Overview report

Safer Peterborough Partnership

A Domestic Homicide Review (DHR) concerning the death of Polly (pseudonym)

(March 2024)

Author – Jackie Dadd

Date completed - October 2024

Family tribute

A daughter, sister, mother, aunty and much more.

Polly was everyone's happiness, the laughter for everyone and a caring soul.

She was a delight to be around and we will never forget her beautiful face and beautiful smile.

Your sister,

Blossom

The Domestic Homicide Review Panel and the members of the Safer Peterborough Partnership Board would like to offer their sincere condolences to the family of Polly, who have lost their loved one in tragic circumstances.

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Preface

The key purpose of any Domestic Homicide Review (DHR) is to examine agency responses and support given to a victim of domestic abuse prior to their death and to enable lessons to be learnt where there may be links with domestic abuse. For these lessons to be learnt as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each death, and most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future. The victim's death in this case met the criteria for conducting a DHR according to Statutory Guidance1 under Section 9 (3)(1) of the Domestic Violence, Crime, and Victims Act 2004. The Act states that there should be a "review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by-

(a) a person to whom he was related or with whom he was or had been in an intimate personal relationship, or

(b) a member of the same household as himself, held with a view to identifying the lessons to be learnt from the death".

The Domestic Abuse Act 2021 and the Home Office defines Domestic Abuse as:

Behaviour of a person ("A") towards another person ("B") is "domestic abuse" if—

(a) A and B are each aged 16 or over and are personally connected to each other, and

(b) the behaviour is abusive.

Behaviour is "abusive" if it consists of any of the following—

(a) Physical or sexual abuse

(b) Violent or threatening behaviour

(c) Controlling or coercive behaviour

(d) Economic abuse

(e) Psychological, emotional or other abuse

and it does not matter whether the behaviour consists of a single incident or a course of conduct.

"Economic abuse" means any behaviour that has a substantial adverse effect on B's ability to—

(a) Acquire, use or maintain money or other property, or

(b) Obtain goods or services.

For the purposes of this Act A's behaviour may be behaviour "towards" B despite the fact that it consists of conduct directed at another person (for example, B's child).

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:

An act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim. The term domestic abuse will be used throughout this review as it reflects the range of behaviours encapsulated within the above definition and avoids the inclination to view domestic abuse in terms of physical assault only.

Recommendations will be made at the end of this report, however, there has been an ongoing action plan introduced by the panel, parallel to this review to ensure that the areas that can be immediately addressed have not incurred unnecessary delay.

A glossary is provided below which will provide explanation to the acronyms used throughout the report.

Glossary

A & E: Accident and Emergency department

AAFDA: Advocacy After Fatal Domestic Abuse

CPFT: Cambridge and Peterborough NHS Foundation Trust (MH)

CPP: Child Protection Plan

CSC: Children Social Care

DA: Domestic Abuse

DASV: Domestic Abuse and Sexual Violence Partnership

ED: Emergency Department (hospital)

EH: Early Help

FRS: First Response Service (MH)

GP: General Practitioner

HMP: Her Majesty's Prison

ICB: Integrated Care Board

ICPC: Initial Child Protection Conference

IDVA: Independent Domestic Violence Advisor

IMHT: Integrated Mental Health Team (Police)

IMR: Individual Management Review

LaDS: Liaison and Diversion Service

MARAC: Multi Agency Risk Assessment Conference

MASH: Multi Agency Safeguarding Hub

MH: Mental Health

NWAFT: North West Anglia NHS Foundation Trust

Section 1 – Introduction

1.1 The commissioning of the review

1.1.1 This review examines agencies responses, provisions and support provided to Polly, a 34-year-old female, prior to the point of her death, where she was found deceased at her home address in Peterborough during a fire at the location in March 2024. Both Police and the Fire service conducted investigations into the cause of the fire which was found to be a naked flame to the side of the bed.

Following an investigation, the police submitted a file to the coroner with a finding that the death was non-suspicious with no suspected third-party involvement.

The Manager of the Cambridgeshire Domestic Abuse and Sexual Violence Partnership made a referral to Safer Peterborough Partnership on 13th March 2024 due to previous incidents of domestic abuse involving Polly. Following a meeting on the same day with the Safer Peterborough Partnership Chair, a decision was made to undertake a Domestic Homicide Review as the definition in Section 9 of the Domestic Violence Crime and Victims Act (2004) had been met.

1.1.2 Contributors to the review

Agency	Contribution
Peterborough Women's Aid	Panel member
Cambridgeshire IDVA/MARAC service	Panel member, Summary report
Cambridgeshire Police	Panel member, IMR
Cambridgeshire Probation Service	Panel member, IMR
Change Grow Live	Panel member, IMR
Peterborough and Cambridgeshire Domestic Abuse and Sexual Violence Partnership	Panel member, oversight
Cambridgeshire Public Health	Panel member
Peterborough City Council - Adult Social Care	Panel member
NHS Cambs and Peterborough Primary Care Integrated Care Board (ICB)	Panel member
GP surgery	IMR
Barnardo's	IMR, Panel member
Cambridge and Peterborough NHS Foundation Trust (CPFT)	Panel member, IMR
North West Anglia NHS Foundation Trust (NWAFT)	Panel member, IMR
Cambridge University Hospitals NHS Foundation Trust (CUH)	Panel member, Summary report
Cambridgeshire Fire and Rescue Service	Panel member, Summary report

East of England Ambulance Service NHS trust (EEAST)	Panel member
Cross Keys Homes	Panel member, IMR

1.1.3 Review Panel

The following agencies/organisations/voluntary bodies have contributed to the Domestic Homicide Review by the provision of reports and chronology. Individual Management Reviews (IMRs) have been requested and supplied:

1.1.4 The panel comprised of the following:

Name	Area of responsibility	Organisation
Vickie Crompton	Domestic Abuse and Sexual Violence Partnership Manager	Cambridgeshire County Council
Joseph Davies	Suicide Prevention Manager	Cambridgeshire Public Health
Rohina Osman	Quality Governance and Safeguarding Lead	Change Grow Live
Helen Whitley	Senior Probation Officer	Peterborough Probation Service
Nicola Williams-Quamina	Deputy Designated Nurse Safeguarding children	NHS Cambs and Peterborough Primary Care Integrated Care Board (ICB)
Andrew Moralee	Detective Inspector	Cambridgeshire Police
Ria Demirsoy	Team Leader	Housing Needs – Peterborough Council
Gemma Cook	Assistant Director of Operations	Cross Keys Homes
Cathy Bates	Team Manager – Special Projects	Barnardo's
Julia Cullum	Domestic Abuse and Sexual Violence Partnership Manager	Cambridgeshire County Council
Sam Hunt	Associate Director of Nursing for Safeguarding	Cambridge and Peterborough NHS Foundation Trust (CPFT)
Charlie Park	Head of Safeguarding	Northwest Anglia NHS Foundation Trust (NWAFT)
Jane Bellamy	Deputy Safeguarding Lead	Cambridge Children Services
Tracy Brown	Adult Safeguarding Lead	Cambridge University Hospitals NHS Foundation Trust
Rob Olivier	Fire Prevention Tactical Commander	Cambridgeshire Fire and Rescue Service
Elaine Joyce	Section Safeguarding Lead	East of England Ambulance Service NHS trust (EEAST)
Philippa Avey-Walters	Service Manager	Adult Social Care – Peterborough City Council
Amanda Geraghty	Chief Executive Officer	Peterborough Women's Aid

1.1.5 All members of the panel and authors of the IMRs have complete independence from any subject in this review. The Review Chair and Panel gave due consideration for the content of the DHR and it was agreed that reports, chronologies, IMRs and other supplementary details would form the basis of the information provided. Thanks goes to all who have assisted and contributed to this review with their valued time and cooperation.

1.1.6 Author of the Overview report

The chair of the review panel and author of this report is Mrs Jackie Dadd, an independent consultant who is independent of the organisation and agencies contributing to this report. She has no knowledge or association with any of the subjects in this report prior to the commissioning of this review. She is a retired Detective Chief Inspector with Bedfordshire Police with vast experience of safeguarding and domestic abuse related issues, having been the Force Lead for domestic abuse, stalking and harassment and serious sexual offences and has been involved in the DHR process since its inception in 2011.

She has completed several training courses including the Home Office online training, the Continuous Professional Development accredited AAFDA DHR Chair training, the Domestic Abuse and Suicide accredited course, and is a member of the AAFDA DHR network, regularly attending the monthly forums for CPD and discussion. Mrs Dadd has recently completed the new Home Office DHR Chair training to obtain the qualification of a level three ONC certificate.

Mrs Dadd has completed and published several DHRs.

1.2 Purpose of the review

The purposes of a DHR are to:

a) 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.

b) 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.

c) Apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate.

d) Prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity.

e) Contribute to a better understanding of the nature of domestic violence and abuse; and

f) Highlight good practice.

DHRs are not inquiries into how the victim died or into who is culpable; that is a matter for the Coroner and criminal courts, respectively, to determine as appropriate. DHRs are not part of any disciplinary inquiry or process. Part of the rationale for the review is to ensure that agencies are responding appropriately to victims of domestic abuse by offering and putting in place appropriate support mechanisms, procedures, resources and interventions with an aim to avoid future incidents of domestic homicide and domestic abuse. The review also assesses whether agencies have sufficient and effective procedures and protocols in place which were understood and adhered to by their staff.

This review will ascertain whether domestic abuse could have been the cause or a contributory factor to the death of Polly. It is not to apportion blame, but to view the circumstances through her eyes.

1.3 Timescales

1.3.1 Following an investigation into the death of Polly and the knowledge of previous domestic abuse against her, the manager of Cambridgeshire Domestic Abuse and Sexual Violence Partnership made a referral to Safer Peterborough Partnership on the 13th of March 2024.

The same day, Safer Peterborough Partnership, in accordance with the December 2016 Multi-Agency Statutory Guidance for the conduct of Domestic Homicide Reviews commissioned this Domestic Homicide Review. Mrs Jackie Dadd was commissioned to provide an independent Chair and Author for this DHR on 18th March 2024. The Home Office were notified on 8th April 2024.

Three separate panel meetings then took place. The completed report was handed to the Safer Peterborough Partnership on 01/11/24.

1.3.2 Table outlining timeline of review

March 2024	Polly found deceased
13/03/24	Manager of the Cambridgeshire DASV sends a referral to Safer Peterborough Partnership
13/03/24	Decision to commission a DHR made by Safer Peterborough Partnership
18/03/24	Mrs Jackie Dadd commissioned as Chair and Author
08/04/24	Home Office notified of decision to commission a DHR
09/05/24	First panel meeting
11/07/24	Second panel meeting
04/09/24	Third panel meeting
01/11/24	Completed report handed to Safer Peterborough Partnership

1.3.3 Home Office guidance states that the review should be completed within six months of the initial decision to establish one. There was a slight delay in the completion of the report due to awaiting information from the GP Surgery and Fire Service to be provided.

1.4 Confidentiality

This report has been treated as Official Sensitive and dissemination kept to those outlined at 1.9.

The pseudonyms used in this report were chosen by Polly's sister and mother to protect the identity of those referred to throughout the report but were then changed at the request of the Home Office for them to become gender neutral. Blossom reluctantly agreed to this.

Full details are found at 1.6 of this report.

The Safer Peterborough Partnership and Author have ensured that the collation of information and the information contained within this report complies with the Data Protection Act 2018 and the General Data Protection Regulation (GDPR).

1.5 Terms of Reference

1.5.1 The full Terms of Reference can be found in Appendix A at the conclusion of this report. The Terms of Reference were discussed and agreed upon during and following the first panel meeting.

It was agreed that the main areas of focus and discussion would be based on the following areas:

a) Was there collaborative working to support Polly as a victim of domestic abuse?
b) What holistic multi-agency responses are considered when a person hasn't engaged with agencies?
c) What considerations are given in safeguarding and supporting adult and child victims of domestic abuse, particularly when they no longer live with the victim or have lost them due to domestic abuse?
d) How effective was the response to Polly's suicidal ideations?

1.5.2 Methodology

Following the initial scoping exercise, it was apparent that there was a lot of contact with agencies between either Polly and her children and/or John (partner), particularly over the last two years of Polly's life.

A number of IMRs were requested including analysis and potential recommendation areas and information has been included from both the police investigation and the fire

investigation following Polly's death. Close contact has been maintained with the Coroner throughout.

The family were approached to gain insight and information into Polly's life and relationships and to ensure they and Polly were centric to this review.

Polly's partner who had served a prison sentence for offences of domestic abuse against her, is currently under supervision from the Probation Service. The Author utilised his case worker to facilitate a meeting to gain a perpetrator's perspective for the review.

Panel meetings provided debate, discussion and confirmation of actionable recommendations.

1.6 Subjects of the review/Family and friends' involvement

1.6.1 In accordance with Home Office guidelines to ensure confidentiality, pseudonyms have been utilised throughout this report for the following: (All ages are recorded at the time of Polly's death).

Polly – The deceased. A 34-year-old white British female.

John – Partner of Polly. A 41-year-old white British male.

Blossom – Polly's younger sister.

Tara – Mother of Polly.

Jack – Eldest child of Polly and Harry. Aged 13 years old.

Finn – Youngest child to Polly and Harry. Aged 11 years.

Harry – Ex-partner of Polly and father to Jack and Finn.

David – Ex-partner of Polly.

Philip – Ex-partner of Polly and father to Charlie.

Charlie – Polly's sole child with Philip. Aged 7 years.

Jay – Eldest child of Polly and John. Aged 1 year old.

Ollie – Youngest child of Polly and John. Three months old.

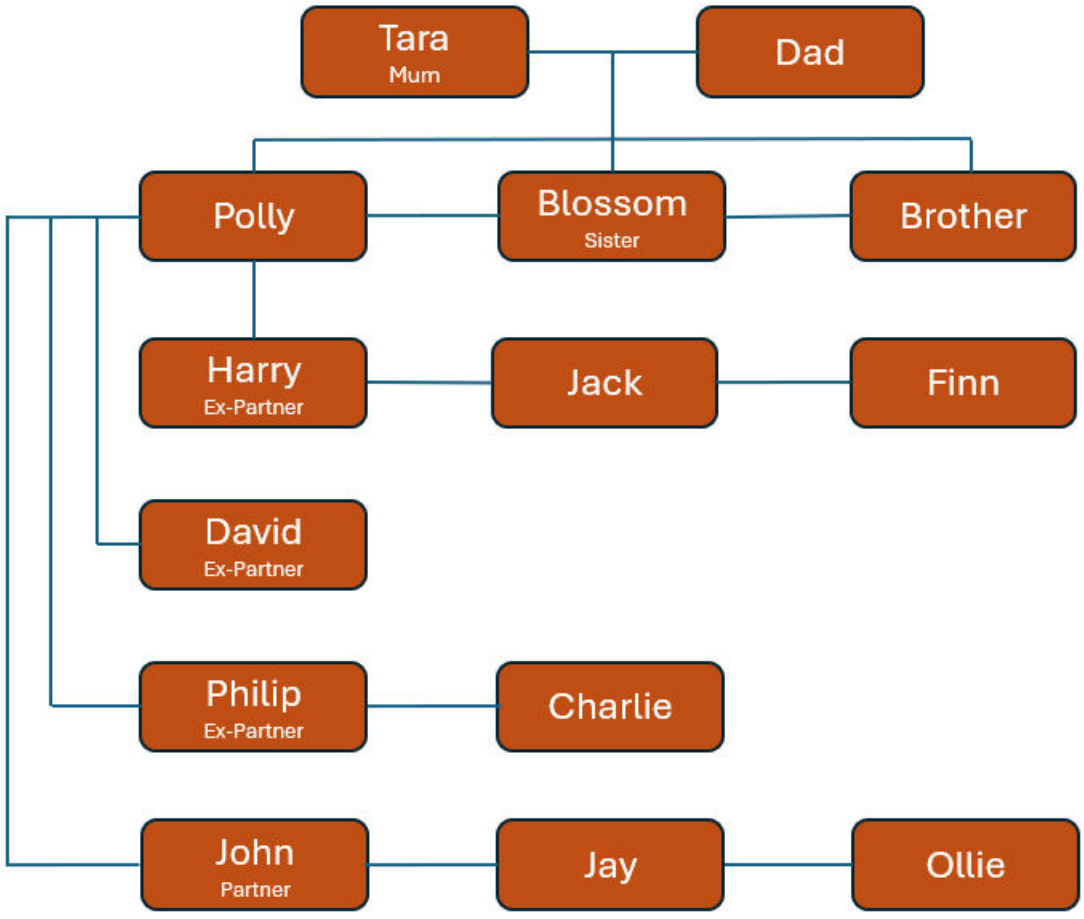
1.6.2 The sister and mother of Polly were fully engaged with the review with her sister, Blossom being the preferred point of contact. Communication was via email and face to face meetings, as was their preference. The author would like to express their gratitude for their significant contribution and assistance provided throughout.

Blossom was sent a letter by the Safer Peterborough Partnership informing her of the decision to commission a DHR and providing information on AAFDA for support. This was

unfortunately following the first panel meeting as contact details had not been identified until then. Following a phone conversation, the author then visited Blossom and her mother at their home address, at their request, where they spoke at length. They were again advised of AAFDA and the support they can offer and this was re-iterated this on each occasion of contact. However, they chose not to take up this offer at this time.

They were offered the opportunity to attend panel meetings but declined as they were content with the author providing updates. Other methods of communication included email and phone conversations. Each were at the choice of Blossom.

1.6.3 Genogram



1.6.4 Blossom and her mother, Tara were sent a copy of the report which they discussed at length with the author in person and although they found it 'a hard read,' they were satisfied with its content and findings and felt it portrayed Polly well.

The author utilised the Probation Service to facilitate an introduction with John, who the author then met in person, holding a lengthy discussion with him to gain a perpetrators perspective towards this review. The author would like to thank the Probation Service for their assistance in enabling this to happen. John states that he was still in a relationship with Polly at the time of her death.

1.7 Parallel reviews

1.7.1 Coroner

The Coroner's inquest has been opened and adjourned awaiting the completion of this review.

A post-mortem took place in which the cause of death was found to be:

1) Carbon Monoxide poisoning

In basic terms, this is smoke inhalation, as a fire has high levels of carbon monoxide in it which starves the body of oxygen and was therefore fatal.

1.7.2 Fire investigation (FI)

A Fire investigation took place following the death of Polly. A full examination was made of the scene. It was found that the fire had started in the bedroom from a single seat halfway down the left-hand side of the bed by the application of a naked flame, which would have had to be applied over time. This will have produced toxic gas and would heat rapidly creating the presence of carbon monoxide. This will have spread very quickly and all things combined would make survivability unsustainable.

Polly was found deceased in the kitchen opposite the bedroom which is the opposite direction to the front door. A dog was also found deceased. No keys were located in the property.

The Fire investigation eliminated candles and electrical malfunctions. Lighter fluid and lighters were found in the kitchen. There was no other smoking paraphernalia found or other cause of ignition. The finding was that the fire had been started deliberately and was not an accident.

An exert from the FI report states:

"Following a full examination of the scene and considered all the information available at the time of the investigation, with all other viable causes excluded, it is my opinion this fire is of a deliberate nature. Where an individual has purposefully set fire to the combustible materials located on the left side of the bedframe, located in the bedroom.

A report has been sent to the Coroner.

1.7.3 IOPC (Independent Office for Police Conduct)

A referral was made to the IOPC as a result of Polly being in custody earlier in the day of her death. A decision was made that a local investigation would take place. This investigation did not find any procedural learning and did not affect this review.

1.7.4 CPFT (Cambridgeshire and Peterborough Foundation Trust)

CPFT had a Rapid Review which was incomplete and paused because of the police investigation. The DHR is now the primary process for review and identifying learning for CPFT.

1.8 Equality and Diversity

1.8.1 The review gave due consideration to each of the protected characteristics under Section 149 of the Equality Act 2010. The relevant legislation that provided the context for the panel was The Equality Act 2010.

Throughout this review process the Panel has considered the issues of equality in particular the nine protective characteristics under the Equality Act 2010. These are:

- Age
- Disability
- Gender reassignment
- Marriage or civil partnership (in employment only)
- Pregnancy and maternity
- Race
- Religion or belief
- Sex
- Sexual orientation

Equality is about ensuring everybody has an equal opportunity and is not treated differently or discriminated against because of their characteristics. Diversity is about taking account of the differences between people and groups of people and placing a positive value on those differences.

1.8.2 Key considerations for the panel were disability, pregnancy and maternity, age and sex.

As a female, national statistics show that one in four women suffer domestic abuse during their lives. The cause of death has yet to be determined by the Coroner so the review is based on the findings of the criminal and fire investigation.

The DASV worked alongside Public Health to review the correlation between suicide and domestic abuse. These outcomes were shared with key stakeholders working on Suicide prevention in Cambridgeshire and Peterborough. Cambridgeshire County Council published a Suicide Prevention Strategy in January 2023.

Research showed:

1. Domestic Abuse is a factor in around 12.5% of female suicide attempts
2. 25% of those in Domestic Abuse services have felt suicidal due to the abuse
3. Domestic Abuse victims are 8x more at risk of suicide than the general population
4. 50% of Domestic Abuse victims who attempt suicide will undertake further attempts within a year

5. 20% of DA Victims attempting suicide are pregnant
6. A third of female suicides are subject to domestic abuse
7. "Suicidal acts…… are more likely where feelings of defeat and entrapment exist alongside beliefs that neither rescue or escape are possible" Williams (2001)
8. 3-10 women a week die by suicide where they have suffered domestic abuse[1]

1.8.3 Polly had five children, all of whom were removed from her care over the course of the last few years of her life, with the last, being the removal at hospital following birth. The Office for National Statistics estimates that around 1% of children are likely to experience the death of their mother before they reach the age of 16 years. This data research was completed up until 2000 with nothing more recent. Polly died at the young age of 34 years. Data supplied from 28 police forces showed that over 50% of police recorded violence against the person offences against women in age groups between 20 and 44 years were domestic abuse related.[2]

Although it is not inevitable that a person will experience domestic abuse during pregnancy, it is a time of increased risk with 30% of all domestic abuse starting in pregnancy, rising to 40% in the period from pregnancy until baby's second birthday.[3] With Polly having five children in which each relationship with each father was abusive, professionals did not recognise the increased risk, based on her history for the births of her youngest three children.

1.8.4 The review analysed the response to Polly during her pregnancies and particularly to the final pregnancy and birth whereby Ollie was removed from her care whilst in the hospital. Although this characteristic mainly focuses on those mothers in the workplace, the panel felt this was relevant to Polly as a victim of domestic abuse to ensure that she was not discriminated against or treated any differently. The midwife took an active part in the child proceedings.

The characteristic of disability was felt relevant due to the mental health struggles that Polly was facing and if the core reason for this was overshadowed by the ongoing child protection hearings and the substance abuse that she was suffering. Was she rightfully considered as a domestic abuse victim and was she discriminated against for staying with the perpetrator?

[1] hoping to help: Identifying and responding to suicidality amongst victims of domestic abuse - Vanessa E Munro, Ruth Aitken, 2020 (sagepub.com)
[2] Home Office statistics - ONS 2023
[3] Why Is Domestic Abuse So Prevalent During Pregnancy? - For Baby's Sake

1.9 Dissemination

Recipients who received copies of this report prior to publication:

Relevant members of Safer Peterborough Partnership

Panel members outlined at 1.1.4

Coroner's office

Family members

Cambridgeshire Police and Crime Commissioner

Domestic Abuse Commissioner

Section 2 – The Facts

2.1 Background information

2.1.1 Polly

Polly was born and raised in Peterborough by her parents being the eldest sibling to a sister, Blossom, who was a year younger than her and a brother. Due to their similar age, Polly and Blossom had the same friendship groups and always 'hung out' together with Blossom describing Polly as funny and always the 'joker of the group.' Polly's mum, Tara states that Polly did well at school and was rarely in trouble, remembering her prom fondly.

On leaving school, Polly went to college to study in Health and Social Care with a view to looking after people, however, she left within the first year when she got a boyfriend in St Neots and moved to a hostel there, coming backwards and forwards to Peterborough to see family and friends. When the relationship ended about a year later, she moved back to Peterborough where she stayed in a hostel as she had got used to her independence. She had different boyfriends in her latter teens but no serious relationship until she met Harry when she was 19 years old, who she went on to have two children with.

In 2010, when she was 21 years old, Polly gave birth to her eldest child, Jack. Her family thought she took to motherhood very well and enjoyed it. She had a second child, Finn with Harry and seemed happy, although she found that Harry was having numerous affairs as she had seen this on his texts and although she stayed for a while as she wanted to keep the family together, she eventually left, taking her children with her and was quickly re-housed to an area a bus stop ride away from her parents' house.

2.1.2 Chronology

In 2015, Polly was in a relationship with a male named David for about a year in which the family state that he was violent towards her. The Police requested a strategy discussion with Children Social Care following Polly alleging that David had hit Finn. Polly had to leave the

house with the children in a panic and ran to the school for help and the Police were called. Two MARACs were scheduled with the first not taking place as David was remanded in custody. Their notes record that Finn had not been feeling well and Polly had put Finn to bed when David became angry and began shouting and slapping Finn. Polly tried to intervene and he grabbed her around the throat. She escaped and ran to the local school to get help. Finn suffered several bruises to the cheeks and buttocks. The MARAC were satisfied a safety plan was in place and tasked a number of actions to ensure all agencies were aware of the progress of the prosecution.

David was charged with assaulting Polly and the children. A section 47 was completed as it was substantiated David had hit Finn, but both this and a Child & Family assessment (C&F) were closed with no further action as it was recorded by Children Social Care that the needs of the children had been met with Polly acting protectively by reporting the incident. Polly was contacted by an IDVA who arranged target hardening to her house, discussed support for the children and also possible orders including a restraining order. Also, Polly attending the freedom programme was discussed but did not come to fruition. IDVA support continued until February 2016 when communication ceased with Polly due to unanswered calls.

2.1.3 During the investigations following this incident, a couple of months later, in 2016, Polly had disclosed that she was in a new relationship with a male named Philip. The school disclosed to the police that they had concerns as they could not get hold of Polly and the children had not been attending to which once Polly had been located, explained the children had been ill and she had moved.

In May 2016, Harry contacted Children services stating that he wished to care for the children and stated he was concerned the children had scratches and headlice on them. At this same time, following a MARAC, the police and Women's Aid attempted to make a Clare's Law Domestic Violence Disclosure to Polly in relation to Phillip, who was known to Women's Aid as a perpetrator of domestic abuse but were unsuccessful and did not complete this. Philip had eight separate custodial and community sentences between 2007-2013 and he was flagged as a domestic abuse perpetrator and was known to probation as he had previously been subject to past licences.

At this point, Polly was six weeks pregnant. Polly attended a maternity appointment and it has been identified that there is no evidence that 'Ask the Question' was asked, which is a routine enquiry into domestic abuse. Polly attended all her appointments throughout the pregnancy.

The IDVA service made contact with Polly throughout 2016 to offer support but she did not wish to meet with them. Polly gave birth to Charlie at the end of that year.

2.1.4 In 2019, the police and ambulance attended Polly's house as she had messaged a friend stating she was going to kill herself. The police found her intoxicated with Charlie, who was 2 years old at the time. She made further suicidal remarks and was taken to the hospital but once there, wanted to leave which the hospital allowed as they were content that she had capacity. Charlie went to stay with Blossom overnight and the police made a referral to

Children Social Care (CSC), Cambridge and Peterborough Foundation Trust (CPFT), who provide mental health support and the Integrated Mental Health Team (IMHT). No further action was taken by CSC as no concerns were highlighted for the child.

Early Help supported the family in 2020. The family state that Polly wasn't coping with a baby and two older children as she still had Jack and Finn living with her at that time and was not in a 'proper' relationship with Philip.

2.1.5 During 2021, Polly, who had been living in a Cross Keys Home for several years, made a number of requests to the Be Kind fund and complaints were received from neighbours in relation to the behaviour of the children and noise from parties at the location. On 23rd February 2021, Polly started an online application to join the Housing Register. She gave no disclosure, details, or circumstances and did not complete the application. Thirteen system generated emails were sent to Polly asking her to complete the Housing Register application. The application was automatically closed on 23rd March 2021 as there was no response.

Towards the end of 2021, Polly began a relationship with John who she had known through mutual friends for a couple of years. In February 2022, the Police recorded a domestic Actual Bodily Harm (ABH) between Polly and John that was reported by a third party outside her flat. She had asked them 'Don't call the police, he'll kill me' before going back into the flat. When the police spoke to her, they saw that she looked like she had been crying with clumps of hair pulled out and a graze to her forehead. She had blood on her neck, face and hands and a scratch to her neck. Polly denied any domestic abuse to the police and stated that she had been in a relationship with him for two months. John was arrested, interviewed and bailed. Polly informed the police that she was pregnant and when the safeguarding midwife received information from police referrals, they ensured contact was made with the MASH to check that Children Services had been informed. Children Services made the decision to proceed with a child and family assessment.

2.1.6 In March 2022, an ex-partner of John reported numerous offences in relation to John that had occurred in November 2021 including ABH, malicious communications and threats to kill. The threats were to burn her house down with her inside it and he had turned violent after they had consumed a bottle of vodka, pulling her hair and strangling her. She required hospital treatment and suffered concussion and two black eyes with a lump to her forehead. She obtained a restraining order and was supported by the IDVA service. She subsequently withdrew her complaint in December 2022 and the CPS made the decision that no further action would be taken. During the investigation, the police found a photograph on his phone of him brandishing a gun and a zombie knife. Following a search of his home where nothing was found, no further action was taken.

During March, the Child and family assessment had been completed and a decision was made to support the family through a Child in Need (CiN) plan. There were concerns over Jack and Finn's presentation with them being withdrawn at times, but Charlie seemed more settled and had positive relationships at school. The report stated that the children liked

John because he bought them nice things. Contact was made with midwifery for a referral for the unborn child.

2.1.7 In April 2022, a neighbour called the police as they had witnessed John kick the front door and then kick the kitchen window shut, trapping and cutting Polly's finger. Jack, Finn and Charlie all witnessed John smash the house up and threaten Polly with a hammer. Polly told the police that John had never assaulted her before. She had a swollen lip and had told the neighbour that he had strangled her but she denied any assault and stated that she wanted him back. The police record that the children seemed frightened of him having spoken to them and called him a 'horrible' man. Polly was taken to hospital due to intoxication and pregnancy.

A MARAC was held following this incident as it had been recorded as high risk. Polly and John had both been under the influence of alcohol. John had been bailed with conditions not to contact Polly who did not feel she could support a prosecution due to fear. This was also the case for the neighbour. The CPS had refused to charge, citing a lack of officers statements and no download of Body Worn Video evidence. All previous incidents were heard at the MARAC which outlined an extensive history of offending and allegations in John's past.

Children Services maintained the Child in Need status. Polly had informed CSC after the second incident that the relationship had ended. Probation stated that John was on an 18month suspended sentence until 22nd April 2022 due to a conviction for a shooting/wounding GBH. Cross Keys Homes confirmed that the property was a sole tenancy in the name of Polly.

Information was shared by Change Grow Live at the MARAC that John had just completed detox from opiates and heroin and had recently received a referral to MIND for his mental health as the Ambulance Service confirmed reports of a recent overdose. Positive actions were made at the MARAC including consideration of Clare's Law, informing the schools and the escalation of the Child in Need for a strategy discussion with midwifery, IDVA and Cross Keys to be invited as it was apparent the relationship was still ongoing.

An unborn baby panel was held but the scheduled strategy meeting was cancelled by CSC which was questioned by the midwife due to the high risk and requested it be escalated. Polly presented to Change Grow Live and booked in for an assessment but did not attend as she stated that she had no childcare. Due to the ongoing domestic abuse, further appointments were offered but her file was closed in June when they could not engage.

2.1.8 On 7th May 2022, the police recorded criminal damage and controlling and coercive behaviour as Polly had disclosed to her child's school that she did not feel safe to return home and that John had told her, "If you kill my baby, I will kill you. I will burn your house down with you and the kids in it." She believed these threats and said that he made them whenever she wanted to leave him or go to the police. Polly told them, "I am petrified to be supporting the police as I think this will end up in him ending my life."

The evening before, John had punched, bitten and strangled her causing swollen lips and nose, a black eye and dried blood on her face. Polly alleged that John had raped her whilst she was pregnant but the CPS did not prosecute due to insufficient evidence.

Polly stated to the police that between 01/02/22 and 10/05/22, John controlled her. He controlled her finances, where she could go, phone communication, what food was in the house and who could eat it.

John was arrested, charged the same day with twelve offences and was remanded in custody until his hearing in December at Crown Court.

Polly attended her midwife appointment where she confirmed the use of alcohol during pregnancy and was unsure if she wanted to keep the baby. The Safeguarding Midwife gave a Clare's Law disclosure to Polly who said that she did not want to resume the relationship. Polly had informed CSC that she had not wanted the baby, but John did.

2.1.9 Jack and Finn permanently went to live with their father, Harry, and Polly would go to visit them from December 2022 onwards. Polly provided differing accounts to agencies as to whether she was back in a relationship with John whilst he was in prison. They were in contact frequently according to Polly's family. During this time, Polly withdrew from the police and the IDVA support. Charlie told school staff that Polly was speaking to John over the phone in prison. Concerns escalated for Charlie and then Jay, when born in the October, as it was recorded by Children Services that Polly was back in a relationship with John and had an unwillingness to safeguard Charlie or Jay and Children services moved them onto a Child Protection Plan.

Charlie then went to live with the father, Philip who would not let Polly see Charlie whilst she was in a relationship with John as he said that it may put Charlie in danger. The family and John both state that this affected Polly as she missed Charlie and it 'got her down.'

2.1.10 In December 2022, Jay was named a Child in Care under an interim Care Order and was placed in foster care in which it was reported that they were doing well. John appeared at Cambridge Crown Court and was sentenced to multiple offences against Polly in which he was sentenced to a suspended imprisonment of ten months concurrent which was suspended for two years, alcohol treatment required and rehabilitation activity required. He was found guilty of these offences following a trial in which Polly had given evidence to the fact that she had 'made it all up.' Due to this, the CPS placed the controlling and coercive to lay on file and no further action was taken on certain offences due to insufficient evidence.

Doctor's notes record that Polly had several consultations during January and February 2024 as she was suffering from panic and anxiety attacks due to the court proceedings.

Incidents occurred involving Jack and Finn and then Charlie, all whilst living with their respective fathers but no further action was taken in regard to them although Charlie continued on the Child Protection Plan.

2.1.11 Throughout the first six months of 2023, options for placement were explored for Jay to meet their needs. Following his release after the trial, John was under the supervision of

the Probation Service. In the six-month period following his sentencing, John attended all but two of his appointments for which there were accepted reasons and he began a detox programme for alcohol with Change Grow Live. Polly had attended in January 2023 and was booked in for an assessment but did not attend. In the March, Polly was booked into a group called 'Blossom Recovery' which is a female only group to Aspire. Attendees to this group may be experiencing domestic abuse and it therefore creates a safe environment. Polly did not respond to correspondence and the appointment was cancelled.

Polly had been receiving contact from a Domestic Abuse Practitioner (DAP) from Barnardo's throughout 2023 to offer support but several appointments were cancelled by Polly and one by the DAP due to attending the strategy meeting. The support was for Safer Us sessions. Each time the DAP rang, caution was taken as they were aware John could overhear the conversation.

Probation recorded that John had been admitted to A and E due to Polypharmacy overdose which he stated was triggered because of his accommodation and lack of support from services. He had presented with angry protector mode which he used to avoid distressing feelings associated with his offences. An externalising the problem exercise was recommended.

2.1.12 In June that year, Polly had disclosed to Social Services that she was pregnant. In August, Jay was placed for adoption and the unborn baby was placed on a Child Protection Plan. During the Initial Child Protection Conference in August, it was agreed unanimously that when the child was born, they were not to leave hospital and the police were to be alerted. This was under the neglect category.

John began the Building Better Relationships programme as per his sentencing which included a referral to a Domestic Abuse Safety Officer who works with victims/partners and he informed them that his partner was pregnant. It was recorded that John continued to use drugs and was on a 40ml script. All of this information was shared with CSC for the Child Protection Conference.

2.1.13 In August 2023, Doctors records show that Polly suffered a fractured fifth metatarsal bone due to a tripping accident down the stairs. She attended A and E but left before treatment. She was to later tell her family that she had injured it whilst tripping in the park and they state that friends were told differing accounts. Polly attended Aspire with John and requested support around her alcohol use stating that CSC had advised her to attend. An appointment was made but Polly did not attend and several attempts by Aspire were made to re-schedule but were unsuccessful.

Polly's tenancy was in question as she had stated that she was living between addresses and it was ended in October 2023 when it was ascertained she had not stayed there for several months. That same month, John requested for Polly to be put on his tenancy which was also a Cross Keys Home but this was not actioned as the request for details and identification was not responded to.

At the beginning of December, Polly gave birth to a son, Ollie. John and Polly were allowed to be in his room with him but not to leave the hospital with him. Four days after he was born, there was a strategy request as a bruise had been found behind Ollie's right ear that was unexplained. CSC had already obtained an Interim Care Order and a safety plan was put around him with Polly and John only having supervised access.

2.1.14 In January 2024, Polly applied for the housing register but did not complete her application or provide documentation. Her online application disclosed that she was living with a friend, John and provided her previous address. She stated that the reason for applying was because: -

'Was living with partner the relationship has ended and there's also not enough room for me and the children here'

Two notification emails were sent to Polly asking her to provide documents in order to process the application. There was no response to the notification and the application was closed on 7th February 2024.

2.2 Circumstances of the death of Polly

2.2.1 In March 2024, Polly was struggling with her mental health and sought to get help. All of the following circumstances occurred within a period of one week.

Polly attended the emergency department (A&E) at Peterborough City hospital having taken an Opiate overdose of seven pregabalin and being suicidal. She stated that she had woken up in the middle of the night experiencing hearing voices that scared her. She went out to a bridge but couldn't jump so went to McDonald's to take the tablets and then sought medical attention.

She stated that her relationship was mature and healthy and that all her children had been removed, one being two months previous. Polly stated that she would engage with a drug and alcohol provider as her partner used them. She saw the Liaison Psychiatric Service (LPS). Polly was assessed that there was no mental health necessity to refer to secondary mental health because Polly denied suicidal thoughts or any current intention to harm herself. Polly did not exhibit acute mental illness symptoms and acknowledged that her current condition was primarily due to illicit substance misuse. She left with a discharge plan.

2.2.2 Polly attended A&E the following day due to feeling 'suicidal, intends to end life' feeling worse than the previous day. She was seen by the same LPS specialist nurse along with another colleague. Polly was unsure about her relationship status as she said that her partner had told her the day before on the phone while she was walking the dog, that the relationship was over and that 'he's had enough.' Hospital recorded the trigger of her MH as having her five children removed. CPFT records state that following a lengthy discussion, she agreed she was safe to return home and was discharged with advice to use the GP as a form of support. The GP was sent a letter the same day and a safeguarding Children action plan

was raised. There was a DV flag on Polly's records which instigated an automatic notification to the DA Co-ordinator who made a referral on behalf of A&E.

Two days later, Probation completed a home visit during which both John and Polly were present. During this appointment Polly disclosed she has relapsed into substance use. John's Probation Officer encouraged her to seek support; however she suggested she did not want to engage with professionals.

2.2.3 At 10.18hrs the following morning, Polly was seen on a bridge over a major trunk road standing on the wrong side of the railings. The police managed to talk her back to the right side where she seemed paranoid and said that she was struggling with her mental health and wanted support. Polly felt like everyone was against her and some people were trying to set her up which led her to feel low and suicidal, so she went to the bridge. An ambulance attended and took her to hospital. Officers followed the ambulance to ensure that Polly went with the paramedics. Hospital staff were made aware of the situation and that Polly could potentially leave the hospital, so when they booked her in, they marked her as a flight risk. At about 11.50hrs, the officers left Polly in the hospitals care. Advice was given to her for if she felt low/suicidal again.

Officers completed a safeguarding referral to the Police MASH and within an hour, the information was shared with her GP, CPFT and Change Grow Live with the consent of Polly. Polly left the hospital before being seen.

2.2.4 At just gone 16.00hrs, the same day, the joint Mental Health Police Response Vehicle attended the same major trunk road to a report of Polly walking along the edge of the road and there was concern for her safety. When she was triaged by the mental health practitioner, Polly stated that she was not suicidal but was trying to speak to her ex-partner John. She stated that she was homeless and that she had been taken to hospital by ambulance earlier the same day due to her mental health needs but left before being seen and had left her coat and phone behind.

The Police initially took Polly to the hospital to form a plan and attempt to get her property back. The hospital records state that they had observed her by continuous monitoring but she absconded. They checked with the police who confirmed that they had arrested Polly for obstructing the highway and took her to a police station.

Polly was fit to be detained although she was to be under constant observation due to what had happened that day and that the mental health nurse had stated that Polly had triggers for suicide after her children were taken into care. Polly was assessed and deemed fit to be detained. Polly was interviewed late at night with a solicitor present and subsequently charged with Wilful obstruction of the highway and bailed, being released from the police station at 05.16hrs having had a prerelease risk assessment stating that a medic had no concerns for her release and she was to be transported home in a police car to ensure her safe entry into her address. Polly did not have any keys in her possession. Officers gained access to the communal area with a universal key and went to her front door with her. There was no answer and Polly stated that she would wait for her partner to come home. The

Police officers assessed this as appropriate and left Polly outside the property at 05.30hrs the same day.

2.2.5 About 09.30hrs the same morning, neighbours from within the block of flats suspected a fire coming from Polly's address due to smoke and contacted 999 at 09.54hrs when he could not rouse any occupants.

The Fire Service attended and notified the police who attended by which time the block of flats had been evacuated and the area cordoned off. Paramedics were giving cardiopulmonary resuscitation (CPR) to Polly on the grass area outside the block of flats. John arrived at this point and saw this. The Fire crew stated that they found her within her flat laying unresponsive surrounded by smoke. At 11.06am, despite the best efforts by the paramedics, Polly's death was confirmed.

There was a fire investigation to establish the cause of the fire as outlined at 1.7.2 and a police investigation which found that there was no evidence of third-party involvement, no suicide note recovered and no criminal offences disclosed. A file was forwarded to the Coroner's office with these findings and that of the Fire investigation.

2.3 Individual management reviews (IMRs)

IMRs were requested from those agencies who had significant communication with Polly and/or John. Information from these have been embedded throughout this report and have not been repeated in this section.

2.3.1 Peterborough Housing Needs

The Peterborough Housing Register is operated and maintained by the council on behalf of the Peterborough Homes Partnership. Applicants wishing to join the Housing Register will need to complete an online application form.

In all circumstances, the council will require the main and joint applicant to upload proof of their:

- identity,
- current circumstances,
- Children details such as identity and child benefit entitlement,
- National insurance number,
- current address,
- eligibility,
- social landlords' acceptance to allow them onto the register.

There may also be other documents which are requested which must be provided prior to any offer of social housing

In terms of the Housing Register, applicants will be required to sign a declaration that:

- The information they have provided is true and accurate and that they will notify the council of any change in circumstances immediately it occurs.
- They will be asked to declare any incidents of anti-social behaviour that they (or people living with or visiting them) have been involved in either as a victim or perpetrator they consent to the council verifying the information that they have provided.

Housing Needs has a privacy notice.

If the customer discloses DA, they are offered a referral to IDVA which must be consented to by the customer. Information can only be disclosed to partner agencies if a consent form is signed.

If there are safeguarding concerns, they can refer to https://www.safeguardingcambspeterborough.org.uk/ and/or the Police. DA training has been implemented team wide.

2.3.2 Probation Service

During John's appointments, substantial rehabilitative intervention has been completed which has focused on his offending, victim awareness and empathy, thinking skills, impact and effect of behaviours, domestic abuse including denial minimisation and blame and anger management. Within contact logs, John is described to have engaged well with intervention albeit there were concerns highlighted in relation to his understanding. On occasions he is described as being withdrawn in sessions. It is important to note that during the period of supervision, John experienced significant events including the removal of Jay and Ollie which are likely to have caused significant trauma and impacting on his wellbeing and engagement.

John attended 39 out of 49 appointments offered with all but one being an acceptable explanation in which he was issued a warning letter.

John was under the influence of alcohol at the time of the offence whilst he suggests this was a causal element of his behaviour, he has indicated he takes full responsibility and does not blame his alcohol use. During the victim empathy work completed he evidenced a high level of victim empathy and remorse.

Building Better Relationships is a 30-session programme for men who have perpetrated violence within relationships. The Post Programme Report highlights John's positive attendance and engagement with the programme. He is described as evidencing motivation to comply even during periods when he was experiencing problematic mental health. He is reported to have met the conditions of success to a good standard. He engaged with all activities on the programme offering his own views and opinions within groups discussions. He spoke openly about his offence and behaviours within relationships and demonstrated that he was able to take full accountability which support his learning. During one-to-one sessions he would discuss the skills he had learnt and how he intended to apply them. He had some

difficulties with the written elements of the programme however facilitators supported with this. John evidenced a good awareness from an early stage of the programme of his risks and triggers to violent and abusive behaviours.

Safeguarding concerns were ongoing throughout John's sentence. It is evident from Probation records that there was open liaison and communication with Social Care. There was attendance at Child Care Reviews and CP meetings and conference. Risk assessments and reports were provided to Social Care and Reports were written for Family Court.

Throughout his sentence there were concerns in relation to his mental health. He was frequently sign posted to his GP for support. A referral was completed to the Commissioned Well Being Service within Probation in November 2023 however, he did not comply with the appointments offered therefore the intervention could not be provided.

In the latter stages of his sentence prior to Polly's death she had attended a number of appointments with John. His Probation Officer engaged with them both and was able to witness the interactions between them. During the appointment she attended on 29th January 2024 they discussed the trauma they were both experiencing following their newborn son being taken into Foster Care. They reported they had referred themselves to CGL and were awaiting an appointment.

2.3.3 Barnardo's – Domestic Abuse Practitioner (DAP)

DAP work is adult led and is not encouraged to be delivered with children present, therefore, the DAP did not see or meet the children at any of the contacts.

Barnardo's first received a referral to support Polly at the beginning of 2023 and due to Polly's uncertainty as to whether she was open to the IDVA service, they contacted them to clarify that she was not. Polly did not attend the first arranged meeting and when a joint meeting through the Social worker was attempted and the Social Worker did not respond, the case was closed.

Following a re-referral during a joint meeting with Polly and her Social Worker and the DAP, Polly agreed to complete 'Safer Us' DA work which began in June 2023. Polly was sent a text reminder the day prior to each session. A total of seven sessions were arranged in the months through to August and Polly attended two sessions. During this time, there were Child protection meetings that the DAP attended.

On the 23rd of August 2023, the DAP called Polly to confirm a session location and John answered. Caution was given by the DAP and Polly confirmed she would attend the session on the 29th of August 2023. On the day the session was due to take place, Polly contacted by text to say she would be running late as she had broken her foot and couldn't drive. The DAP received no response to text so called her to ask if it would be easier for her to re-schedule and heard who she believed to be John in the background saying 'That was nice' indicating it may be on speaker phone.

Due to the DAP recognising risk signs of control, a meeting was held the same week with IDVA and the Social Worker to discuss options, review safety planning for contact with Polly.

On 4th September 2023, Polly sent a text message to the DAP stating 'Hello, just to let you know I will not be attending anymore sessions'.

The DAP informed IDVA and the Social Worker and raised the question whether a referral should be made to MARAC. The case was closed the same day with the MARAC referral not addressed.

The DAP worker liaised with Children Social Care and IDVA service. Children Social Care were following legal process around safeguarding. The DAP was included and involved in professional meetings to share information.

2.3.4 IDVA Service

The IDVA Service first received a referral for Polly in 2015 where they arranged target hardening and support for the children as they were placed on Child in Need category and a referral for the Freedom programme was made. Shortly after this, Polly declined a face-to-face visit and withdrew with a number of attempts to contact her and arrange meetings but all unsuccessful. The case was closed early in 2016.

The next referral was received in 2022 and following a MARAC, received one for a different victim but the same perpetrator (John). Over the next few months, the IDVA liaised with the school and the Social Worker but had not managed to make contact with Polly and became aware that further offences were being committed against her due to Police reports. The IDVA was unable to attend the CiN meeting which was then cancelled due to Polly not calling into it and then couldn't attend a joint visit with the Police due to COVID.

Due to a delay in the IDVA initially establishing contact, it had not been identified that Polly had not been in possession of a phone. A phone with credit was provided and dropped off at the school for Polly to collect which was arranged by the Social Worker. The IDVA again could not attend an arranged joint unannounced meeting with the Police to see Polly at school pick up time which was re-arranged and completed. The IDVA completed a homeless application for Polly.

2.3.5 Children Social Care

Children Social Care became involved with Polly in 2011 due to concerns relating poor parental mental health and domestic violence. Jack and Finn were opened to children's services in 2015, after a strategy discussion was convened as Polly alleged that her then partner, David had physically assaulted Finn. A Child and Family (C&F) assessment was completed which determine that threshold was not met for Children Social Care involved, as David was incarcerated and so did not pose a risk to the children.

In February 2022, Children Social Care became aware of Polly's relationship with John, following the police making a referral following a call being made by a third-party raising concern regarding a domestic abuse incident between Polly and John, with John as the alleged perpetrator. The reported incident was serious and indicated that Polly had suffered harm following an assault from John.

In March 2022, the police shared information with Children Social Care relating to John being arrested for a historical crime of domestic related damage, actual bodily harm, stalking and malicious communications against a former partner.

The C&F assessment completed in March 2022 considered the history of concerns well. However, the analysis of the significance of the domestic abuse incident coupled with the historical allegations was undeveloped. A Child in Need plan was agreed despite concerns relating to the level of harm posed by John to Jack, Finn and Charlie. The Child in Need plan highlighted the need for Polly to be supported with understanding the risk of domestic abuse and that she should engage in support with her alcohol misuse. The plan did not identify what work John should complete, considering the risk of domestic violence and contained minimal safety planning to ensure the risk to the children did not increase, whilst support and interventions were offered.

On 10th May 2022 further contact was made by Children Social Care by the police raising concerns around the risk of domestic violence. The referral detailed an escalation in risk which the children were said to have witnessed, this included physical assaults from John and damage being caused to the home. Polly also spoke about the coercion and control she suffered following the commencement of her relationship with John. Polly was pregnant with Jay at this time and despite this, she alleged that the physical violence continued to escalate.

In September 2022 Jack and Finn were closed to Children Social Care as they were living with their father, Harry. Records indicate that prior to living with their father, both Jack and Finn witnessed the escalation in violence and because of this, family time between Polly, Jack and Finn would be supported by Harry to reduce the risk of them being exposed to domestic abuse. Charlie and Jay, who was an unborn baby at the time remained living with Polly and John.

In November 2022, a Strategy Discussion was convened, due to the increase in risk to Charlie and unborn baby Jay. Polly was open with professionals about her view that she did not support prosecution of John and she would be withdrawing her statement. The Child in Need plan, which had been in place since May 2022 had not been effective and there was limited targeted work completed with Polly to increase the safety network around her, to ensure she was well supported to respond protectively for her children.

The child protection plan was in place for a very short period before escalation into the court arena for Jay, who was now born and six weeks old. Concerns were raised that John was no longer in prison and neither Polly or John were engaging with the Public Law Outline process and that the risks had increased. In December 2022, Jay was placed in foster care under an Interim Care Order and Charlie went to live with her father. The Child Protection Plan ended for Jay, as he was now a child in care, but continued for Charlie until June 2023.

Concerns were raised for Charlie after she initially went to live with her father, Philip, in March 2023, these concerns related to alleged sexual abuse to Charlie by Philip's partners child and another concern regarding Philip's presentation at school. Both incidents were assessed and responded to, the outcome of Children Social Care assessments was that Philip

was able to provide Charlie with the care that she needed. Charlie was closed to Children Social Care in October 2023; she now resides in Northamptonshire area and so has had no further involvement with Peterborough Children's Services since this time.

Jay remained in foster care until April 2024 when he moved to live with his father's cousin. Assessments were completed with both John and Polly as part of the court care proceedings which concluded that they would not be able to meet Jay's needs. There were concerns around both parents' engagement in assessments and that Jay would be at risk of significant harm if he were to return to his parents' care. A care and placement order were granted in August 2023, however the plan for adoption was not progressed for Jay as a family member came forward. In April 2024, the plan for Jay changed from adoption to living with family (his father's cousin) under a Special Guardianship Order.

Ollie was born early December 2023; an Interim Care Order was granted three days later for Ollie whilst still in hospital when on release, he went to live in the same foster home as Jay. John and Polly shared in the child in care review held on 16th January 2024 that they were not pursuing a return of Jay and Ollie or disputing them moving to live with John's cousin. Jay and Ollie remain open to Children Social Care, as they are children in care until their care orders are revoked.

2.3.6 GP Surgery

The Integrated Care Board represented Primary Care on the review panel and an IMR was requested from Polly's GP surgery which they were happy to facilitate. Correspondence has taken place to explain the sharing of information and to provide details such as whether a policy is in place for domestic abuse. Limited information has been provided.

Polly was coded as having suicidal thoughts but not as a vulnerable adult. This is visible to Clinicians and external services that use systmone (electronic system). Records show that they were aware of her being a victim of domestic abuse from 2022 but there is no record of any conversations regarding this or any referrals made.

They state that Polly had minimal contact with the surgery. Where a person is not engaging, the policy states to attempt contact twice. The review was provided with minimal information from the GP surgery.

2.3.7 Cross Keys Homes (CKH)

Cross Keys Homes (CKH) are a Social Landlord with over 12,000 units, mostly in the Peterborough and Cambridgeshire area. CKH has a stand-alone policy and procedure for residents experiencing domestic abuse, a separate policy and procedure for employees and a dedicated team to manage cases and attend MARAC meetings. Policies and procedures have been developed/ updated recently in accordance with the Domestic Abuse Housing Alliance, eight priority standards.

Staff receive a three- tier training programme for employees covering basic awareness, DASH training and enhanced safe at home training.

Both Polly and John were tenants of Cross Keys Homes in separate properties for a number of years. CKH provided support to Polly in relation to furniture and white goods. CKH became aware of the domestic abuse on Polly in 2022 and attended all multi-agency forum meetings.

A visit was booked with John on 15th February 2022 three days after a reported incident of domestic abuse. There is no record of a conversation in relation to this although there is reference to a 'girlfriend' but no further information. There was a 'DA' icon on Polly's account. Following the incident in April 2022, there was contact with the IDVA and neighbourhood management to provide support for Polly.

CKH were aware that Polly was moving in with John and were aware of previous offences occurring on their property between them in which they had offered Polly support.

The specification of flat fire doors is really high (the new ones fitted cost around £2k for example) to ensure containment of the fire for a period of time. The Fire Service utilises Cross Keys Homes flats at another location for training purposes.

2.3.8 Cambridge and Peterborough Foundation Trust – CPFT

Under the LaDS Women's Protocol, custody staff should have access to a referral form and data base for women's services which can be completed when the LaDS service is unavailable, so support for vulnerable women can still be arranged. In addition, LaDS leaflets should be given to provide information on how you can self-refer as the service accepts self-referrals at a later date.

Prior to Polly's children being removed, CPFT clinical electronic record system showed an alert on her 'front page.' It stated, if Polly was seen by any professional, they should get an up-to-date phone number and inform the health visitor (HV) 'as she is a victim of domestic abuse and the children are subject to child protection (CP) plans.' The contact details for the HV were shown on the record. The telephone number had been updated. This evidences good practice.

2.3.9 CPFT Joint Mental Health Police Response Vehicle (JRV) is an arrangement where experienced CPFT specialist mental health practitioners work alongside Cambridgeshire Constabulary (CC) Officers to provide an immediate response to people in the community who are experiencing a mental health crisis. The mental health practitioner carries out a brief triage to ascertain whether a person can safely remain at home to avoid unnecessary attendance at acute hospitals, offer safety planning, sign posting and referrals into MH services, safeguarding or other services if needed. They will also support officers in making decisions around the use of S. 136 Mental Health Act and Mental Capacity Act.

CPFT Liaison and Diversion (LaDS) identify people who have mental health, learning disability, substance misuse or other vulnerabilities when they enter the criminal justice system, predominately in police custody and courts. The service can then support people through the early stages of criminal system pathway, refer them for appropriate health or social care or enable them to be diverted away from the criminal justice system into a more appropriate setting, if required. LaDS work with people of all ages, providing assessments

and sign posting for vulnerabilities such as mental ill-health or learning disabilities and drug and alcohol misuse with the aim of improving overall health outcomes for people and supporting people in the reduction of re-offending.

Support can include:

- Vulnerability assessment in custody or place of individuals choosing.
- Bespoke court reports if required highlighting vulnerabilities and support required to attend court.
- Primary mental health treatment requirements for women
- Signposting and referrals to other longer-term services.
- Support to attend initial appointments.
- Liaising with other services such as GP, housing, drug and alcohol services.
- Supporting those aged 10 years old and upwards with any vulnerability
- Person centred support plans, with short term support (6-12 weeks can be offered)
- There is a Women's Pathway which supports young women aged 14 years of age and over.
- There is a Young Peoples Pathway specifically for those young people aged 10 years and over.
- Hours of operation are 8am to 8pm 7 days a week.

https://www.cpft.nhs.uk/adults-specialist-mental-health-asmh-/

Liaison Psychiatry Teams (LPS) within Emergency Department (ED) Peterborough City Hospital - CPFT have dedicated LPS services in our local acute hospitals. These mental health staff are on honorary contracts in our local hospitals ED and ward. They provide rapid access to assessment of acute mental health needs providing a plan which may include advice, signposting and/or referrals to community mental health teams and partner agencies and/or treatment of mental health problems.

LPS staff complete clinical records using the general hospital electronic record keeping systems and follow the general hospital safeguarding processes.

LPS work in partnership with local specialist substance and alcohol services who are based alongside LPS staff in the ED. Their clinical records are accessible to the general hospital. Hours of operation are 24 hours a day 7 days a week at Peterborough City Hospital.

Integrated Mental Health Team (IMHT) are specialist mental health practitioners based at the police force control room in Cambridgeshire, providing frontline officers with telephone advice and support when dealing with someone in mental health crisis. Core hours may vary but are usually 7 days a week 8am to 10pm. They are employed and managed by CPFT.

2.3.10 Terms of reference

CPFT provides domestic abuse training to all staff, ensuring they understand the Domestic Abuse Act 2021 also recognises domestic abuse can impact on a child who sees or hears, or experiences the effects of the abuse. It treats such children as victims of domestic abuse in their own right where they are related to or under parental responsibility of either the victim or the perpetrator.

CPFT staff complete mandatory child safeguarding training, which includes being able to recognise the signs of domestic abuse in children (including the unborn child), the impact on the child and the appropriate responses and referrals by staff.

Where CPFT staff have concerns that a child may be the victim of domestic abuse, including living in a home with domestic abuse, CPFT safeguarding leads provide case supervision and advice to the staff member to safeguard the child.

Parents and carers can contact CPFT 0-19 Healthy Child Program (HCP) duty desk for guidance and support to meet the child's needs. CPFT's HCP is in keeping with National Guidance.

CPFT school nurses can also offer support and 1:1 session's with children who have experienced DA.

CPFT have a dedicated Mental Health Perinatal Service supporting mums from pregnancy to baby's first birthday, in order to support and protect both mum and baby.

In every contact with a child, there is a section in the CPFT recording templates which enables the practitioner to capture the voice of the child.

CPFT has embedded learning from serious case reviews and local guidance from safeguarding partnership board on the lived experience of the child to develop practice guidance.

2.3.11 Charlie's voice is clearly documented within her health record following emotional and wellbeing work that has been completed by her school nurse.

Polly was assessed by CPFT on two consecutive days.

Comprehensive risk assessments were completed. During these assessments, Polly acknowledged that her current condition was primarily due to illicit substance misuse, manifesting as withdrawal symptoms such as paranoia, irritability, pressured speech, drug-induced psychosis, fear, and extreme suspicion. There were periods when, due to the substances, she had active suicidal thoughts and intentions to harm herself, but the suicidal thoughts and self-harm stopped once she abstained from the substances.

Capacity to make decisions about substance misuse was informally assessed. The LPS specialist nurse was satisfied Polly understood and could weigh up the adverse effects of illicit substances on her mental health and circumstances and concluded Polly demonstrated the capacity to make both wise and unwise decisions.

Likewise, there was no indication she lacked capacity for decisions about treatment and support. She understood the support which was recommended and could weigh that information to come to a decision. Patients are signposted to substance misuse services rather than making a referral as it is based on guidance which shows more effective engagement and treatment if the patient has the autonomy for the referral and subsequent treatment.

The assessments did highlight that at times of substance misuse Polly was very vulnerable. Her ability to protect herself from others was reduced and her risk to herself increased.

Clare's Law is embedded into CPFT's Domestic Abuse staff training. There is also information on Clare's Law contained in the CPFT Domestic Abuse Policy and Standard Operating Procedures (SOP) plus also on the staff safeguarding intranet page.

CPFT policy requires all CPFT staff who either observe domestic abuse or where it is disclosed, staff must record an incident report and/or Safeguarding Request for Support form. All incidents of safeguarding, including domestic abuse, are automatically forwarded to the CPFT Think Family Safeguarding teams where experienced safeguarding leads give case supervision, advice and guidance including guidance on Clare's Law.

North West Anglia NHS Foundation Trust – NWAFT

NWAFT have recently implemented an 'emergency department risk assessment form.' The form states the following: -
'This form has been designed to help registered clinicians consider the risk to a patient of self-harm and/or suicide and/or risk of harm to others.'

This form helps to guide front line staff around identifying signs of mental health and referring to psych liaison for a review as front-line Emergency department staff are not the experts in this speciality. From feedback on this form, it has been recommended that as part of the risk assessment, the number of presentations low to medium mental health presentations are utilised as part of the wider consideration of next steps.

NWAFT refer all patients that present with suspected suicidal ideations to CPFT for a psychiatric liaison regardless of the number of presentations as per policy.
A substance misuse worker is hosted within the ED but this is not 24/7.

2.4 Summary reports

2.4.1 Change Grow Live (CGL)– Aspire

Change Grow Live have been providing substance misuse services in Peterborough since 2012 after being awarded the contract to deliver services by Peterborough City Council Public Health Team. CGL are a registered charity, delivering community-based services across England, Wales and Scotland. Services provided include prescribed opioid substitution therapy, alcohol detoxification, psychological therapies, and social and harm reduction interventions.

Change Grow Live are a voluntary sector organisation, working with adults and children/families who have been affected by substance misuse. Attendance is voluntary unless ordered by the courts within the criminal justice system.

Change Grow Live offer one-to-one key work sessions, group work (psychological and social interventions), opioid substitution therapy, alcohol detoxification and opportunities for peer support.

As part of the recovery process, people coming for structured support will be comprehensively assessed by a Recovery Coordinator, medically assessed by a doctor or non-medical prescriber (where appropriate), including an assessment of potential risky behaviours. They are encouraged to participate in developing a personalised recovery and risk management plan which will inform their individual recovery interventions.

John had been with CGL under Aspire since 2017 due to a conviction requirement for drug rehabilitation and then in April 2022 was referred for smoking cessation.

Polly attended Aspire for support, advising that CSC had advised her to attend the service. She did not provide CGL Aspire consent to discuss with CSC or provide any details around their involvement. CGL Aspire were not aware of up to date or specific concerns around her children therefore there were no substantiated concerns to raise with CSC without overstepping/being intrusive. John's involvement with CSC involvement was not limited to Polly's children, but also his own therefore CGL Aspire were involved in this process. Children Social Care did not contact Aspire with a referral for Polly.

2.4.2 Cambridgeshire and Peterborough Domestic Abuse and Sexual Violence Partnership – DASV

IBA (Alcohol Identification and brief Advice) is the delivery of 'simple brief advice' which follows identification of how much a patient/client is drinking and any problems they may be experiencing. IBA is usually delivered by non-alcohol specialists and has shown to be effective in helping people to reduce their alcohol health risk. This training is delivered to professionals in the Cambridgeshire area by 'Healthy You.'

This is currently available as online training, free of charge to frontline professionals. All specialist DASV staff are being asked to consider taking up the offer of this training, and it has been promoted in the October DASV Newsletter which goes out to over five hundred frontline professionals across Cambridgeshire and Peterborough.

A session of IBA will also be delivered in collaboration with the DASV Partnership.

2.4.3 Cambridgeshire Public Health

Cambridgeshire Public Health can confirm that there is little information available around suicide by fire and mainly centres around protest and international countries. No up-to-date statistics are available and there is very little research in this area.

2.4.4 Cambridgeshire Fire and Rescue Service (CFRS)

The table below is data for deliberate fire in someone's own home for the last 5 years.

Included is 'under the influence of drugs and alcohol' as a separate category just in case these are related to mental health or suicide but has not been specifically recorded in the free text fields on the recording system.

The data suggests an increase trend of deliberate fires attributed to suicidal as the human factor. It is important to note, this is what attending crews have reported as the human factor and it may not be following an outcome of an investigation.

Cause : Deliberate - own property

Human Factor	Sep-19 to Aug-20	Sep-20 to Aug-21	Sep-21 to Aug-22	Sep-22 to Aug-23	Sep-23 to Aug-24	Total	% of Total	Trend
Mental Health	6	1	0	6	4	17	29%	
Suicidal	0	0	1	2	5	8	14%	
Under the influence (Alcohol / Drugs)	1	2	1	3	1	8	14%	
Other	7	4	3	5	7	26	44%	
Total	14	7	5	16	17	59	100%	

On attendance at the fire, there were issues with gaining entry which caused delay. The doors installed caused issues, mainly being that the lock installed is snap proof and drill proof, meaning that our first entry techniques of lock snapping and drilling cannot be done. The door frame is UPVC which give in, flex or cracks when we try to use the crows foot tool meaning this cannot be used. This leaves the enforcer (heavy battering ram type tool) to knock the door in, which is tough as the door and frame flex, the composite material absorbs a lot of the shock and takes slot of time/effort to break through. This is also not very controlled.

Following the incident hot debrief, CFRS contacted Cross Keys (housing provider) who have helped in organising with the manufacturer a day of testing with operational crews in determining the best means of entry. The manufacturer provided a number of doors, which an operational crew and training team practiced on. A video recording was taken by CFRS training team and has been shared within service on how to gain entry to this type of door.

This may be updated with further information gathered from sharing of information from other Fire & Rescue Services through National Operational Learning.

Cross keys Homes have insisted that they have no concerns with how we make entry in emergency situations or what we do to the door as these will be replaced following forced entry.
No information was shared with CFRS from any agency/organisation prior to the fire in relation to threats being made. There is a wider piece of work led by the CPLRF regarding this area and the requirements of the Civil Contingencies Act for emergencies which sits outside of current referral pathways.

Section 3 - Analysis

3.1 Family and friends' involvement and perspective

3.1.1 (The below uses the words of Tara, Polly's mum, and Blossom, Polly's sister who jointly gave an account, as was their wish)

Polly had been part of a close-knit family all her life with constant contact, especially with her sister, Blossom.

Although Polly had relationships and children with men who treated her badly and were in trouble with the police, Polly always seemed to 'bounce back' and always tried to look after her children and keep them safe. She was never a depressed person. Her family state that she never really had a relationship with Philip but had become pregnant nearly straight away having met him.

When she first started 'seeing' John, she stopped contacting her mum and sister and they thought it was just because of the 'honeymoon' period of a relationship, but then it got to the point where they could only contact her through WhatsApp as she said the speaker on her phone had broken and she eventually stopped contacting. Tara recalls how she missed Christmas with the family for the first time and then didn't attend her grandads funeral which was all out of character. By chance, one day, Tara banged into Polly outside a food store and she seemed really uneasy. John stood behind her and she didn't speak so Tara let her go as she was concerned that she would be in trouble if she stayed to chat.

3.1.2 The family first found out that John had been arrested when they read it in the newspaper and reached out to Polly who then maintained contact with them. She had never contacted them when she had been in trouble with John. She told her family that she was not sure whether to stay with him, but they maintained contact whilst he was in prison by talking through her Alexa. She didn't ever say that she didn't want contact with him.

Following his release from prison, the family state that John appeared to have changed. He didn't drink anymore and when Jay was born, Blossom used to go round to visit and they seemed fine and happy. The family do not believe there was any further domestic abuse. Polly spoke to Blossom around Christmas 2023 about moving in with her and ending her relationship with John and said how much fun they would have.

The night before Polly died, whilst she was in police custody, Blossom rang to ask about her and when she would be released. The officer told her that she could not provide any information. Blossom states that she could have gone to pick her up and taken her back home with her when she was released so she wasn't alone but the officer would not engage in conversation and nobody contacted her to tell her she was being released, even though the police were aware Polly's mental health was not good at the time.

Blossom has three children aged 13, 10 and 8 years old, respectively. On the day that Polly died, Police officers attended her house to tell her that there had been a fire and that Polly was in a serious condition. They had not asked to speak to her alone and she had not known

what they were going to say. As she began to respond to them, a voice was heard on the police radio stating that Polly had died. They all heard it with no warning. This traumatised the children with the youngest being most affected. At Easter, he painted his Easter egg black and orange like fire and they have all had to have counselling through the school.

Blossom states that if they had asked to speak to her alone, she would have realised something was wrong and the children would have been prevented from hearing this. Also, the way in which she heard the news over the police radio was an awful way for her to find out.

3.2 Terms of reference areas

3.2.1 Was there collaborative working to support Polly as a victim of domestic abuse?

Throughout this review, there has been good evidence of collaborative working, sharing of information and appropriate referrals. This has been shown through the extensive agency attendance at MARAC and at the Child Conferences. MARAC records are thorough and continued with updates from both actions and changing circumstance following the meeting.

A challenge was made by the midwife when a strategy meeting to discuss the children was cancelled by Children Social Care in 2022 when the case had been deemed as being a high risk. The midwife also showed good practice in identifying and following up on missed ante-natal appointments in all of Polly's pregnancies and ensured their attendance and sharing of information with other agencies at the Child Conferences. The midwife provided the disclosure for Clare's Law in 2022 when the IDVA and the Police had not been able to complete this due to Polly not being at home on the occasions they attended.

Throughout the period that Polly was open to the IDVA Service there was evidence of good liaison with other professionals such as social workers, school, Victim and Witness Hub, probation and police.

In the initial stages of the Police investigations of the offences committed by John against Polly, they were on the verge of being filed, recorded as being due to the lack of engagement from Polly. The officer in the case tried the option of a Domestic Violence Disclosure, meeting with Polly at her child's school. This worked with Polly engaging and agreeing to be interviewed. However, it was not recorded as to whether the disclosure was provided. (Recommendation refers). John was subsequently charged with twelve offences and remanded in custody. Appropriate referrals in relation to victim support and the children were made by the police.

Whilst awaiting to give evidence at John's trial, Polly disengaged with police and she subsequently became a hostile witness when giving her evidence in court. John and Polly were in frequent contact whilst he was in prison following one of the charges being controlling and coercive behaviour. John exercising this control, even from within a prison that was a measure to safeguard Polly, may have provided her a lack of trust or confidence in the judicial system. The evidence lost due to Polly's testimony had an adverse effect on John's sentencing with a number of offences not proceeded with including the Controlling and coercive behaviour. (Recommendation refers)

Probation had provided a pre-sentence report (PSR) in which there was no reference to consideration of a restraining order. The Police had included this request within the file of evidence but the CPS made the decision not to apply for one as the victim was a hostile witness and referred to recent case law in this area.

DA checks were received by Probation prior to the PSR being completed however there is no reference to the pattern of police calls in relation to Polly and John's previous partner which included sexual offences. It is important to note that Probation receive arrest list information from the police therefore if he had been arrested Probation would have been aware but details of call outs without arrest need to be requested. His assessment report did not reflect the wider concerns in relation to call outs. (Recommendation refers)

Threats were made to Polly from John in relation to setting her house on fire with her children in it. These threats were not shared with the Fire Service and it would appear that no agency would regular share this information with them if they became aware of such a threat, although the Fire Service do sit on CSP meetings and attend safeguarding meetings when requested to do so. (Recommendation refers)

3.2.2 What holistic multi-agency responses are considered when a person hasn't engaged with agencies?

In the early stages of a new order from the Court, the Probation Service should complete a home visit in the early stages, however, this was not undertaken in 2022 and there is no rationale for it not being completed. Given the proximity of John and Polly's recorded addresses at that time, insight from a visit may have assisted with risk assessing for all agencies as Polly had disengaged with all others.

A lengthy discussion by the panel took place in relation to the lack of referrals to CGL/Aspire to assist Polly with her alcohol use. Polly twice self-referred to Aspire to ask for support but then disengaged and did not attend the assessments. Two occasions where referrals could have benefited were highlighted by Aspire. One of these occasions was when CSC advised Polly to attend and she did but no referrals had been received so when her appointments were missed, her case was closed. When Polly was suffering suicidal ideations, no referral was received from the hospital but advice was given to engage. Both of these situations were at a time when Polly was suffering from multiple struggles and a referral would have been a meaningful action as it would have assisted her rather than her having to be reliant on herself to take the step forward and would also highlight key risks from a professionals point of view so that if someone did not engage, a further welfare action could potentially take place as they could consider potential consequences if no contact could be established. In care proceedings, this communication with other agencies can negate the misconception that someone is receiving treatment when they are not.

The panel discussed both consent and also the negative impact that forcing someone to receive support for alcohol use at a time when they may not be ready to accept that support may have and explored other avenues that may assist an individual.

Children Social Care did make consistent efforts to engage both Polly and John in planning with both attending child in care review meetings and they engaged with assessments for Jay and Ollie. Professionals remained concerned about Polly and John's relationship but felt powerless to act as Polly was an adult with capacity to make her own decisions and records do indicate that Polly was provided with the information to do so.

Barnardo's observed that barriers to engagement may have been that information from DAP is shared with Children Social Care. Polly may have viewed this as a reason to feel reluctant to engage, she had previously had children taken into care, which may offer her a negative experience reducing the desire to engage. A further barrier to engagement for Polly from her own history and previous experience may be that she may normalise domestic abuse and appeared to struggle to understand the potential impacts on her children.

When risk was identified by the DAP, good collaborative working was seen with the social worker and IDVA but there was a failure to record any rationale as to why the case was not referred back to MARAC by any party or whether a decision was actually made. (Recommendation refers)

Although it was established that Polly had vulnerabilities, the panel discussed this and although it was identified that referrals were not made to Adult Social Care, it was deemed that she would not have met the needs for care and support under the Care Act2014, so therefore, any referrals would not have led to support being offered by ASC.

3.2.3 What considerations are given in safeguarding and supporting adult and child victims of domestic abuse, particularly when they no longer live with the victim or have lost them due to domestic abuse?

Children Social Care did respond to the concerns raised around domestic abuse between Polly and John and supported the family via a Child in Need plan. However, the children were exposed to an escalation in violence which indicates that Child Protection planning could have been triggered at an earlier time. When John was in prison there was also a missed opportunity to complete targeted work with Polly, to increase her support network and to aid her understanding of domestic abuse and impact on the children, to enable her to be a protective parent to the children.

The children were exposed to domestic abuse and for Finn and Jack, this exposure ended when they were moved to their father's care. Protection was in place when John went to prison, although following his release contact was established with Polly which is indicative that safety planning could have been strengthened. Shortly after John's release and the birth of Jay, the children were removed from Polly and John's care which meant they were protected from exposure to domestic abuse.

Children Social Care did continue to work with Polly and raise concerns around the risk of domestic abuse, however, the support offered was limited following the removal of the children.

The children's voices were recorded on Children's Social Care's files, however, sometimes the significance of what the children were saying was not recognised. Charlie spoke about

fearing John and the exposure to violence. Consideration of the lived experience of the children and living in a home with such violence, was underdeveloped, which meant that work was not always as child centred as it could have been.

Following the birth of Ollie, the safeguarding midwife visited Polly on the postnatal ward where she consented to a referral to MPower. This provides work to improve the lives of women who have had more than one child removed from their care and the services and systems that affect them. This referral was made the same day. Baby footprints were completed with Polly and blanket squares given to her. The midwife states that it is difficult to identify if adequate emotional support was provided for Polly following the birth of Ollie. The hospital analysis is that triggers for her mental health struggles stem from the removal of her children.

Children Social Care do not have a specific policy citing the support to be provided following the death of a parent. For Jay and Ollie, life story work will be completed, talking about Polly and her sad passing. Following the first panel meeting where a question was raised over Jack, Finn and Charlie, bereavement support has been shared by the suicide prevention manager with the children's schools and all of Children Social Care, to ensure they know how to access support for children when this is needed. (Recommendations refer)

3.2.4 How effective was the response to Polly's suicidal ideations?

The removal of a child from their biological parent's care is one of the most extreme forms of state intervention into family life. Changing Lives state that the effects of child removal on mothers are damaging and include grief, substance use, depression and increased risk of suicide attempts.[4] Polly experienced all of these effects. Although steps to support Polly following the removal of Ollie have been recorded, it is not apparent that the holistic view was taken into consideration and the heightened risk recognised and was also not the case with any of the other children following their removal from her care.

It is of note that John states that Polly only turned to alcohol and substance abuse following the removal of Ollie as the six months previous to that time, she had abstained in support of him not drinking.

Children Social Care records indicate that both Polly and John suffered from poor mental health. Polly spoke to professionals about her mental health in the Child Protection Conference held on the 24th of November, stating that she was feeling much better and that she had support around her. The health visitor confirmed that this would be monitored as part of health visiting reviews to ensure Polly was well and to determine if she needed any specific support. Children Social Care records speak about Polly sensitively and recognised her vulnerability.

The GP was made aware of Polly's attendance at the hospital days prior to her death but made no response to this. Due to this review, the GP Surgery now have a process whereby the Safeguarding administration will liaise with the GP and ensure that that contact is made

[4] "Where Does That Leave Me?" The Effects of Child Removal | Changing Lives

with patients that are coded as being at risk of abuse to offer support and signpost to other services that can help. There will be a clear pathway in the practice that will be shared with all staff to support vulnerable patients and those at risk of abuse.

Polly attended the hospital due to suicidal thoughts two days running just a few days prior to her death. She was seen by the same LPS specialist nurse which provides continuity but can also potentially provide a pre-conceived assessment on the second occasion. A second practitioner was present which is good practice. During the assessments, a referral for a Mental Health Act Assessment was not indicated. There was no assessment with regards to Domestic Abuse specifically at these two attendances and as it was clearly documented as a risk, so this is an area of learning. Records appear to be contradictory as they outline the suicidal thoughts and tendencies as the reason for Polly's attendance yet discharge her as not having suicidal thoughts and her mood due to the illicit substances she is taking. The panel felt the this would not eradicate her suicidal thoughts. Due to this, a review of the attendances just prior to Polly's death have been made jointly by CPFT including the manager of the Psychiatric Liaison Service and NWAFT in which they discussed any lessons to be learnt. They were unable to identify any failures in the system other than on the occasion when Polly left prior to being seen, for which they do not know the reason. On this occasion, they alerted the health staff and the police for welfare checks. They have confirmed that there is an escalation process when a Mental Health Act assessment is required but this was not appropriate in relation to Polly.

Challenges were identified with working with third sector substance misuse services as they do not have access to their treatment plans in patient records.

Polly had been at the hospital having been found by ambulance threatening to jump from a bridge and had voluntarily walked out of hospital before any assessment had been carried out. She was found on a main arterial road whereby the police initially took her to the hospital but before entering, they made the decision to arrest her for obstruction of the highway. The police were aware of the mental health struggles that Polly was experiencing as indicated by the assessments whilst in custody. Although she was assessed as fit to be detained, the question will always arise as to whether a police custody suite is the best environment for someone with suicidal ideations.

Good practice of sending the Joint Mental Health Police Response Vehicle was initially taken and the recording of the triage on the health electronic system so that it could be seen across the trust was good practice. However, there is no documentation of safe routine questioning at that point or the reason why it was not discussed.

The LaDS service is available in custody seven days a week from 8am until 8pm, but due to staff sickness, cover finished at 5pm on that day just before Polly arrived so she did not have access to the LaDS mental health practitioner for a vulnerability screen (triage) and support planning. Leaflets are available in custody to be provided so that the person can self-refer to LaDS community outreach for support.

When Polly was released from custody, although care was taken to transport her in a police car, officers were aware that she could not get into her address and that she would be left

outside, alone. No attempts to contact her family to facilitate a safe release into their care was given either prior to her release or after her release.

3.3 Perpetrator's perspective

3.3.1 (The below uses the words of John and his account)

John fully accepts that he has been a perpetrator of domestic abuse and states he will always regret it.

John states that he began a relationship with Polly in January 2022 having known her for the previous two years before that following meeting through mutual friends. He blames the domestic abuse on alcohol and comments that he is 'an arsehole' when he has had a drink and Polly could be difficult after she had a drink and that the two domestic incidents that occurred between them were caused by him having been drinking heavily.

John states that hitting Polly whilst she was pregnant was a wakeup call to him and he hasn't had a drink of alcohol since May 2022 because of this. Polly also said that she wouldn't either and they did it together. He attended Aspire which helped and states he has not had an alcohol relapse since.

The Building Better Relationships Programme that he attended as part of his sentencing taught him a lot and was really helpful, including how to keep his temper during a difference of opinion and communication techniques to prevent arguments. He was open to it before attending which he thinks helped.

3.3.2 Polly attended his probation meetings with him for support and he describes her as his 'rock' who picked him up on multiple occasions. He states that she struggled a bit at the fact that Philip would not allow her to see Charlie and then when Jay was taken by Social Services it didn't help but she still seemed fine given the circumstances. However, when Ollie was taken at the hospital, it really hit her hard as she was under the impression she could take him home and then couldn't. John states that Children Services promise the world and then don't do anything, like arranging for them to see Jay.

Polly's mental health went downhill after Ollie was taken as he stated that they were not given any support or help. Everything they do is so slow yet since Polly died, they managed to review things and make things happen quickly. 'If only they had done it whilst she was alive.'

When asked by the author of the status of his relationship with Polly at the time of her death, John said that they were still a couple but Polly had taken drugs twice since Ollie had been taken to 'numb the pain' as Polly had explained to him and he had threatened that he was going to leave if she took them again but was only saying that to make her stop.

Although Polly was clearly down, he had never thought that she would take her life and she had never mentioned fire to him at all.

John felt like Children services had worked against them and not with them and that they had 'dragged his past' up in order to take Ollie from them.

3.3.3 Building Better Relationships[5]

The Building Better Relationships (BBR) programme is a His Majesty's Prison (HMP) and Probation (HMPPS) moderate-intensity cognitive-behaviour programme for adult men convicted of an Intimate Partner Violence (IPV) offence. The Ministry of Justice have published a document in 2023 evaluating the Building Better Relationships (BBR) programme which is delivered in the community.

It is concluded that evaluation of this programme is complex and poses several challenges but may be feasible but no data is provided thus far that can be relied upon accurately.

Section 4 – Conclusions and Recommendations

4.1 Conclusions

4.1.1 The cause of death has yet to be determined by the Coroner so the review is based on the findings of the criminal and fire investigation.

4.1.2 Polly suffered domestic abuse in the presence of her children in previous relationships. Child protection was not deemed necessary for Jack and Finn on the occasion that she left the relationship with David but all three children from previous relationships and the two children that she had with John were removed as she remained in a relationship with him and they were assessed as being at risk. Opportunities to further safeguard and support Polly, educate her on her choices as a victim of domestic abuse and the mother to children who were victims were missed, particularly whilst John was in HMP on remand.

4.1.3 There is evidence of the voice of the child being recorded but not specifically heard as with Jack, initially happy with John but then became fearful and Charlie spoke about the fear of him yet even though it was deemed as a high-risk case, a strategy meeting was cancelled and it was due to the MARAC and the midwifery that it was escalated and progressed. Although the risk has been identified, there was not the urgency to progress which may also have been a misunderstanding by the CSC as they had been told by Polly that the relationship with John was over yet other agencies held information to identify they were still in contact. This identifies the necessity for information sharing and collaborative working.

[5] Evaluating the Building Better Relationships (BBR) programme

4.1.4 Positively, the children's fathers were involved in planning which increased the protection for them and meant that for Jack, Finn, and Charlie that they were able to remain living within their family. Philip attended the Child Protection Conference for Charlie which enabled him to be fully aware of the risks and concerns. However, the panel have noted that the history of domestic abuse involving Philip in previous relationships would still be a concern.

The Police recorded 23 incidents during the review timescales.

- 8 x Welfare/protection of Polly's children.
- 4 x Polly adult protection/welfare.
- 3 x Polly a victim of crime with John as a suspect. (All linked to one investigation).
- 1 x John as a suspect with victim being another female (not Polly).
- 2 x John - possession of firearms.
- 1 x Polly arrest/charge.
- 1 x Polly - Investigation into her death.
- 3 x Adult Protection/concern for welfare of John (All after Polly's death).

4.1.5 Cambridgeshire Constabulary guidance for responding to Domestic Abuse, Child Protection and Adults at Risk refer to College of Policing (CoP) Authorised Professional Practice (APP). The APP's are detailed however they are not specific to an individual force respective processes and procedures. Both Bedfordshire Police and Hertfordshire Constabulary have their own Standard Operating Procedure (SOP) for Domestic Abuse, Child Protection and Adults at Risk. These SOPs compliment CoP APP as well as clarifying each force policy and procedures. Cambridgeshire Constabulary need to consider whether to implement their own specific Domestic Abuse, Child Protection and Adults at Risk SOPs. This would then ensure account is taken of Cambridgeshire policy and procedures.

4.1.6 It was well documented that Polly struggled with alcohol abuse in recent years and actually approached CGL on two occasions herself asking for support, however, there were no referrals made to CGL by any agencies, only advice given to Polly. A discussion took place surrounding alcohol referrals and although it is agreed that forcing someone onto a programme (if the powers exist) is not productive, making a referral for CGL to be able to contact and provide the opportunity and also have context from the referral should always be considered.

4.1.7 Due to this review, where a service user presents multiple times but does not engage and states that CSC have asked them to engage, Aspire would now contact CSC to advise of this presentation. This is not to be intrusive or to access information inappropriately, but simply to make the correct professional aware of presentation, so that appropriate further support or formal referral can be put into place. Where CGL Aspire receives a concerning MASH report for an individual known to CGL Aspire who may be closed to the service/not engaged, depending on risks raised, Aspire may decide to contact that individual and see if they would like to access treatment.

4.1.8 The perpetrator's perspective highlights the benefits of the Building Better relationship's course and the understanding of their own behaviour that a perpetrator can learn from this.

4.1.9 There is evidence of good practice throughout the years of information sharing and agencies working together. There is excellent recording of the MARAC decisions, actions, and progress thereafter, however, there are times when information sharing could have taken place or been timelier.

4.1.10 There is an absence of reported allegations of domestic abuse in the fifteen months prior to Polly's death and her family report her to seem happier in this time although this cannot negate that the abuse was on-going. Polly was suffering from alcohol and drug abuse prior to her death and it cannot be known whether this was due to domestic abuse, the loss of her children being taken into care or another cause. It is noted that she spoke to her sister over the Christmas period, speaking of whether she should remain in the relationship and talking of going to live with her. She re-iterated this to her sister, Blossom on the phone the day before she died stating that her and John were over and 'it was nothing to do with John, it was all her as she needed space.' This would indicate that she had made the decision to leave which correlates with her requesting to go on the housing register for a new home.

4.1.11 Polly was clearly struggling with her mental health and felt suicidal as she indicated when she attended the hospital of her own volition and it was deemed that she did not meet the criteria for a referral for a mental health assessment. She attended due to her suicidal state yet these thoughts were deemed to be due to the substances she had taken; however, this should not have deterred from the fact that she felt suicidal.

4.1.12 Health professionals have stated that the removal of Polly's children may have had an adverse state on her mental health and although the midwife took steps to support her in the immediate aftermath at the hospital, it is not clear what, if any support was provided afterwards by any agency.

4.1.13 Although it is understood by the panel that the arrest of Polly was for her own safety and attendances at the hospital over the past few days had not alleviated her struggles and she had left earlier in the day, it is a concern that a person who is clearly struggling with their mental health is placed in a cell on their own in that environment. It is clear that protocols were adhered to and assessments completed but no consideration was given to contacting the family for them to collect Polly and look after which meant that she was unable to get into her home on the face of it and alone in the middle of the night.

4.1.14 When the police delivered the message to Polly's sister, Blossom, initially of the fire itself, then measures could have been taken to avoid trauma to the children by asking for them not to be present and then using earpieces for their radio so that they could have broken the news of Polly's death to Blossom in a sensitive manner.

4.1.15 Polly's family describe her as fun loving and happy in her early years with no reliance on alcohol and having a stance against drugs.

4.1.16 The panel were inquisitive as to how Polly could not initially gain access to her address and had no keys when the Police took her home yet was found inside hours later when emergency services responded to the fire. John had initially stated that he had the only key so he would always leave the door unlocked but later provided a statement to say he was not in a possession of a key at the time. John arrived at the scene as Polly was receiving CPR outside the block of flats.

The officers who took Polly home state that they saw Polly knock on the door to the flat. They did not see her try the door handle. They did not feel the need to knock on the door themselves because Polly knocked hard on the door. They did not try the door handle themselves. Polly did not say anything about the keys or suggest another way into the flat. Polly was content to be left in the communal area.

One of the officers states that they offered Polly a lift to another address of friends or family but she declined that offer. Intermittent CCTV from another building does not show any person arriving or leaving the outside of the block of flats during the relevant time although this cannot be relied on. It has not been determined/possible to state if the door was locked from the inside or with a key from the outside.

4.2 Lessons to be learnt

4.2.1 The importance of sharing information in a timely manner

Following the remand of John into custody, agencies were receiving differing information on the status of Polly's relationship with John. The police initially took the view that it had ended as Polly provided them with a statement. Children Services were initially told by Polly that the relationship was over and she was working with other agencies but did not clarify that this was still the case in future conversations. It was identified through MARAC that this was not the case and the Social Worker was actioned to escalate this to enable a strategy discussion that Children Social Care had not thought necessary based on the information directly from Polly. The police were aware of contact between the two of them from information provided by the prison and the family were aware of the contact but had not been approached to provide an opportunity to disclose this. (Recommendation refers)

Within Probation's pre-sentence report John is described as not being in a relationship however at his initial appointment within 24 hours of release from custody he advises he is in relationship with the victim. There is no evidence of liaison with the prison to confirm whether there was contact between them during his period of remand. This information may have provided an indication that the relationship had not terminated. (Recommendation refers)

If the information is not shared in regard to the relationship status, then risk assessments regarding the children, Polly and that of John's sentencing will not be accurate.

4.2.2 The importance of the continuance of the safeguarding of a DA victim

Polly had a number of abusive partners previously and may not have had confidence in the Judicial system. Having gained that confidence with remanding John in prison and obtaining a statement from her, John was then able to frequently contact her from the prison prior to the trial.

This contact provided an opportunity for John to either dissuade Polly from giving evidence against him or to display stage 2 of the Homicide/suicide timeline outlined by Jane Monckton-Smith[6] whereby the perpetrator goes back to the charming stage the victim is groomed once again.

Statutory Services including the Police, Her Majesty's Prison service and the Probation service have a duty to ensure that safeguarding is continuous and providing the victim with the opportunity for space and time from the perpetrator to be able to clear their minds, not feel in fear and make uninfluenced choices. (Recommendation refers)

Engagement with the IDVA during the period Polly was open fluctuated. Initially, she was keen to accept support, but this changed once contact with John in prison was made. This appeared to be a turning point in her withdrawing support for police action and retracting her evidence. It also appeared to be a factor in her decision to keep the baby, and not go through with a termination. A time when she would have potentially felt more vulnerable.

4.3 Recommendations

National

There are no national recommendations in relation to this review.

Local

1. **Cambridgeshire Constabulary to review their processes for the documentation and recording of Domestic Violence Disclosures (Clare's Law).**
   The Domestic Violence Report dated 17/05/2016 regarding the Domestic Violence Disclosure has never been finalised to show that Polly was informed. Current processes need to be reviewed to ensure any future disclosures are fully documented with the outcome prior to finalisation.

2. **Cambridgeshire Constabulary to amend their processes to ensure that domestic abuse related investigations with the same suspect are linked.**
   This will ensure that cases are investigated as a whole and not in isolation so that they are presented to the CPS/Court with full facts of offending so that all evidence of all offences can be taken into consideration. -

[6] In control -Jane Monckton-Smith - Bloomsbury

3. **Cambridgeshire Constabulary to renew their Intelligence processes to ensure that repeat domestic abusers are flagged to enable consideration of action to be taken against such individuals.**
   This will negate the same repeat offender with different victims being dealt with in isolation and ensure the Courts are presented with the accumulative offending and risk posed. It will also provide opportunities for other offences nonrelated to be processed as a disruptive safeguarding measure.

4. **Cambridgeshire Constabulary to review their responses for dealing with detainees suspected of mental health issues and/or suicidal thoughts.**
   Although processes are in place, the review has highlighted areas such as whether police custody is a suitable place, family contact/involvement that could enhance the safeguarding when released from custody and reduce demand etc.

5. **Cambridgeshire Constabulary to consider implementing their own specific Domestic Abuse, Child Protection and Adults at Risk SOPs.**
   This will make the processes and responses in these areas specific and bespoke to the needs of Cambridgeshire whilst dovetailing into the National policy and strategies.

6. **Cambridgeshire Police to implement a process that when an offender is on remand or sentenced, they provide the prison with witness and victim numbers to be barred from the PIN list.**
   This will provide ongoing safeguarding by preventing the offender directly contacting the victim or witnesses and asserting control or fear from within the prison.

7. **Cambridgeshire Police to ensure all officers receive training in delivering sympathetic messages and that communication is sent to all officers as a reminder of how to remain sensitive in those circumstances.**
   This will negate the circumstances surrounding Blossom learning of Polly's death re-occurring.

8. **Cambridgeshire and Peterborough MARAC to ensure that discussions during the meeting include confirming safe contact details and if the victim has access to a phone.**
   This will provide shared information and confirmation of the safeguarding required and implemented safety plan for the victim.

9. **Probation Service to re-communicate the process to practitioners in relation to the use of home visits and frequency of police call-out checks.**
   This will provide early communication with the perpetrator and potentially the only contact with a victim if they have disengaged with other services and are still in a relationship with the perpetrator providing information to risk assess. Call-out information will enhance Probations knowledge of contact with the victim and perpetrator

10. **Peterborough Children Social Care to include in processes when there is a risk of domestic abuse and the alleged perpetrator is incarcerated, Child in Need planning should be focussed on supporting the victim with strengthening their support network, including holding a family meeting.**
    This will ensure that every opportunity is taken to provide support at the optimum time which may lead to the children being able to stay with the parent who is the victim of the abuse.

11. **Peterborough Children Social Care to ensure that escalations to Child Protection should be timely and the impact of domestic abuse on the child's wellbeing fully considered alongside their lived experience when making a threshold decision.**
    This is to include the use of multiagency information for holistic decision making to negate decisions being based on what they have been told by the person/persons involved. It should also include the recognition of children being victims of domestic abuse whilst living in the household.

12. **Peterborough Children Social Care to ensure that the recommendation to make a Clare's law application features in children's plans.**
    This will provide an opportunity for a victim to have further information on how they and their children have been at unknown risk and allow informed decision making which can be taken into account to try and prevent victims of domestic abuse also losing parental control of their children.

13. **Peterborough Children Social Care to ensure that plans have multi-agency contribution to consider all the risks and understand the support they can offer to both CSC and families.**
    This will provide holistic specialist support to meet the bespoke needs of the family. It will also contain information from all sources providing a holistic picture of their needs and an understanding of the situation with greater context.

14. **Peterborough Children Social Care to ensure plans consider the work to be completed by perpetrators of abuse alongside any work to be completed by the victim.**
    This will assist the family in the future if the relationship remains.

15. **Polly's GP surgery to implement a process that any patient discussed in Management daily meetings will be followed up by the safeguarding administration to ensure a continuation of care is met.**
    This will provide further opportunity for support and proactiveness on the information received.

16. **Cross Keys Homes to revise their domestic abuse policy and procedure to ensure action to hold perpetrators of domestic abuse to account is included and assurances that survivors are signposted to make well informed housing related decisions.**
    This may negate or minimise the occasions when a victim of domestic abuse moves into a Cross Keys Homes property with the perpetrator when they are already known as a domestic abuse victim.

17. **Cambridgeshire Fire and Rescue Service to re-communicate and promote the information sharing protocol for all fire relating concerns including threats.**
    This will provide intelligence to analyse, identify patterns of potential risk and provide the Fire Service with opportunities to potentially negate or minimise the risk.

Appendices

Appendix A

Terms of Reference

- The date parameters under consideration are from 2015 up to a month after the date of Polly's death in order to evaluate the initial response.
- This is to be reviewed as a suicide or an unexplained death based on the investigation by appropriate authorities. The purpose is to establish if DA was a factor in the death of Polly.
- Ensure the review seeks to involve the family in the process and takes account of who the family may wish to have involved as lead members. Identify any other people the family think may assist or be relevant in the review process, including voice of the child.
- Where we know children are victims of domestic abuse, what protections and support are provided to those children?
- How effectively do agencies listen to the voice of the child?
- What provisions and support are available in the event of a parental death due to DA?
- How effective was the Criminal Justice system in responding to domestic abuse for this family?
- Was Polly assessed as vulnerable in her own right?
- Establish whether the response to Polly's mental health concerns with medical professionals was responded to effectively
- What support is provided for parents when the child is removed when it is known that DA is in the relationship.
- How effective is communication and information sharing between local government housing departments and Housing Associations to ensure domestic abuse is identified and risk assessments are appropriately completed?
- How effective was MARAC in increasing safety for Polly and her children?
- Are agencies considering Clare's Law and providing guidance and advice when it is identified that this may be relevant?
- When a person isn't engaging with agencies, are adequate enquiries made to ascertain the reason why and are they provided with sufficient information to ensure they are aware of pathways for support that are available in the future.
- Where there is more than one specialist domestic abuse service involved with the case, is it clear as to which agency is taking which actions and which is leading with regards to safety planning and safeguarding?
- Identify and highlight good practice for wider sharing
- Panel to have a parallel action plan for expedited implementation where practicable during the review

- Were procedures sensitive to the ethnic, cultural, linguistic, and religious identity of the deceased? Was consideration for vulnerability and age necessary? Were any of the other protected characteristics relevant in this case?

Executive Summary

A Domestic Homicide Review (DHR) concerning the death of Polly (pseudonym)

March 2024

Author – Jackie Dadd

Date completed – October 2024

Family Tribute

A daughter, sister, mother, aunty and much more.

Polly was everyone's happiness, the laughter for everyone and a caring soul.

She was a delight to be around and we will never forget her beautiful face and beautiful smile.

Your sister,

Blossom

The Domestic Homicide Review Panel and the members of the Safer Peterborough Partnership would like to offer their sincere condolences to the family of Polly, who have lost their loved one in tragic circumstances.

Contents

1. The review process

1.1 This review examines agencies responses, provisions and support provided to Polly, a 34-year-old female, prior to the point of her death, where she was found deceased at her home address in Peterborough during a fire at the location in March 2024. Both Police and the Fire service conducted investigations into the cause of the fire which was found to be a naked flame to the side of the bed.

Following an investigation, the police submitted a file to the coroner with a finding that the death was non-suspicious with no suspected third-party involvement.

1.2 The Manager of Cambridgeshire Domestic Abuse and Sexual Violence Partnership made a referral to Safer Peterborough Partnership on 13th March 2024 due to previous incidents of domestic abuse involving Polly. Following a meeting on the same day with the Safer Peterborough Partnership Chair, a decision was made to undertake a Domestic Homicide Review as the definition in Section 9 of the Domestic Violence Crime and Victims Act (2004) had been met.

The Coroner's inquest has been opened and adjourned awaiting the completion of this review.

1.3 A post-mortem took place in which the cause of death was found to be:

1) Carbon Monoxide poisoning

In basic terms, this is smoke inhalation, as a fire has high levels of carbon monoxide in it which starves the body of oxygen and was therefore fatal.

1.4 A Fire investigation took place following the death of Polly. A full examination was made of the scene. It was found that the fire had started in the bedroom from a single seat halfway down the left-hand side of the bed by the application of a naked flame, which would have had to be applied over time. This will have produced toxic gas and would heat rapidly creating the presence of carbon monoxide. This will have spread very quickly and all things combined would make survivability unsustainable.

Polly was found deceased in the kitchen opposite the bedroom which is the opposite direction to the front door. A dog was also found deceased. No keys were located in the property.

The Fire investigation eliminated candles and electrical malfunctions. Lighter fluid and lighters were found in the kitchen. There was no other smoking paraphernalia found or other cause of ignition. The finding was that the fire had been started deliberately and was not an accident.

An exert from the FI report states:

“Following a full examination of the scene and considered all the information available at the time of the investigation, with all other viable causes excluded, it is my opinion this fire is of a deliberate nature. Where an individual has purposefully set fire to the combustible materials located on the left side of the bedframe, located in the bedroom.

1.5 In accordance with Home Office guidelines to ensure confidentiality, pseudonyms have been utilised throughout this report for the following: (All ages are recorded at the time of Polly’s death).

Polly – The deceased. A 34-year-old white British female.

John – Partner of Polly. A 41-year-old white British male.

Blossom – Polly’s younger sister.

Tara – Mother of Polly.

Jack – Eldest child of Polly and Harry. Aged 13 years old.

Finn – Youngest child to Polly and Harry. Aged 11 years.

Harry – Ex-partner of Polly and father to Jack and Finn.

David – Ex-partner of Polly.

Philip – Ex-partner of Polly and father to Charlie.

Charlie – Polly’s sole child with Philip. Aged 7 years.

Jay – Eldest child of Polly and John. Aged 1 year old.

Ollie – Youngest child of Polly and John. Three months old.

IMRs were requested from those agencies who had significant communication with Polly and/or John.

2. Review panel members

2.1 Review Panel

The following agencies/organisations/voluntary bodies have contributed to the Domestic Homicide Review by the provision of reports and chronology. Individual Management Reviews (IMRs) have been requested and supplied.

2.2 All members of the panel and authors of the IMRs have complete independence from any subject in this review. The Review Chair and Panel gave due consideration for the content of the DHR and it was agreed that reports, chronologies, IMRs and other

supplementary details would form the basis of the information provided. Thanks go to all who have assisted and contributed to this review with their valued time and cooperation.

2.3 The panel comprised of the following:

Name	Area of responsibility	Organisation
Vickie Crompton	Domestic Abuse and Sexual Violence Partnership Manager	Cambridgeshire County Council
Joseph Davies	Suicide Prevention Manager	Cambridgeshire Public Health
Rohina Osman	Quality Governance and Safeguarding Lead	Change Grow Live
Helen Whitley	Senior Probation Officer	Peterborough Probation Service
Nicola Williams-Quamina	Deputy Designated Nurse Safeguarding children	NHS Cambs and Peterborough Primary Care Integrated Care Board (ICB)
Andrew Moralee	Detective Inspector	Cambridgeshire Police
Ria Demirsoy	Team Leader	Housing Needs – Peterborough Council
Gemma Cook	Assistant Director of Operations	Cross Keys Homes
Cathy Bates	Team Manager – Special Projects	Barnardo's
Julia Cullum	Domestic Abuse and Sexual Violence Partnership Manager	Cambridgeshire County Council
Sam Hunt	Associate Director of Nursing for Safeguarding	Cambridge and Peterborough NHS Foundation Trust (CPFT)
Charlie Park	Head of Safeguarding	Northwest Anglia NHS Foundation Trust (NWAFT)
Jane Bellamy	Deputy Safeguarding Lead	Cambridge Children Services
Tracy Brown	Adult Safeguarding Lead	Cambridge University Hospitals NHS Foundation Trust
Rob Olivier	Fire Prevention Tactical Commander	Cambridgeshire Fire and Rescue Service
Elaine Joyce	Section Safeguarding Lead	East of England Ambulance Service NHS trust (EEAST)
Philippa Avey-Walters	Service Manager	Adult Social Care – Peterborough City Council
Amanda Geraghty	Chief Executive Officer	Peterborough Women's Aid

3. Contributors to the review

Agency	Contribution
Peterborough Women's Aid	Panel member
Cambridgeshire IDVA/MARAC service	Panel member, Summary report
Cambridgeshire Police	Panel member, IMR
Cambridgeshire Probation Service	Panel member, IMR
Change Grow Live	Panel member, IMR
Peterborough and Cambridgeshire Domestic Abuse and Sexual Violence Partnership	Panel member, oversight
Cambridgeshire Public Health	Panel member
Peterborough City Council - Adult Social Care	Panel member
NHS Cambs and Peterborough Primary Care Integrated Care Board (ICB)	Panel member
GP surgery	IMR
Barnardo's	IMR, Panel member
Cambridge and Peterborough NHS Foundation Trust (CPFT)	Panel member, IMR
North West Anglia NHS Foundation Trust (NWAFT)	Panel member, IMR
Cambridge University Hospitals NHS Foundation Trust	Panel member, Summary report
Cambridgeshire Fire and Rescue Service	Panel member, Summary report
East of England Ambulance Service NHS trust (EEAST)	Panel member
Cross Keys Homes	Panel member, IMR

4. Author of the Overview report and Chair

The chair of the review panel and author of this report is Mrs Jackie Dadd, an independent consultant who is independent of the organisation and agencies contributing to this report. She has no knowledge or association with any of the subjects in this report prior to the commissioning of this review. She is a retired Detective Chief Inspector with Bedfordshire Police with vast experience of safeguarding and domestic abuse related issues, having been the Force Lead for domestic abuse, stalking and harassment and serious sexual offences and has been involved in the DHR process since its inception in 2011.

She has completed several training courses including the Home Office online training, the Continuous Professional Development accredited AAFDA DHR Chair training, the Domestic Abuse and Suicide accredited course, and is a member of the AAFDA DHR network, regularly attending the monthly forums for CPD and discussion. Mrs Dadd has recently completed the

new Home Office DHR Chair training to obtain the qualification of a level three ONC certificate.

Mrs Dadd has completed and published several DHRs.

5. Terms of Reference

The Terms of Reference were discussed and agreed upon during and following the first panel meeting.

It was agreed that the main areas of focus and discussion would be based on the following areas:

a) Was there collaborative working to support Polly as a victim of domestic abuse?
b) What holistic multi-agency responses are considered when a person hasn't engaged with agencies?
c) What considerations are given in safeguarding and supporting adult and child victims of domestic abuse, particularly when they no longer live with the victim or have lost them due to domestic abuse?
d) How effective was the response to Polly's suicidal ideations?

6. Summary chronology

6.1 In 2010, when Polly was 21 years old, she was in a relationship with Harry which lasted over three years. During this time, she had two children with him who remained with her when the relationship ended.

6.2 In 2015, Polly suffered from domestic abuse from her then partner David and the police were called by Polly when she had to flee the house with the children to the school as her child, Finn, had been assaulted by him causing bruising to the cheeks and buttocks and then grabbed Polly around the throat when she intervened. A MARAC was held and a s47 completed which found that Polly had met the needs of the children by her actions. An IDVA arranged target hardening for her home. David was sentenced to a term of imprisonment.

6.3 In 2016, Polly was in a relationship with Phillip and became pregnant with her third child. Harry contacted Children's Services with concerns over his children and a Clare's Law was attempted by the Police and IDVA service to disclose to Polly the previous offending of Phillip. The IDVA service made contact with Polly throughout 2016 to offer support but she did not wish to meet with them. Polly gave birth to Charlie at the end of that year.

6.4 In 2019, Polly made suicidal remarks to a friend. Police found her intoxicated in charge of her youngest child, Charlie and took her to hospital and was assessed to have capacity. Charlie went to stay with an aunt Blossom overnight and referrals were made to Children Social Care (CSC), Cambridge and Peterborough Foundation Trust (CPFT), who provide

mental health support and the Integrated Mental Health Team (IMHT). No further action was taken by CSC as no concerns were highlighted for the child.

6.5 Polly received Early Help support in 2020. Towards the end of 2021, Polly began a relationship with John who she had known through a mutual friendship for a couple of years. In February 2022, the Police recorded a domestic Actual Bodily Harm (ABH) between Polly and John that was reported by a third party outside her flat. She had asked them 'Don't call the police, he'll kill me' before going back into the flat. When the police spoke to her, they saw that she looked like she had been crying with clumps of hair pulled out and a graze to her forehead. She had blood on her neck, face and hands and a scratch to her neck. Polly denied any domestic abuse to the police and stated that she had been in a relationship with him for two months. John was arrested, interviewed and bailed. Polly informed the police that she was pregnant and when the safeguarding midwife received information from police referrals, they ensured contact was made with the MASH to check that Children Services had been informed. Children Services made the decision to proceed with a child and family assessment.

6.6 In March 2022, an ex-partner of John reported numerous offences in relation to John that had occurred in November 2021 including ABH, malicious communications and threats to kill. The threats were to burn her house down with her inside it and he had turned violent after they had consumed a bottle of vodka, pulling her hair and strangling her. She required hospital treatment and suffered concussion and two black eyes with a lump to her forehead. She obtained a restraining order and was supported by the IDVA service. She subsequently withdrew her complaint in December 2022 and the CPS made the decision that no further action would be taken.

During March, the Child and family assessment had been completed and a decision was made to support the family through a Child in Need (CiN) plan. There were concerns over Jack and Finn's presentation with them being withdrawn at times, but Charlie seemed more settled and had positive relationships at school. The report stated that the children liked John because he bought them nice things. Contact was made with midwifery for a referral for the unborn child.

6.7 In April 2022, a neighbour called the police as they had witnessed John kick the front door and then kick the kitchen window shut, trapping and cutting Polly's finger. Jack, Finn and Charlie all witnessed John smash the house up and threaten Polly with a hammer. Polly told the police that John had never assaulted her before. She had a swollen lip and had told the neighbour that he had strangled her but she denied any assault and stated that she wanted him back. The police record that the children seemed frightened of him having spoken to them and called him a 'horrible' man. Polly was taken to hospital due to intoxication and pregnancy.

A MARAC was held following this incident as it had been recorded as high risk. Polly and John had both been under the influence of alcohol. John had been bailed with conditions not to contact Polly who did not feel she could support a prosecution due to fear. This was also the case for the neighbour. The CPS had refused to charge, citing a lack of officers

statements and no download of Body Worn Video evidence. All previous incidents were heard at the MARAC which outlined an extensive history of offending and allegations in John's past.

Children Services maintained the Child in Need status. Polly had informed CSC after the second incident that the relationship had ended. Probation stated that John was on an 18month suspended sentence until 22nd April 2022 due to a conviction for a shooting/wounding GBH.

6.8 On 7th May 2022, the police recorded criminal damage and controlling and coercive behaviour as Polly had disclosed to her child's school that she did not feel safe to return home and that John had told her, "If you kill my baby, I will kill you. I will burn your house down with you and the kids in it." She believed these threats and said that he made them whenever she wanted to leave him or go to the police. Polly told them, "I am petrified to be supporting the police as I think this will end up in him ending my life."

The evening before, John had punched, bitten and strangled her causing swollen lips and nose, a black eye and dried blood on her face. Polly alleged that John had raped her whilst she was pregnant but the CPS did not prosecute due to insufficient evidence.

Polly stated to the police that between 01/02/22 and 10/05/22, John controlled her. He controlled her finances, where she could go, phone communication, what food was in the house and who could eat it.

John was arrested, charged the same day with twelve offences and was remanded in custody until his hearing in December at Crown Court. Jack and Finn permanently went to live with their father. Polly provided differing accounts to agencies as to whether she was back in a relationship with John whilst he was in prison. They were in contact frequently according to Polly's family. During this time, Polly withdrew from the police and the IDVA support. Charlie told her school that Polly was speaking to John over the phone in prison. Concerns escalated for Charlie and then Jay, once born in the October as it was recorded by Children Services that Polly was back in a relationship with John and had an unwillingness to safeguard Charlie or Jay and Children services moved them onto a Child Protection Plan.

Charlie then went to live with Philip and Jay was placed in foster care, having been born in the October.

6.9 During Johns trial, Polly had given evidence to the fact that she had 'made it all up.' John was sentenced to a suspended imprisonment of ten months concurrent which was suspended for two years, alcohol treatment required and rehabilitation activity required. John was released from custody and their relationship resumed with John being managed by the Probation Service.

6.10 During 2023, John attended an alcohol rehabilitation programme with Aspire in which Polly approached them for help on two occasions but then did not attend any follow up appointments. John attended the Building Better Relationships programme which he stated gave him more of an understanding of how to handle conflict in a relationship.

Polly had moved in with John as they had both lived in Cross Keys Homes as tenants separately for a number of years and was pregnant with his child to which a Child Protection Conference was held. A few days after Ollie was born in the December and had remained in hospital, a doctor found bruising behind the right ear which was unexplained. CSC had already obtained an Interim Care Order and a safety plan was put around the baby with Polly and John only having supervised access.

In January 2024, Polly applied for the Housing register online and also spoke to her sister in regard to moving in with her. No domestic abuse had been recorded or disclosed since John's release from custody.

6.11 In March 2024, Polly was struggling with her mental health and sought to get help. All of the following circumstances occurred within a period of one week.

Polly attended the emergency department (A&E) at Peterborough City hospital having taken an Opiate overdose of seven pregabalin and being suicidal. She stated that she had woken up in the middle of the night experiencing hearing voices that scared her. She went out to a bridge but couldn't jump so went to McDonald's to take the tablets and then sought medical attention.

She stated that her relationship was mature and healthy and that all her children had been removed, one being two months previous. Polly stated that she would engage with a drug and alcohol provider as her partner used them. She saw the Liaison Psychiatric Service (LPS). Polly was assessed that there was no mental health necessity to refer to secondary mental health because Polly denied suicidal thoughts or any current intention to harm herself. Polly did not exhibit acute mental illness symptoms and acknowledged that her current condition was primarily due to illicit substance misuse. She left with a discharge plan.

6.12 Polly attended A&E the following day due to feeling 'suicidal, intends to end life' feeling worse than the previous day. She was seen by the same LPS specialist nurse along with another colleague. Polly was unsure about her relationship status as she said that her partner had told her the day before on the phone while she was walking the dog, that the relationship was over and that 'he's had enough.' Hospital recorded the trigger of her MH as having her five children removed. CPFT records state that following a lengthy discussion, she agreed she was safe to return home and was discharged with advice to use the GP as a form of support. The GP was sent a letter the same day and a safeguarding Children action plan was raised. There was a DV flag on Polly's records which instigated an automatic notification to the DA Co-ordinator who made a referral on behalf of A&E.

Two days later, Probation completed a home visit during which both John and Polly were present. During this appointment Polly disclosed she has relapsed into substance use. John's Probation Officer encouraged her to seek support; however, she suggested she did not want to engage with professionals.

6.13 At 10.18hrs the following morning, Polly was seen on a bridge over a major trunk road standing on the wrong side of the railings. The police managed to talk her back to the right side where she seemed paranoid and said that she was struggling with her mental health

and wanted support. Polly felt like everyone was against her and some people were trying to set her up which led her to feel low and suicidal, so she went to the bridge. An ambulance attended and took her to hospital. Officers followed the ambulance to ensure that Polly went with the paramedics. Hospital staff were made aware of the situation and that Polly could potentially leave the hospital, so when they booked her in, they marked her as a flight risk. At about 11.50hrs, the officers left Polly in the hospitals care. Advice was given to her for if she felt low/suicidal again.

Officers completed a safeguarding referral to the Police MASH and within an hour, the information was shared with her GP, CPFT and Change Grow Live with the consent of Polly. Polly left the hospital before being seen.

6.14 At just gone 16.00hrs, the same day, the joint Mental Health Police Response Vehicle attended the same major trunk road to a report of Polly walking along the edge of the road and there was concern for her safety. When she was triaged by the mental health practitioner, Polly stated that she was not suicidal but was trying to speak to her ex-partner John. She stated that she was homeless and that she had been taken to hospital by ambulance earlier the same day due to her mental health needs but left before being seen and had left her coat and phone behind.

The Police initially took Polly to the hospital to form a plan and attempt to get her property back. The hospital records state that they had observed her by continuous monitoring but she absconded. They checked with the police who confirmed that they had arrested Polly for obstructing the highway and took her to a police station.

Polly was fit to be detained although she was to be under constant observation due to what had happened that day and that the mental health nurse had stated that Polly had triggers for suicide after her children were taken into care. Polly was assessed and deemed fit to be detained. Polly was interviewed late at night with a solicitor present and subsequently charged with Wilful obstruction of the highway and bailed, being released from the police station at 05.16hrs having had a prerelease risk assessment stating that a medic had no concerns for her release and she was to be transported home in a police car to ensure her safe entry into her address. Polly did not have any keys in her possession. Officers gained access to the communal area with a universal key and went to her front door with her. There was no answer and Polly stated that she would wait for her partner to come home. The Police officers assessed this as appropriate and left Polly outside the property at 05.30hrs the same day.

6.15 About 09.30hrs the same morning, neighbours from within the block of flats suspected a fire coming from Polly's address due to smoke and contacted 999 at 09.54hrs when he could not rouse any occupants.

The Fire Service attended and notified the police who attended by which time the block of flats had been evacuated and the area cordoned off. Paramedics were giving cardiopulmonary resuscitation (CPR) to Polly on the grass area outside the block of flats. John arrived at this point and saw this. The Fire crew stated that they found her within her

flat laying unresponsive surrounded by smoke. At 11.06am, despite the best efforts by the paramedics, Polly's death was confirmed.

7. Key issues arising from the review

7.1 The importance of involving families

Polly was suffering with her mental health and attended the hospital on two occasions seeking assistance with suicidal ideations in the week leading to her death with the police removing her from the wrong side of a bridge over a busy trunk road on one occasion. The hospital did not contact her family when she was discharged to provide her support. The police took her into custody for obstruction of the highway when she was found walking down the side of a busy trunk road. She remained in custody through the night with her sister calling but not being able to obtain any information. The police had on record that Polly was a DA victim from John, yet did not contact her family when she was released but took her to her home address to ensure her safety, knowing that she did not have keys to the premises. When she could not gain access, she chose to remain outside the flat at 05.00hrs in the morning but was found deceased inside a few hours later. Her family state that had they been contacted by either the police or the hospital, they would have attended the police station or her home address to be with her.

7.2 Clare's Law to be advised as common practice (DVDs) by all agencies

A disclosure of Clare's Law was relevant in regard to more than one partner of Polly's. During this review, it became apparent that this is not necessarily an area that is considered by a number of agencies to advise a victim to either make an application or make one on their behalf.

It was identified by the police that a disclosure was appropriate in regard to Polly's relationship with Phillip but attempts were made to provide the disclosure alongside an IDVA and when they attempted to do this on three occasions and Polly was not at her address, it does not appear (no record) that it was ever disclosed.

A Clare's Law disclosure was made by the midwife to Polly in relation to John but had not been considered by several other agencies.

8. Conclusions

8.1 The cause of death has yet to be determined by the Coroner so the review is based on the findings of the criminal and fire investigation.

8.2 Polly suffered domestic abuse in the presence of her children in previous relationships. Child protection was not deemed necessary for Jack and Finn on the occasion that she left the relationship with David but all three children from previous relationships and the two

children that she had with John were removed as she remained in a relationship with him and they were assessed as being at risk. Opportunities to further safeguard and support Polly, educate her on her choices as a victim of domestic abuse and the mother to children who were victims were missed, particularly whilst John was in HMP on remand.

8.3 There is evidence of the voice of the child being recorded but not specifically heard as with Jack, initially happy with John but then became fearful and Charlie spoke about fear of him, yet even though it was deemed as a high-risk case, a strategy meeting was cancelled and it was due to the MARAC and the midwifery that it was escalated and progressed. Although the risk has been identified, there was not the urgency to progress which may also have been a misunderstanding by the CSC as they had been told by Polly that the relationship with John was over yet other agencies held information to identify they were still in contact. This identifies the necessity for information sharing and collaborative working.

8.4 Positively, the children's fathers were involved in planning which increased the protection for them and meant that for Jack, Finn, and Charlie that they were able to remain living within their family. Philip attended the Child Protection Conference for Charlie which enabled him to be fully aware of the risks and concerns. However, the panel have noted that the history of domestic abuse involving Philip in previous relationships would still be a concern.

The Police recorded 23 incidents during the review timescales.

- 8 x Welfare/protection of Polly's children.
- 4 x Polly adult protection/welfare.
- 3 x Polly a victim of crime with John as a suspect. (All linked to one investigation).
- 1 x John as a suspect with victim being another female (not Polly).
- 2 x John - possession of firearms.
- 1 x Polly arrest/charge.
- 1 x Polly - Investigation into her death.
- 3 x Adult Protection/concern for welfare of John (All after Polly's death).

8.5 Cambridgeshire Constabulary guidance for responding to Domestic Abuse, Child Protection and Adults at Risk refer to College of Policing (CoP) Authorised Professional Practice (APP). The APP's are detailed however they are not specific to an individual force respective processes and procedures. Both Bedfordshire Police and Hertfordshire Constabulary have their own Standard Operating Procedure (SOP) for Domestic Abuse, Child Protection and Adults at Risk. These SOPs compliment CoP APP as well as clarifying each force policy and procedures. Cambridgeshire Constabulary need to consider whether to implement their own specific Domestic Abuse, Child Protection and Adults at Risk SOPs. This would then ensure account is taken of Cambridgeshire policy and procedures.

8.6 It was well documented that Polly struggled with alcohol abuse in recent years and actually approached CGL on two occasions herself asking for support, however, there were no referrals made to CGL by any agencies, only advice given to Polly. A discussion took place

surrounding alcohol referrals and although it is agreed that forcing someone onto a programme (if the powers exist) is not productive, making a referral for CGL to be able to contact and provide the opportunity and also have context from the referral should always be considered.

8.7 Due to this review, where a service user presents multiple times but does not engage and states that CSC have asked them to engage, Aspire would now contact CSC to advise of this presentation. This is not to be intrusive or to access information inappropriately, but simply to make the correct professional aware of presentation, so that appropriate further support or formal referral can be put into place. Where CGL Aspire receives a concerning MASH report for an individual known to CGL Aspire who may be closed to the service/not engaged, depending on risks raised, Aspire may decide to contact that individual and see if they would like to access treatment.

8.8 The perpetrator's perspective highlights the benefits of the Building Better relationship's course and the understanding of their own behaviour that a perpetrator can learn from this.

8.9 There is evidence of good practice throughout the years of information sharing and agencies working together. There is excellent recording of the MARAC decisions, actions, and progress thereafter, however, there are times when information sharing could have taken place or been timelier.

8.10 There is an absence of reported allegations of domestic abuse in the fifteen months prior to Polly's death and her family report her to seem happier in this time although this cannot negate that the abuse was on-going. Polly was suffering from alcohol and drug abuse prior to her death and it cannot be known whether this was due to domestic abuse, the loss of her children being taken into care or another cause. It is noted that she spoke to her sister over the Christmas period, speaking of whether she should remain in the relationship and talking of going to live with her. She re-iterated this to her sister, Blossom on the phone the day before she died stating that her and John were over and 'it was nothing to do with John, it was all her as she needed space.' This would indicate that she had made the decision to leave which correlates with her requesting to go on the housing register for a new home.

8.11 Polly was clearly struggling with her mental health and felt suicidal as she indicated when she attended the hospital of her own volition and she should have received a referral for a mental health assessment. She attended due to her suicidal state yet these thoughts were deemed to be due to the substances she had taken; however, this should not have deterred from the fact that she felt suicidal.

8.12 Health professionals have stated that the removal of Polly's children may have had an adverse state on her mental health and although the midwife took steps to support her in the immediate aftermath at the hospital, it is not clear what, if any support was provided afterwards by any agency.

8.13 Although it is understood by the panel that the arrest of Polly was for her own safety and attendances at the hospital over the past few days had not alleviated her struggles and she had left earlier in the day, it is a concern that a person who is clearly struggling with their

mental health is placed in a cell on their own in that environment. It is clear that protocols were adhered to and assessments completed but no consideration was given to contacting the family for them to collect Polly and look after which meant that she was unable to get into her home on the face of it and alone in the middle of the night.

8.14 When the police delivered the message to Polly's sister, Blossom, initially of the fire itself, then measures could have been taken to avoid trauma to the children by asking for them not to be present and then using earpieces for their radio so that they could have broken the news of Polly's death to Blossom in a sensitive manner.

8.15 Polly's family describe her as fun loving and happy in her early years with no reliance on alcohol and having a stance against drugs.

8.16 The panel were inquisitive as to how Polly could not initially gain access to her address and had no keys when the Police took her home yet was found inside hours later when emergency services responded to the fire. John had initially stated that he had the only key so he would always leave the door unlocked but later provided a statement to say he was not in a possession of a key at the time. John arrived at the scene as Polly was receiving CPR outside the block of flats.

8.17 The officers who took Polly home state that they saw Polly knock on the door to the flat. They did not see her try the door handle. They did not feel the need to knock on the door themselves because Polly knocked hard on the door. They did not try the door handle themselves. Polly did not say anything about the keys or suggest another way into the flat. Polly was content to be left in the communal area.

8.18 One of the officers states that they offered Polly a lift to another address of friends or family but she declined that offer. Intermittent CCTV from another building does not show any person arriving or leaving the outside of the block of flats during the relevant time although this cannot be relied on. It has not been determined/possible to state if the door was locked from the inside or with a key from the outside.

9. Lessons to be learnt

9.1 The importance of sharing information in a timely manner

Following the remand of John into custody, agencies were receiving differing information on the status of Polly's relationship with John. The police initially took the view that it had ended as Polly provided them with a statement. Children Services were initially told by Polly that the relationship was over and she was working with other agencies but did not clarify that this was still the case in future conversations. It was identified through MARAC that this was not the case and the Social Worker was actioned to escalate this to enable a strategy discussion that Children Social Care had not thought necessary based on the information directly from Polly. The police were aware of contact between the two of them from information provided by the prison and the family were aware of the contact but had not been approached to provide an opportunity to disclose this. (Recommendation refers)

Within Probation's pre-sentence report John is described as not being in a relationship however at his initial appointment within 24 hours of release from custody he advises he is in relationship with the victim. There is no evidence of liaison with the prison to confirm whether there was contact between them during his period of remand. This information may have provided an indication that the relationship had not terminated. (Recommendation refers)

If the information is not shared in regard to the relationship status, then risk assessments regarding the children, Polly and that of John's sentencing will not be accurate.

9.2 The importance of the continuance of the safeguarding of a DA victim

Polly had a number of abusive partners previously and may not have had confidence in the Judicial system. Having gained that confidence with remanding John in prison and obtaining a statement from her, John was then able to frequently contact her from the prison prior to the trial.

This contact provided an opportunity for John to either dissuade Polly from giving evidence against him or to display stage 2 of the Homicide/suicide timeline outlined by Jane Monckton-Smith[1] whereby the perpetrator goes back to the charming stage the victim is groomed once again.

Statutory Services including the Police, Her Majesty's Prison service and the Probation service have a duty to ensure that safeguarding is continuous and providing the victim with the opportunity for space and time from the perpetrator to be able to clear their minds, not feel in fear and make uninfluenced choices. (Recommendation refers)

Engagement with the IDVA during the period Polly was open fluctuated. Initially, she was keen to accept support, but this changed once contact with John in prison was made. This appeared to be a turning point in her withdrawing support for police action and retracting her evidence. It also appeared to be a factor in her decision to keep the baby and not go through with a termination. A time when she would have potentially felt more vulnerable.

[1] In control -Jane Monckton-Smith - Bloomsbury

10. Recommendations

National

There are no national recommendations in relation to this review.

Local

1. **Cambridgeshire Constabulary to review their processes for the documentation and recording of Domestic Violence Disclosures (Clare's Law).**
   The Domestic Violence Report dated 17/05/2016 regarding the Domestic Violence Disclosure has never been finalised to show that Polly was informed. Current processes need to be reviewed to ensure any future disclosures are fully documented with the outcome prior to finalisation.

2. **Cambridgeshire Constabulary to amend their processes to ensure that domestic abuse related investigations with the same suspect are linked.**
   This will ensure that cases are investigated as a whole and not in isolation so that they are presented to the CPS/Court with full facts of offending so that all evidence of all offences can be taken into consideration. -

3. **Cambridgeshire Constabulary to renew their Intelligence processes to ensure that repeat domestic abusers are flagged to enable consideration of action to be taken against such individuals.**
   This will negate the same repeat offender with different victims being dealt with in isolation and ensure the Courts are presented with the accumulative offending and risk posed. It will also provide opportunities for other offences nonrelated to be processed as a disruptive safeguarding measure.

4. **Cambridgeshire Constabulary to review their responses for dealing with detainees suspected of mental health issues and/or suicidal thoughts.**
   Although processes are in place, the review has highlighted areas such as whether police custody is a suitable place, family contact/involvement that could enhance the safeguarding when released from custody and reduce demand etc.

5. **Cambridgeshire Constabulary to consider implementing their own specific Domestic Abuse, Child Protection and Adults at Risk SOPs.**
   This will make the processes and responses in these areas specific and bespoke to the needs of Cambridgeshire whilst dovetailing into the National policy and strategies.

6. **Cambridgeshire Police to implement a process that when an offender is on remand or sentenced, they provide the prison with witness and victim numbers to be barred from the PIN list.**
   This will provide ongoing safeguarding by preventing the offender directly contacting the victim or witnesses and asserting control or fear from within the prison.

7. **Cambridgeshire Police to ensure all officers receive training in delivering sympathetic messages and that communication is sent to all officers as a reminder of how to remain sensitive in those circumstances.**
   This will negate the circumstances surrounding Blossom learning of Polly's death re-occurring.

8. **Cambridgeshire and Peterborough MARAC to ensure that discussions during the meeting include confirming safe contact details and if the victim has access to a phone.**
   This will provide shared information and confirmation of the safeguarding required and implemented safety plan for the victim.

9. **Probation Service to re-communicate the process to practitioners in relation to the use of home visits and frequency of police call-out checks.**
   This will provide early communication with the perpetrator and potentially the only contact with a victim if they have disengaged with other services and are still in a relationship with the perpetrator providing information to risk assess. Call-out information will enhance Probations knowledge of contact with the victim and perpetrator

10. **Peterborough Children Social Care to include in processes when there is a risk of domestic abuse and the alleged perpetrator is incarcerated, Child in Need planning should be focussed on supporting the victim with strengthening their support network, including holding a family meeting.**
    This will ensure that every opportunity is taken to provide support at the optimum time which may lead to the children being able to stay with the parent who is the victim of the abuse.

11. **Peterborough Children Social Care to ensure that escalations to Child Protection should be timely and the impact of domestic abuse on the child's wellbeing fully considered alongside their lived experience when making a threshold decision.**
    This is to include the use of multiagency information for holistic decision making to negate decisions being based on what they have been told by the person/persons involved. It should also include the recognition of children being victims of domestic abuse whilst living in the household.

12. **Peterborough Children Social Care to ensure that the recommendation to make a Clare's law application features in children's plans.**
    This will provide an opportunity for a victim to have further information on how they and their children have been at unknown risk and allow informed decision making which can be taken into account to try and prevent victims of domestic abuse also losing parental control of their children.

13. **Peterborough Children Social Care to ensure that plans have multi-agency contribution to consider all the risks and understand the support they can offer to both CSC and families.**
    This will provide holistic specialist support to meet the bespoke needs of the family. It will also contain information from all sources providing a holistic picture of their needs and an understanding of the situation with greater context.

14. **Peterborough Children Social Care to ensure plans consider the work to be completed by perpetrators of abuse alongside any work to be completed by the victim.**
    This will assist the family in the future if the relationship remains.

15. **Polly's GP surgery to implement a process that any patient discussed in Management daily meetings will be followed up by the safeguarding administration to ensure a continuation of care is met.**
    This will provide further opportunity for support and proactiveness on the information received.

16. **Cross Keys Homes to revise their domestic abuse policy and procedure to ensure action to hold perpetrators of domestic abuse to account is included and assurances that survivors are signposted to make well informed housing related decisions.**
    This may negate or minimise the occasions when a victim of domestic abuse moves into a Cross Keys Homes property with the perpetrator when they are already known as a domestic abuse victim.

17. **Cambridgeshire Fire and Rescue Service to re-communicate and promote the information sharing protocol for all fire relating concerns including threats.**
    This will provide intelligence to analyse, identify patterns of potential risk and provide the Fire Service with opportunities to potentially negate or minimise the risk.

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	Recommendation	Scope of recommendation	Action to take	Lead Agency	Key Milestones achieved in enacting recommendation	Target Date	Completion date and outcome
1	Cambridgeshire Constabulary to review their processes for the documentation and recording of Domestic Violence Disclosures (Clare's Law).	Local	Review current process to ascertain if disclosures are made when required. Ensure inclusion in policy and process. Disseminate to staff.	Cambridgeshire Police Role – DA Lead	DVDS is now dealt with in the MASH through a dedicated team. This team own the disclosure process from the outset and complete research before delivering the disclosure where appropriate. Onward safeguarding also forms a large part of the disclosure process which is monitored in it's entirety by the MASH until the whole process has been completed. HMICFRS also monitor the Constabulary's compliance around DVDS and we have to report them quarterly	15/02/25	

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					with performance data. July 2025 - A review of the Constabulary's DVDS process is currently underway, with peer visits to Cheshire and Essex Police due in July 2025 to identify good practice. DVDS demand has more than doubled in Cambridgeshire since April 2024 which has led to the creation of dedicated resources to deal with the demand. The aim from the DVDS review is to create an efficient process which addresses safeguarding through prompt and effective		

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					action in a timely manner.		
2	Cambridgeshire Constabulary to amend their processes to ensure that domestic abuse related investigations with the same suspect, where possible, are allocated to the same investigating officer.	Local	Agree through crime standard delivery group. Disseminate decision. Communication plan to investigative departments.	Cambridgeshire Police Role – DA Lead/Head of Crime	01/10/24 - Cambridgeshire Constabulary are currently implementing a delivery plan to improve the standards of Domestic Abuse investigation across the organisation. A key principle of this will be the holistic investigation of Domestic Abuse, including taking into context not just the single incident but the current lifestyle and experiences of the household. This will give a better understanding of how Domestic Abuse is affecting the lives of	31/12/24	Completed July 2025 implemented as part of the Domestic Abuse Strategic Delivery Plan

					the parties involved, as well as their children. The single OIC forms part of this process and will apply to open investigations as well as those recently closed, with the aim of building or maintaining rapport with victims. July 2025 – This action forms part of the Domestic Abuse Strategic Delivery plan which is currently underway in Cambridgeshire. This plan strives to improve the standards of Domestic Abuse investigation across the organisation. A key principle of this is the holistic investigation of Domestic Abuse,		

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					including taking into context not just the single incident but the current lifestyle and experiences of the household. This will give a better understanding of how Domestic Abuse is affecting the lives of the parties involved, as well as their children. The single OIC forms part of this process and will apply to open investigations as well as those recently closed, with the aim of building or maintaining rapport with victims.		
3	Cambridgeshire Constabulary to renew their Intelligence processes to ensure that repeat domestic abusers are flagged to	Local	Approach Athena team to identify feasibility.	Cambridgeshire Police Role – DA Lead	July 2025 – The Centralised Intelligence Bureau (CIB) produce a	31/03/25	Completed July 2025, monthly High Harm

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	enable consideration of action to be taken against such individuals.		Implement as a process in IMU and CIB		monthly VAWG High Harm list which examines repeat victimisation and repeat suspects for VAWG offences. Utilising the Cambridge Harm Index (CHI), victims and suspects are scored based on the frequency and seriousness of offences. This allows for the highest harm victims and perpetrators to be identified and shared on a monthly basis. The list is shared with local crime managers, allowing them to implement bespoke plans to those at the greatest risk and to those who pose the greatest risk of harm.		list produced

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4	Cambridgeshire Constabulary to review their responses when releasing detainees suspected of mental health issues and/or suicidal thoughts to ensure that where consent is given, consideration is given to utilise family members for safeguarding.	Local	Review of current process to identify suitable timeframe whilst person in custody and how to ensure suitability of family member. Custody Sergeants to be trained for implementation.	Cambridgeshire Police Role - Head of CJ and Custody		February 2025	Update from DCI Savill Aug '25 As part of the risk assessments in custody, custody officers will identify MH and Suicidal concerns and engagement will occur with HCP and LADS /MH team where required. Upon their release if not S136

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							custody officers would routinely consider family members to assist in safeguarding on their release by engaging with the detainee and will ensure they are released into appropriate care – i.e partner collects detainee etc.
5	Cambridgeshire Constabulary to consider	Local	Review Beds and Herts SOPs.	Cambridgeshire Police		April 2025	

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	implementing their own specific Domestic Abuse, Child Protection and Adults at Risk SOPs.		Create policy relevant to Cambs area. Implementation and ratification	Role – DA Lead			
6	Cambridgeshire Police to implement a process that when an offender is on remand or sentenced, they provide the prison with witness and victim numbers to be barred from the PIN list.	Local	Review process within the CFSSU/CPU for already existing prison links. Implement this as part of DA write off when detecting crimes. Identify system to ensure consistency.	Cambridgeshire Police Role – DA Lead	July 2025 – This remains a work in progress	January 2025	
7	Cambridgeshire Police to ensure all officers receive training in delivering sympathetic messages and that communication is sent to all officers as a reminder of how to remain sensitive in those circumstances.	Local	Research any National training available. Produce training package. Deliver in CPD events.	Cambridgeshire Police Role -People and Professionalism Inspector	01/10/24 – Agreement for training within scheduled sessions July 2025 – This remains a work in progress.	March 2025	

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8	Cambridgeshire and Peterborough MARAC to ensure that discussions during the meeting include confirming safe contact details and if the victim has access to a phone.	Local	Communication to Chairs. Audit of MARAC meeting minutes to ensure this is being adhered to.	Cambridgeshire and Peterborough MARAC Role – MARAC Manager		November 2024	Update from JC 2/7/25 MARAC Chairs have all been informed of the need to ensure a safe contact number, and this has been included in the police guidance for MARAC Chairs. Future Audits will look to ensure this is being done. The MARAC Operating Protocol is

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							due for review but is waiting for the recommendations of the recent Safe Lives review. Once completed this will be included in the revised version.
9	Probation Service to re-communicate the process to practitioners in relation to the use of home visits and frequency of police call-out checks.	Local	Communication plan. Home visit protocol to be reviewed to ensure relevance. Recording mechanism identified.	Cambridgeshire Probation Service Role – Senior Probation Officer		December 2024	
10	Peterborough Children Social Care to include in processes when there is a risk of	Local	Revise family group conference protocols.	Peterborough Children Social Care	The revised family group conference offer has been revised,	January 2025	

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	domestic abuse and the alleged perpetrator is incarcerated, Child in Need planning should be focussed on supporting the victim with strengthening their support network, including holding a family meeting.		Refresh training in relation to DA to staff.	Role - Director	which includes holding family meetings at the earliest opportunity. This is now going through the final stages of approval. There is a practice development session with children social care staff on 4th November, which will focus on domestic abuse and coercive control and the importance of completing work safety work with victims, including utilising time in custody where appropriate.	November 2024	
11	Peterborough Children Social Care to ensure that escalations to Child Protection should be timely and the impact of domestic abuse on the child's	Local	Audit responses to DA from all service areas. Complete a benchmark report.	Peterborough Children Social Care Role - Director	Audit activity relating to the response to domestic abuse from all service areas in Children Social Care has been completed. A	September 2024	Complete- although this will continue to be part of audit

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	wellbeing fully considered alongside their lived experience when making a threshold decision.		Arrange practice development forums to improve DA response.		benchmarking report relating to the quality of responses to domestic abuse has been completed. Practice development forums and workforce development activity will continue to focus on improving responses to domestic abuse.		activity and training and developme nt.
12	Peterborough Children Social Care to ensure that the recommendation to make a Clare's law application features in children's plans.	Local	Communication to CP Chairs. QA process identified and implemented	Peterborough Children Social Care Role - Director	01/10/24 – Communication to CP chairs provided to include in CP planning. 05/10/24 – QA process implemented	September 2024	Complete - This will continue to be monitored through audit activity and plans will be reviewed with Social Workers during collaborativ

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							e audits to ensure this is on the plan where appropriate
13	Peterborough Children Social Care to ensure that plans have multi-agency contribution to consider all the risks and understand the support they can offer to both CSC and families.	Local	Identify already existing forums for information sharing. Review previous cases to identify patterns of missed opportunities. Communication plan for processes to include multi agency approach.	Peterborough Children Social Care Role - Director	25/09/24 – Considered by Audit Board. Work is ongoing with the Children's safeguarding board. 09/10/24 - Audit activity continues to find that inconsistencies relating to multi-agency planning. Discussion to be taken forward with the safeguarding board in November relating to what training can take	November 2024	Complete- also a safeguarding board priority (making the child protection system work)

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					place with providers regarding this		
14	Peterborough Children Social Care to ensure plans consider the work to be completed by perpetrators of abuse alongside any work to be completed by the victim.	Local	Complete a benchmarking exercise through auditing. Complete a practice development forum to focus on perpetrator engagement.	Peterborough Children Social Care Role - Director	A benchmarking exercise has been completed through audit activity to find that for some families work continues to be victim focused. Practice development forum is scheduled for November.	November 2024	Complete- audit activity has shown an improvement in this area. This will continue to be monitored through ongoing audit activity
15	Polly's GP surgery to implement a process that any patient discussed in Management daily meetings will be followed up by the safeguarding administration to ensure a continuation of care is met.	Local	Communication to be sent out within the practice to reiterate process. Yearly dip audits to assure adherence to process.	GP Surgery Role – Clinic manager	All allocated GP's to be up to date and aware of safeguarding cases within their cohort of patients.	February 2025	All staff have completed Domestic abuse training was added

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							to blue stream for all staff to complete *we have monthly significant event/ safeguarding meetings and MDT meetings to discuss safeguarding patients *GP's are sent a task when a patient is identified as at risk of DA and the safeguarding team are made aware. *Patients are coded

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							at risk and their safeguarding notes are updated *Staff have been made aware/reminded the safeguarding processes and have been given information on where to go for support or advice.

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16	Cross Keys Homes to revise their domestic abuse policy and procedure to ensure action to hold perpetrators of domestic abuse to account is included and assurances that survivors are signposted to make well informed housing related decisions.	Local	Policy to be updated. Dissemination to departments for consistency in practice. Implement auditing process	Cross Keys Homes Role – Assistant Director of Operations	Updated policy to include additional points and actions. Share with the Neighbourhood Management, Lettings and Customer First Team to ensure correct advice and signposting is provided in respect of housing related decisions. DA case audits and contact audits in place – continue to review and manage.	November 2024 November 2024 Ongoing from November 2024	Update from Gemma Cook 8/7/25 Complete. The document is updated in particular to reflect further action should a survivor of domestic abuse wish to end their tenancy. This sets out DA case audits and contact

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							audits in place – continue to review and manage. Ongoing from November 2024 responsibilities to establish reasons and support before ending the tenancy. Shared with the teams. Case audits continue to be completed every month.

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17	Cambridgeshire Fire and Rescue Service to re-communicate and promote the information sharing protocol for all fire relating concerns including threats.	Local	Develop workshop sessions and packages to educate partners in CFRS offerings with clear information sharing pathways.	Cambridgeshire Fire and Rescue Service Role – Head of Fire Prevention	Named Partners of the DHR have received workshop or online presentations and referral link shared.		Update from Rob Oliver 15/7/25 I have written an articl e for the Domestic Violence Partnership newsletter. We have also attended

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							multiple Community Safety Partnership meetings since the recommendation and shared our services and online tool. On 17/07/25 The new Head of Fire Prevention and his team will be presenting at the CPLRF (Cambridgeshire and Peterborou

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							gh Local Resilience Forum) event made up of all partner agencies, to communicate our offer.

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Sarah Fines
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Cambridgeshire Domestic Abuse & Sexual Violence Partnership
The Butts Fowlmere,
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18th August 2025

Dear Sarah,

Thank you for resubmitting the Domestic Homicide Review (Polly) for Safer Peterborough Community Safety Partnership to the Home Office Quality Assurance (QA) Panel. The report was reassessed in August 2025.

The QA Panel noted that the opening tribute from Polly's sister and the condolences provided were very moving. The engagement with Polly's mother and sister was recognised as important, as it helped the reader gain a greater understanding of what Polly was like. There was a clear effort to ensure that Polly's voice was heard within the report and to identify learning from her experience of services and her engagement with them. The panel also felt that there was an appropriate level of local specialism on the panel, evidenced by the inclusion of recommendations to several agencies and the broad panel membership and contributing agencies.

The QA Panel felt that the report was easy to follow in its communication style, with a useful and clear genogram and summary of police contact within the executive summary. They felt that the Equality and Diversity section was good, particularly in the use of reference points to illustrate relevance. The Panel also thought it was positive that the author met with the perpetrator via his Probation Officer.

The QA Panel acknowledged that most of the issues raised in the previous feedback letter have now been addressed the Home Office is content that on completion of the changes below, the DHR may be published.

Before publication, please review and implement the following feedback:

- References to the sex of the children have not been removed throughout the report. For example; three references on page 21, one on page 23 and one on page 44. Please ensure these have been removed before publication.

- The new pseudonyms for the children are not gender neutral, please review.

- In terms of the layout, although all of the relevant information may be in the report, there are discrepancies between the structure/order of the sections when cross-referencing the contents page to the headings outlined in the statutory guidance template. Please take note for future DHRs.

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