the scene but no details of either the child or boyfriend are recorded. The IMR Author considers that concerns should have been raised with Children's Services. It was also discovered that Louise had a history of depression and concerns should have been raised with Adult Social Care.

22nd July 2015

5.76 A substance misuse worker called EMAS saying that Louise had threatened suicide. EMAS attended at Louise's address and were met by three men who denied knowing who Louise was. The ambulance left the scene without seeing a patient. EMAS raised concerns with Children's Services and Adult Social Care. The GP and health partners for both Louise and the child were notified

28th August 2016

5.77 EMAS attended a 999 call from the boyfriend saying that Louise had thrown him out of the house, and she had taken an overdose. Louise was found at her house. It was discovered that she had a history of crack cocaine and heroin abuse and extensive history of depression. Louise declined treatment and refused to go to hospital. She was deemed to have capacity to make that decision and signed to that effect. Louise was left in the care of her boyfriend. EMAS crew informed partner agencies by telephone. The IMR Author considers that it would have been better to confirm the telephone call with a written referral. There however, is no record of any enquiry being made about the children or that Louise was spoken to on her own.

21st August 2017

5.78 EMAS attended to Louise after she had taken an overdose of tablets. The crew noted a history of drug use and depression. She was taken to hospital. The information given indicated that was a vulnerable adult and the IMR Author considers that a referral should have been made to Adult Social Care.

May 2018

5.79 EMAS responded to a call from a male person saying that a neighbour had hung herself. The crew found Louise's boyfriend carrying out CPR. Adrenalin was administered and a spontaneous circulation returned. Louise was taken to hospital. The crew declared that the boyfriend mentioned that he and had been involved in a domestic dispute with Louise prior to her being found. The IMR Author considers that this should have alerted the crew to raise safeguarding concerns. This matter has been taken up with the crew concerned.

5.80 The EMAS IMR makes two recommendations:

- Recommendation No 1

  The author of this review will inform the Ambulance Operations Manager (AOM) of the outcome of the review and request that the attending crew members have up to date training on clinical record keeping.

- Recommendation No 2

  On the conclusion of the IMR the author will complete a patient story, and lessons learnt article to be disseminated throughout the organisation. This will have the following specific information:

  - Professional curiosity
  - Importance in recognising vulnerable patients and the need to explore care and support needs.
  - Requirement for crews to follow up verbal discussions with partner agencies with a referral.
  - The need to obtain the names of all individuals on scene rather than writing "partner"

5.81 **Children First Northamptonshire** became involved with Louise first of all in January 2010 following a referral from Sure Start Family Centre to the effect that Louise, who had a history of drug abuse, was pregnant. A further referral was made via Leicester City Children's Services expressing concerns about the living conditions at the boy-friends home where the newborn child was also living. Concerns increased when both parents, Louise and the boyfriend tested positive for drugs and were known to 'top up' from street drugs such as heroin. The child was born and tested positive for the existence of drugs, but no concerns were raised as the child was due to live with Louise and her mother. The case on the child was closed in June 2010 following signs of improvement in the parent's use of drugs. The CFN (Children First Northampton) IMR states:

> 'It can be argued, based on the number re-referrals, that Children's Social Care's involvement often came to an end to soon, without ensuring there was sustained on-going improvement'.

5.82 The Overview Report Author considers that closing the case with the known history of both parents was optimistic and naïve. The Child Protection Conference in December 2015 considered that both parents were unlikely to give up the use of drugs and that although there is no evidence that the child witnessed the domestic behaviour, it is likely to have left the child at risk of emotional harm.

5.83 In July 2015, records indicate that a decision was made that the child was to live with Louise's mother and should not return to the care of the parents. It was also suggested that Louise's mother should be supported in applying for a Special Guardianship Order, (SGO). This in fact did not happen. Louise's mother was given the forms but no other information or assistance until the CFN representative of the DHR panel became aware and took steps to ensure that this was completed and an SGO granted.

5.84 The Overview Author considers that there are two immediate actions to be taken by CFN:

- There needs to be urgent action taken to ensure either CFN or the child's maternal grandmother obtain parental responsibility for the child. Strategic and Service managers put deadline of 5th Oct 2018 for Grandmother to be supported to complete and submit SGO application (which, by January 2020, had still not been submitted).
- Support needs to be provided to the child and Grandmother following the loss their mother / daughter respectively. Social worker confirms support has been offer and Grandmother has chosen to address mother's death and support the child herself. She herself prefers to have support from the family.

5.84 The CFN IMR also makes three internal recommendations:

- CFN ensure supervision take places as per the Supervision Standards and there is management oversight to ensure actions are completed.
- CFN review its policy on the required level of management seniority needed to close a case in order to prevent cases closing prematurely.
- CFN to use learning from this case to provide additional guidance / training to Social Workers / managers on legal status' for children when CFN decide the child is unable to return to a parent's care

5.85 **The Sunflower Centre** deal with high-risk referrals. In the main, when Louise was referred to the Sunflower Centre her risk assessment on those occasions, was measured at medium risk and she therefore did not meet the criteria for support from the Sunflower Centre on the information provided by the referring agency. On several occasions Louise was either out of the county or did not engage with the referral. However, on one occasion the Sunflower Centre did make a referral to MARAC on behalf of Louise.

6. Conclusions

6.1 Despite an in-depth Police investigation into the death of Louise and also into her life with her boyfriend, there have been no criminal charged brought against any person.

6.2. What is clear however is that Louise suffered a great deal of domestic abuse from her boyfriend, the results of which were witnessed by family members and other people. Emma, Louise's sister went to great lengths to remove Louise from her boyfriend's influence and attempted to wean her off her drug habit, but at the first opportunity he

had the boyfriend coaxed her back to his house and her drug use started again immediately.

6.3 There were missed opportunities by several agencies to improve contact with Louise and to provide better services. Some of these have been recognised in open and honest recommendations however it is clear that lack of professional curiosity and probing was a common factor. The family feel that sadly Louise's drug addiction was frequently seen as a problem rather than the cause of the actual abuse that underpinned her decision making.

6.4 Louise was offered numerous services which she was unable to accept as the influence, control and grip the boyfriend had over her and her daily life was so strong it had eroded her capacity to make informed choices and decisions that could have enabled her to engage and rebuild her and her daughter's life. In order for her to have done this the family feel strongly that a more proactive, non-discriminative network of support and communication from multi-agencies would have given her the maximum opportunity for recovery.

6.5 Without the involvement of the boyfriend in this review process, the review has to rely in the evidence provided in the IMRs and that from family members. Efforts to engage with the boyfriend have been made but have been unsuccessful.

6.6 There is evidence however, that the boyfriend was a coercive person who used abusive behaviour to control Louise in the form of stalking, none fatal strangulation and 'gas lighting', a phrase used to describe a form of psychological manipulation in which a person seeks to sow seeds of doubt in a targeted individual, making them question their own memory, perception, or sanity. Using denial, misdirection, contradiction, and lying, gas lighting involves attempts to destabilize the victim and delegitimize the victim's beliefs. All of these behaviour types are regarded as indicators of **High-Risk** behaviour by perpetrators.

Recommendations

Overview Report Recommendation

Recommendation No 1

Kettering Borough Council Housing Department to review its procedures regarding being proactive in taking steps to recover outstanding rent arrears.

Recommendation No 2

Kettering Borough Council Housing Department to review its procedures regarding being proactive in responding to neighbour's complaints and not relying on the community to identify problem area especially where incidents of domestic abuse are evident.

IMR Recommendations

Northamptonshire Police

- Northamptonshire Police to remind officers of the importance of considering the use of DVPN's or DVPO's even when the victim is refusing to engage with the investigation.

- Northamptonshire Police to remind officers of the importance of completing a DASH risk assessment even if the victim refuses to cooperate.

- Northamptonshire Police should remind officers of the importance of maintaining contact with the victims of domestic abuse especially following referrals from the SFC.

- The Northamptonshire Police Domestic Abuse procedures should be regularly reviewed and updated to ensure that they remain fit for purpose.

- Northamptonshire Police should continue to promote the roles of the DAPIT and SFC to ensure that officers and staff are aware of the additional support that exists.

- Northamptonshire Police should remind supervisors the importance of actively managing investigations where the victim(s) are vulnerable and reluctant to engage with the police beyond the initial report. A more lateral problem-solving approach and awareness of previous incidents may assist with the successful resolution of the particular issue.

- Northamptonshire Police to remind officers to consider evidence lead prosecutions, in conjunction with the CPS, in cases where the victim is refusing

or reluctant to support a prosecution.

- Consideration should be given to reviewing the quantity and effectiveness of the actions generated from MARAC and to establishing processes to ensure those actions are completed in a timely manner.

Kettering General Hospital NHS Foundation Trust

- To review the electronic patient alert system and ascertain if any changes would support forced reading of alerts and implement changes that are possible

- Utilise the findings regarding the Mental Capacity Act issues within this report as a learning opportunity within training specifically related to documentation regarding consent

- Review of the Mental Capacity Act audit tool to include audit of review of Deprivation of Liberty Safeguards authorisations and implement any actions from findings to ensure compliance with the Mental Capacity Act.

Northamptonshire Healthcare Foundation Trust

- Domestic abuse notifications should be considered as part of any risk assessment by mental health teams.

- The inpatient teams should be made aware of the importance of contemporaneous record keeping and risk assessments. This should be shared learning at team meetings in relation to this case.

- Professional curiosity should be part of everyday practice, to ensure that patient's accounts of events can be corroborated thus aiding a more accurate risk assessment and safety planning. NHFT staff to continue work within the boundaries of Information Governance and Information Sharing agreements to ensure best practice and care to our patients.

S2S

- S2S to create a service pathway which will outline end to end MARAC procedures including a template for how MARAC information is recorded in case management systems.

- S2S 'missed appointments check list' will be audited regularly by designated county safeguarding leads to support all managers to monitor service users' engagement, identify appropriate actions for case managers and reduce risk.

- S2S to introduce a new protocol regarding discharge planning processes for all service users exiting the service to ensure that discharge planning is linked to wider governance arrangements.

Nene & Corby CCG GP Practice

- General Practice should utilise the IT tools available on their practice system to view all safeguarding codes collectively so that vulnerability and increasing risk can be identified in a timely manner and appropriate action taken to safeguard.

- The development of an information sharing agreement between MARAC and practices would greatly enhance information sharing and allow practices to accurately code and have oversight for victims of DA in order to be able to assess risk and respond appropriately.

- General practice clinicians should ensure that when DA is disclosed by an individual, a risk assessment is carried out. This will inform their management and enable victims to be signposted to the appropriate service.

Kettering Borough Council Housing Department

- Place flags on various KBC systems to contact relevant officer when we are actively trying to engage with victims of domestic abuse.

- Make more persistent attempts to contact victims of domestic abuse.

East Midlands Ambulance Service

- The author of this review will inform the Ambulance Operations Manager (AOM) of the outcome of the review and request that the attending crew members have up to date training on clinical record keeping.

- On the conclusion of the IMR the author will complete a patient story, and lessons learnt article to be disseminated throughout the organisation. This will have the following specific information:

    - Professional curiosity
    - Importance in recognising vulnerable patients and the need to explore care and support needs.
    - Requirement for crews to follow up verbal discussions with partner agencies with a referral.
    - The need to obtain the names of all individuals on scene rather than writing “partner”

Children First Northamptonshire

The Overview Author considers that there are two immediate actions to be taken by CFN:

- There needs to be urgent action taken to ensure either CFN or the child's maternal grandmother attain parental responsibility for the child. Strategic and Service managers put deadline of 5th Oct 2018 for Grandmother to be supported to complete and submit SGO application.

- Support needs to be provided to the child and Grandmother following the loss their mother / daughter respectively. Social worker confirms support has been offer and Grandmother has chosen to address mother's death and support the child herself. She herself prefers to have support from the family.

The CFN IMR also makes three internal recommendations:

- CFN ensure supervision take places as per the Supervision Standards and there is management oversight to ensure actions are completed.

- CFN review its policy on the required level of management seniority needed to close a case in order to prevent cases closing prematurely.

- CFN to use learning from this case to provide additional guidance / training to Social Workers / managers on legal status' for children when CFN decide the child is unable to return to a parent's care

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Invisible Chains: Overcoming Coercive Control in Your Intimate Relationship Lisa Aronson Fontes 2015

Why Does He Do That? Inside the minds of angry and controlling men. Lundy Bancroft 2002

A Red Flag for Homicide Prof. Heather Douglas University of Queensland Australia October 2018

Action Plan

(Please note this action plan is a live document and subject to change as outcomes are delivered)

Overview Report Recommendations

Recommendations	Agreed by	Required Action	Agency Lead	Timescales and Dates for Completion	Summary of Action Taken	Information for Audit
Recommendation No 1 Kettering Borough Council Housing Department to review its procedures regarding being proactive in taking steps to recover outstanding rent arrears.	-	Review procedures regarding being proactive in taking steps to recover outstanding rent arrears	Kettering Borough Council, now North Northamptonshire Council		NNC Income Policy adopted in April 2021. Prioritises proactive steps to contact tenants by all means available, including telephone, text, letter, email and home visits. Adherence to pre-court protocols	Policy in place

Recommendations	Agreed by	Required Action	Agency Lead	Timescales and Dates for Completion	Summary of Action Taken	Information for Audit
					and equalities duty	
Recommendation No 2 Kettering Borough Council Housing Department to review its procedures regarding being proactive in responding to neighbour's complaints and not relying on the community to identify problem area especially where incidents of domestic abuse are evident.	-	Review procedures regarding being proactive in responding to neighbour's complaints	Kettering Borough Council, now North Northamptonshire Council	-	New ASB policy and procedure in place 2018. Enhanced triage of all ASB complaints. This includes completion of perpetrator and victim risk assessments following all complaints relating to neighbour complaints/ASB. Housing Officers work closely with Northants Police and other statutory partners to support victims and perpetrators of ASB and DA, including active involvement at the Cuckooing Forum	Policy in place

IMR Recommendations

Northamptonshire Police

Recommendations	Agreed by	Required Action	Agency Lead	Timescales and Dates for Completion	Summary of Action Taken	Information for Audit
Recommendation No 1 Northamptonshire Police to remind officers of the importance of considering the use of DVPN's or DVPO's even when the victim is refusing to engage with the investigation.	-	To remind officers of the importance of considering the use of DVPN's or DVPO's even when the victim is refusing to engage with the investigation	Northamptonshire Police	-	Most recent comms/guidance on DVPO issued to the Force on 29/8/24. DVPO's are covered throughout training and through DA matters training, which each officer has received. There are step by step guides to be found in our Learning Library to suit all styles of learning and	As per action taken

Recommendations	Agreed by	Required Action	Agency Lead	Timescales and Dates for Completion	Summary of Action Taken	Information for Audit
					levels are monitored, with the small Supt cohort key to prompting their use.	
Recommendation No 2 Northamptonshire Police to remind officers of the importance of completing a DASH risk assessment even if the victim refuses to cooperate.	-	To remind officers of the importance of completing a DASH risk assessment even if the victim refuses to cooperate	Northamptonshire Police	-	Completion of the DASH is mandatory and any cases where DASH is not completed is flagged to allow completion	Evidenced internally through NICHE reviews, business assurance documents and board minutes.
Recommendation No 3 Northamptonshire Police should remind officers of the importance of maintaining contact with the victims of domestic abuse especially following referrals from the SFC.	-	To remind officers of the importance of maintaining contact with the victims of domestic abuse especially following referrals from the SFC	Northamptonshire Police	-	The quantity and quality of victim contact continues to be the subject of scrutiny, through the Senior Officer Review process, performance insight data, public scrutiny panels, victim satisfaction surveys, DI and DCI serious crime	Evidenced internally through NICHE reviews, business assurance documents, victim satisfaction surveys and board minutes

Recommendations	Agreed by	Required Action	Agency Lead	Timescales and Dates for Completion	Summary of Action Taken	Information for Audit
					reviews. All of these data sources are reviewed at multiple governance boards in the Police who ensure ownership and accountability	
Recommendation No 4 The Northamptonshire Police Domestic Abuse procedures should be regularly reviewed and updated to ensure that they remain fit for purpose	-	Domestic Abuse procedures should be regularly reviewed and updated to ensure that they remain fit for purpose	Northamptonshire Police	-	All DA policies and procedures are updated annually, with any changes in legislation/best practice included. All Northamptonshire Police DA policies all up to date	Stored in the online Northamptonshire Police Policy Library, with annual reminders sent to owners to review their policy. It is not possible to circumvent these processes
Recommendation No 5 Northamptonshire Police should continue to promote the roles of the DAPIT and SFC to ensure that officers and staff are aware of the	-	Continue to promote the roles of the DAPIT and SFC to ensure that officers and staff are aware of the	Northamptonshire Police	-	DAPIT is now called DAIU and will be relaunched as such in January 2025. Its officers can be easily contacted through several	Internal data capture/business assurance undertaken by both Voice and Police

Recommendations	Agreed by	Required Action	Agency Lead	Timescales and Dates for Completion	Summary of Action Taken	Information for Audit
additional support that exists		additional support that exists			platforms, a learning library exists for guidance even when the team are not on duty. Every victim of high-risk abuse is referred to Voice/SFC through the MARAC process irrespective of consent, with victims otherwise referred to Voice/Sunflower with their consent. The Force monitors victim referrals, victim contact, with all completed DASH forms sent across to Voice/Sunflower	
Recommendation No 6 Northamptonshire Police should remind supervisors the	**-**	Remind supervisors the importance of actively	Northamptonshire Police	**-**	The quantity and quality of supervisor reviews continues	Evidenced internally through NICHE reviews, business

Recommendations	Agreed by	Required Action	Agency Lead	Timescales and Dates for Completion	Summary of Action Taken	Information for Audit
importance of actively managing investigations where the victim(s) are vulnerable and reluctant to engage with the police beyond the initial report. A more lateral problem-solving approach and awareness of previous incidents may assist with the successful resolution of the particular issue		managing investigations where the victim(s) are vulnerable and reluctant to engage with the police beyond the initial report			to be the subject of scrutiny, through the Senior Officer Review process, public scrutiny panels, CPS scrutiny panels, DI and DCI serious crime reviews, with data reviewed through multiple governance boards in the Police who ensure ownership and accountability	assurance documents and board minutes
Recommendation No 7 Northamptonshire Police to remind officers to consider evidence lead prosecutions, in conjunction with the CPS, in cases where the victim is refusing or reluctant to support a prosecution	-	To remind officers to consider evidence lead prosecutions, in conjunction with the CPS, in cases where the victim is refusing or reluctant to	Northamptonshire Police	-	Most recent comms/guidance on ELP issued to the Force on 25/9/24. This approach is also captured in Police training curriculums	As per action taken

Recommendations	Agreed by	Required Action	Agency Lead	Timescales and Dates for Completion	Summary of Action Taken	Information for Audit
		support a prosecution				
Recommendation No 8 Consideration should be given to reviewing the quantity and effectiveness of the actions generated from MARAC and to establishing processes to ensure those actions are completed in a timely manner	-	Review the quantity and effectiveness of the actions generated from MARAC and to establishing processes to ensure those actions are completed in a timely manner	Previously, Northamptonshire Police, now Voice/Sunflower	-	Awaiting update	

Kettering General Hospital NHS Foundation Trust

Recommendations	Agreed by	Required Action	Agency Lead	Timescales and Dates for Completion	Summary of Action Taken	Information for Audit
Recommendation No 1 To review the electronic patient alert system and ascertain if any changes would support forced reading of alerts and implement changes that are possible.	-	To review the possibility of making all alerts a must read on the electronic patient record system	KGH - Nhamo Pazvakavambwa	November 2024	The current record system cannot be modified to make alerts a must read but it has been adjusted to ensure that the alerts tag must be closed as a pop up on the patient record	The use of alerts is monitored via an internal group which monitors the use of all alerts
Recommendation No 2 Utilise the findings regarding the Mental Capacity Act issues within this report as a learning opportunity within training specifically related to documentation regarding consent	-	Improve the documentation of Mental Capacity Act Assessments across the trust	KGH - Nhamo Pazvakavambwa	November 2024	The trust is Compliance currently rolling out new assessments' paperwork for MCA/DoLS and Best Interest Decision making. Paperwork	Compliance is monitored via audit which is reported into Safeguarding Operational Group quarterly

Recommendations	Agreed by	Required Action	Agency Lead	Timescales and Dates for Completion	Summary of Action Taken	Information for Audit
					developed after extensive consultation with staff and learning from multi-agency reviews	
Recommendation No 3 Review of the Mental Capacity Act audit tool to include audit of review of Deprivation of Liberty Safeguards authorisations and implement any actions from findings to ensure compliance with the Mental Capacity Act.	-	Ensure that the audit tool include DoLS	KGH - Nhamo Pazvakavambwa	Nov 2024	New audit tool in place and include DoLS and Best interest decision making processes	Audit reported into Safeguarding Operational Group quarterly

Northamptonshire Healthcare Foundation Trust

Recommendations	Agreed by	Required Action	Agency Lead	Timescales and Dates for Completion	Summary of Action Taken	Information for Audit
Recommendation No 1 Domestic abuse notifications should be considered as part of any risk assessment by mental health teams.	-	To review current processes relating to Domestic Abuse Notifications received to the Safeguarding Team. To review ensure that there is a MARAC information is visible on mental health records to aid decision making and risk assessments.	Safeguarding Team- NHFT corporate services	01.11.2024	The Safeguarding Team receives Domestic Abuse Notifications from the Police when there has been an incident of abuse where children are residing in the victim's home. The information is added to the children's records, which afford a level of intelligence for health care professionals to	The Safeguarding complete a specific domestic abuse audit as part of a quality schedule to offer assurance through the Trust wide Safeguarding group. The audit identifies if NHFT is managing domestic abuse requirements and that they are being managed appropriately, and if there are any gaps in the service offer.

Recommendations	Agreed by	Required Action	Agency Lead	Timescales and Dates for Completion	Summary of Action Taken	Information for Audit
					support families and their health care profession. NHFT has a dedicated researcher who reviews, completes and documents all incidents of abuse to the relevant patients' electric records. MARAC invites, details and required actions are also documented on the patients' records. Mental health services have access to the documentation that a MARAC is planned/taking place.	Action plans will be created post-audit completion.

Recommendations	Agreed by	Required Action	Agency Lead	Timescales and Dates for Completion	Summary of Action Taken	Information for Audit
					Other actions also include identifying professionals (including GPs) and sharing the MARAC information to support those identified victims.	
Recommendation No 2 The inpatient teams should be made aware of the importance of contemporaneous record keeping and risk assessments. This should be shared learning at team meetings in relation to this case.	-	To review current process to determine if records keeping is accurate and reflective of best practice in accordance with NICE 2015- Record keeping standards. That risk assessments of patients are fluid and identify and address and risk with robust safety	Safeguarding Team- NHFT corporate	01.11.2024	Since the time of the review, a new process of records keeping has been established within NHFT mental health setting. Where a patient holds a safety plan, the plan is available on the patients' electronic records, therefore providing the	Record Keeping Audits take place and action plans, and learning are established +/- actions plans and mitigation of provision risks.

Recommendations	Agreed by	Required Action	Agency Lead	Timescales and Dates for Completion	Summary of Action Taken	Information for Audit
		plans which are adaptive to the needs of the patient.			most current and accurate interventions for those patients in need of help. All safety plans/risk assessments are reviewed and updated where necessary by a multi-disciplinary team of professionals on a daily basis. NHFT services provide educational 'STAR' training days which include details and learning from Safeguarding Reviews. The Safeguarding Team have	

Recommendations	Agreed by	Required Action	Agency Lead	Timescales and Dates for Completion	Summary of Action Taken	Information for Audit
					provided bespoke domestic training sessions across all mental inpatient settings.	
Recommendation No 3 Professional curiosity should be part of everyday practice, to ensure that patient's accounts of events can be corroborated thus aiding a more accurate risk assessment and safety planning. NHFT staff to continue work within the boundaries of Information Governance and Information Sharing agreements to ensure best practice and care to our patients.	-	Professional Curiosity will be discussed and taught via Safeguarding Training and reviewed within safeguarding supervision sessions. That risk assessments of patients are fluid and identify and address any risk with robust safety plans which are adaptive to the needs of the patient. That IG training is mandatory and	Safeguarding Team- NHFT corporate	01.11.2024	Professional Curiosity is taught on all levels of safeguarding training. Safeguarding Level 3 Adults training is above the Trust required compliance rate. A new immersive mandatory level 3 Safeguarding training is in production which will provide a 'think family' model of	Trust mandatory training requirements are managed across NHFT to ensure that they meet compliance levels. Where there are consistent concerns of compliance, escalation or risk is provided through the hierarchy of NHFT governance. Feedback is collated after all teaching

Recommendations	Agreed by	Required Action	Agency Lead	Timescales and Dates for Completion	Summary of Action Taken	Information for Audit
		that the Trust consistently meets the agreed compliance percentage. To keep contemporaneous records that aid risk planning and support further decision making and corroboration of events.			domestic abuse, therefore supporting additional curiosity when reviewing the needs of patients. That IG training is mandatory and that the Trust consistently meets the agreed compliant percentage.	sessions to ensure that professional support needs are addressed in training- all feedback to date has been positive. Record Keeping Audits take place and action plans, and learning are established +/- actions plans and mitigation of provision risks.

S2S

Recommendations	Agreed by	Required Action	Agency Lead	Timescales and Dates for Completion	Summary of Action Taken	Information for Audit
Recommendation No 1 S2S to create a service pathway which will outline end to end MARAC procedures including a template for how MARAC information is recorded in case management systems.	-	Develop a clear MARAC service pathway and template for use. Review and provide feedback on the proposed pathway. Receive training on using the MARAC template and process.	S2S	-	Pathway mapped, and template designed and circulated Feedback integrated into final pathway Training sessions completed for all relevant staff.	Template embedded in case management systems. Audit log to ensure correct use. Audit logs to confirm all MARAC cases follow this pathway. Attendance records and usage audits in case management systems.
Recommendation No 2 S2S 'missed appointments check list' will be audited regularly by designated county safeguarding leads to support all managers to	-	Create an audit schedule for missed appointment checklists. Ensure all teams use the	S2S	-	Audit framework finalised and audits conducted.	Audit results stored for accountability. Trends reviewed quarterly. Evidence of consistent

Recommendations	Agreed by	Required Action	Agency Lead	Timescales and Dates for Completion	Summary of Action Taken	Information for Audit
monitor service users' engagement, identify appropriate actions for case managers and reduce risk.		missed appointments checklist. Review and follow up on audit findings to improve practices.			Staff trained and checklist implemented. Improvements actioned based on audit results	checklist use and outcomes. Record of actions taken and improved outcomes.
Recommendation No 3 S2S to introduce a new protocol regarding discharge planning processes for all service users exiting the service to ensure that discharge planning is linked to wider governance arrangements.	-	Develop and approve the discharge planning protocol. Train staff on the new discharge planning protocol. Ensure protocol aligns with wider governance arrangements.	S2S	-	Protocol designed and approved. Staff trained, and planning incorporated into processes. Governance linkages reviewed and embedded.	Audit logs of discharged cases for adherence to the protocol. Training records and case reviews. Evidence of strategic alignment in service reports.

Nene & Corby CCG GP Practice (now Northamptonshire Integrated Care Board)

Recommendations	Agreed by	Required Action	Agency Lead	Timescales and Dates for Completion	Summary of Action Taken	Information for Audit
Recommendation No 1 General Practice should utilise the IT tools available on their practice system to view all safeguarding codes collectively so that vulnerability and increasing risk can be identified in a timely manner and appropriate action taken to safeguard.	Safeguarding team for primary care.	Within the GP electronic health record, a) create a template to enter safeguarding codes and b) create a filter to display existing safeguarding codes.	Safeguarding team for primary care.	Both the safeguarding template and safeguarding filter were finalised during 2019.	Northamptonshire practices have access to a safeguarding data entry template so that relevant codes can be added from incoming reports. The practices can look for these codes in an individual's record by applying a filter and use this information to guide decisions.	The template and filter can be found on the GP clinical system used by practices.
Recommendation No 2 The development of an information sharing agreement between MARAC and practices	Safeguarding team for primary care.	Create a report template that MARAC can use to share	Safeguarding team for primary care.	A bespoke report template was created and piloted in 2019.	A successful trial of an enhanced report was carried out.	Piloted report template and current notification form

Recommendations	Agreed by	Required Action	Agency Lead	Timescales and Dates for Completion	Summary of Action Taken	Information for Audit
would greatly enhance information sharing and allow practices to accurately code and have oversight for victims of DA in order to be able to assess risk and respond appropriately.		relevant information with GP practices.		The new style reports were well received by practices. The pilot was stopped by MARAC in June 2019 as MARAC health advised that they did not have the time to complete the reports.	A decision was made by MARAC to revert to the earlier more basic report.	are available if required.
Recommendation No 3 General practice clinicians should ensure that when DA is disclosed by an individual, a risk assessment is carried out. This will inform their management and enable victims to be signposted to the appropriate service.	Safeguarding team for primary care.	A risk assessment framework was developed locally called GRACE.	Safeguarding team for primary care.	Training in the use of GRACE was provided to all local practices in 2018 through a series of learning events co-produced by the CCG safeguarding team and the Sunflower centre.	GRACE was developed to assess the degree of control and coercion and risk of escalation of harm following a disclosure of DA.	GRACE documentation can be provided if required.

Kettering Borough Council Housing Department (now North Northamptonshire Council)

Recommendations	Agreed by	Required Action	Agency Lead	Timescales and Dates for Completion	Summary of Action Taken	Information for Audit
Recommendation No 1 Place flags on various KBC systems to contact relevant officer when we are actively trying to engage with victims of domestic abuse.	-	Consider placing flags on system to support engaging with victims of domestic abuse	Kettering Borough Council, now North Northamptonshire Council	-	We have considered the recommendation and suggest that individual tasking to named officers to engage with a victim of DA face to face is the safest and most sensitive response. Placing flags on systems through the wider organisation could cause unintended information disclosure and increase risk to the victim	-

Recommendations	Agreed by	Required Action	Agency Lead	Timescales and Dates for Completion	Summary of Action Taken	Information for Audit
Recommendation No 2 Make more persistent attempts to contact victims of domestic abuse.	--	Strengthen MARAC tasking response	Kettering Borough Council, now North Northamptonshire Council	-	MARAC chair tasks individual officer to contact victim of DA when it is apparent that DA support services have been unable to contact. Housing Officer will arrange home visit within the timescale prescribed by the MARAC chair and will persist with making contact in a sensitive and safe way. Actions to contact high-risk victims of DA are tasked and completions monitored through the MARAC process and failure to	MARAC processes and actions

Recommendations	Agreed by	Required Action	Agency Lead	Timescales and Dates for Completion	Summary of Action Taken	Information for Audit
					complete those actions is escalated through the MARAC escalation process	

East Midlands Ambulance Service

Recommendations	Agreed by	Required Action	Agency Lead	Timescales and Dates for Completion	Summary of Action Taken	Information for Audit
Recommendation No 1 The author of this review will inform the Ambulance Operations Manager (AOM) of the outcome of the review and request that the attending crew members have up to date training on clinical record keeping.	Lucy Gascoigne	Inform the Ambulance Operations Manager (AOM) of the outcome of the review and request that the attending crew members have up to date training on clinical record keeping	Lucy Gascoigne	Completed before 25/11/2024	The individual learning for EMAS was disseminated to the AOM and the attending crew have completed their training to ensure they are compliant, and learning has been shared	Action completed
Recommendation No 2 On the conclusion of the IMR the author will complete a patient story, and lessons learnt article to be disseminated throughout the organisation. This will have the following specific information: Professional curiosity Importance in recognising	Lucy Gascoigne	Complete a patient story and lessons learnt article to be disseminated throughout the organisation that includes the information within the recommendation	Lucy Gascoigne	Completed before 25/11/2024	The learning around naming perpetrators, and all people on scene is disseminated through our education, training, top tips videos and our audit programme. Individual learning is shared via	Action completed

Recommendations	Agreed by	Required Action	Agency Lead	Timescales and Dates for Completion	Summary of Action Taken	Information for Audit
vulnerable patients and the need to explore care and support needs. Requirement for crews to follow up verbal discussions with partner agencies with a referral. The need to obtain the names of all individuals on scene rather than writing "partner"					division if we highlight any concerns around appropriate information not being obtained. As we are an emergency service it is sometimes difficult to obtain all people on scene's details, but we advocate this where possible and explain to the crews why this information is pertinent to partner agencies.	

Children First Northamptonshire (now Northamptonshire Children's Trust)

Recommendations	Agreed by	Required Action	Agency Lead	Timescales and Dates for Completion	Summary of Action Taken	Information for Audit
Recommendation No 1 CFN ensure supervision take places as per the Supervision Standards and there is management oversight to ensure actions are completed.	-	Ensure supervision take places as per the Supervision Standards and there is management oversight to ensure actions are completed	CFN (now NCT)	-	In NCT we have checks in place to ensure supervision is undertaken as per policy, this date is reported to leaders and managers as part of our monthly reporting data. Also, our QA service through our Auditing Process undertakes QA work around supervision to ensure we are meeting our standards	Auditing process in place

Recommendations	Agreed by	Required Action	Agency Lead	Timescales and Dates for Completion	Summary of Action Taken	Information for Audit
Recommendation No 2 CFN review its policy on the required level of management seniority needed to close a case to prevent cases closing prematurely.	-	Review policy on the required level of management seniority needed to close a case to prevent cases closing prematurely	CFN (now NCT)	-	Policy updated - to close a case in NCT there needs to be team manager authorisation and agreement, this level of seniority is felt proportionate and appropriate	Policy in place
Recommendation No 3 CFN to use learning from this case to provide additional guidance / training to Social Workers / managers on legal status for children when CFN decide the child is unable to return to a parent's care	-	Use learning from this case to provide additional guidance / training to Social Workers / managers on legal status for children when CFN decide the child is unable to return to a parent's care	CFN (now NCT)	-	Currently undertaking a review of Legal training that will produce additional guidance to social workers and managers	Legal training package being updated

Home Officer Letter

Shaun Sannerude

Safer Communities Officer

Safer Communities Team

North Northamptonshire Council

Cedar Drive, Thrapston

Northamptonshire

NN14 4LZ

6th August 2025

Dear Shaun,

Thank you for resubmitting the report (Louise) for North Northamptonshire Community Safety Partnership to the Home Office Quality Assurance (QA) Panel.

The report was reassessed in June 2025.

The QA Panel noted that the author had submitted a reference document outlining the changes made in response to QA Panel's feedback, which was helpful.

Reflections from Louise's family have been incorporated throughout the report and condolences from the author and CSP were extended to Louise's family.

Overall, most of the QA Panel's feedback has now either been addressed, or an explanation has been provided where that is not the case. Areas that still require amendment are set out below.

There were aspects of the report which the QA Panel felt needed further revision. On completion of these changes, the view of the Panel is that the DHR may now be published as they understand that this has been requested by the family.

Areas of Development

- The author appears to have rebutted, rather than addressed, the QA Panel's

earlier comments regarding the inclusion and examination of the perpetrator's background. While they note that relevant arrests listed in the terms of reference have been mentioned, this overlooks the broader concern. This background should be explored in the report, as it is directly relevant and could have informed discussions around the Domestic Violence Disclosure Scheme (DVDS) and perpetrator management.

Answer: **There are almost 30 pages of the police IMR, (there is not one for Probation) and there were multiple calls for police response to domestics, assaults, neighbourly issues, drugs events etc dating back to 2012. Sometimes there is mention of the child and in those cases, there are referrals to Child Abuse Investigations. In most of the other cases where there were allegations made, contact was made by the police via DASH, MARAC, SFC, MASH, IDVA ASC, mental health and so on. There were also referrals to CPS for advice about charging, BUT in most incidents, there was either no complaint or a change of mind regarding complaining resulting in CPS not authorising charging and/or proceedings. Proceedings, policies and guidance have changed over this period of times across most if not all agencies, which means that issues around DVDS and perpetrator management are now regularly considered and implemented by all agencies involved in domestic abuse related situations.**

- There are still some inconsistencies in the report. For example, section 1.7 states the review period as 31 December 2005 to May 2018, yet section 3 refers to events "prior to the scoping date of the review" without clarifying what that date is. It then shifts to a timeframe of "1 December 2016 – May 2018," creating confusion. Please clarify this.

Answer This has been clarified to read 1st December 2016 to May 2018

Once completed the Home Office would be grateful if you could provide us with a digital copy of the revised final version of the report with all finalised attachments and appendices and the weblink to the site where the report will be published. Please ensure this letter is published alongside the report.

Please send the digital copy and weblink to DHREnquiries@homeoffice.gov.uk. This is for our own records for future analysis to go towards highlighting best practice and to inform public policy.

The DHR report including the executive summary and action plan should be converted to a PDF document and be smaller than 20 MB in size; this final Home Office QA Panel feedback letter should be attached to the end of the report as an annex; and the DHR Action Plan

should be added to the report as an annex. This should include all implementation updates and note that the action plan is a live document and subject to change as outcomes are delivered.

Please also send a digital copy to the Domestic Abuse Commissioner at DHR@domesticabusecommissioner.independent.gov.uk

On behalf of the QA Panel, I would like to thank you, the report chair and author, and other colleagues for the considerable work that you have put into this review.

Yours sincerely,

Home Office DHR Quality Assurance Panel