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HUNTINGDONSHIRE DISTRICT COUNCIL
COMMUNITY SAFETY PARTNERSHIP

DOMESTIC ABUSE DEATH REVIEW

OVERVIEW REPORT

LOUISE AGED 29

DIED AUGUST 2020

REVIEW PANEL CHAIR AND REPORT AUTHOR
HELEN COLLINS BA (Hons) PGCE PCET

Version 1 **May 2021**
Report Date **March 2023**
Amended **April 2024/ January 2025**

CONTENTS

Message of Condolence from the Panel

The Panel wishes, at the outset of this report, to express its sincere condolences to the family, friends and associates of Louise in relation to her death. It has striven throughout this process to place Louise at the centre of their thoughts, discussions and debates, and with this in mind her voice can be heard loud and clear in the body of the report.

Family Statement

Louise's mother was asked if she wished to provide a statement to include at the beginning of this report, to give further insight. The below is the statement which was provided.

> *Louise was my amazing daughter, the one in the middle of her siblings, and a fantastic mother. Louise's personality was bubbly, smiley, loyal, fun, caring and had the kindest of hearts. She would always put her children first in every situation. Her three children were her world, she went above and beyond to support them. She would never leave them not in a million years. Louise worked so hard to give them the best possible start in life.*

1. INTRODUCTION

1.1. This Domestic Abuse Death Review (DADR) examines agency responses and support given to ‘Louise’[1], a resident of Huntingdonshire District Council (HDC) prior to her death in August 2020, when she was tragically found hanged in the bathroom of her home.

1.2. In addition to agency involvement, the review will also examine the past history of interactions with Louise to identify any relevant background or trail of abuse before the death, whether support was accessed within the community and whether there were any barriers to accessing support. By taking a holistic approach the review seeks to identify appropriate recommendations to improve service responses and interventions.

1.3. The review will consider agency contact and involvement with Louise and her family from January 2015 to the day of her death, in August 2020. Any relevant facts from their earlier life will be included in background information.

1.4. The key purpose for undertaking DADRs is to enable lessons to be learned from deaths, where a person dies and there is a potential causal link to domestic violence and/or abuse. For these lessons to be learned as widely and thoroughly as possible, professionals need to understand fully what happened in each death, and most importantly, what needs to change to reduce the risk of such tragedies happening in the future.

1.5. One of the operating principles for this review has been to be guided by humanity, compassion, and empathy, with Louise’s ‘voice’ at the heart of the process. This was an appalling tragedy for the family, and through the Chair, the Panel offers heartfelt condolences for their loss.

1.6. In line with best practice principles, the Panel meetings and this report follow the Home Office guidance on both conducting and authorising a Domestic Homicide Review (DHR). In following this best practice, two lovely photographs of Louise were provided to the Panel by her mother. These were used to remind the Panel to keep Louise at the center of their thoughts and evaluations, placing Louise at the center of the Review.

Note

1.7. The victim’s mother chose the pseudonyms for the family used in this report. She did not choose the name used for Louise’s partner at the time of her death, as it felt that this was inappropriate, the name used was chosen by the Chair.

[1] Not her real name, all names used in relation to non-Panel members are Pseudonyms

TIMESCALES

1.8. After the death of Louise, the Chair/Author was appointed to conduct a review into the holistic circumstances of the case preceding her death. This review was commissioned by the Chair of the Huntingdonshire District Council (HDC) Community Safety Partnership (CSP).

1.9. Partners had already been contacted immediately after Louise's death and a scoping exercise had been undertaken. From this exercise the Review Panel was selected, based on those agencies who held information, those agencies which did not hold information but may have been able to assist and those needed for legitimacy of the process were also invited. These agencies were then contacted to seek support for a DADR, and to ensure the securing of any records held.

1.10. The Chair was appointed in February 2021, and a Panel was immediately convened, sitting for the first occasion on 23rd February 2021.

1.11. Prior to this meeting, a draft Terms of Reference (ToR) – Appendix 1 - along with a proposed agenda were circulated to potential Panel Members and the net was thrown wide, in terms of attendance, to ensure the capturing of all possible contact with the family prior to Louise's death. Potential Panel members were also asked to forward the details of any other parties they felt should be present.

1.12. At the first meeting the draft ToR was discussed fully by the Panel and agreed. Chronology reports were commissioned from all identifiable public and voluntary bodies that may have had relevant contact with the family.

1.13. The scope of the review was set as 1st January 2015 – 10th August 2020, after being fully discussed by the Panel. As a result, it was decided to include any information in these reports which existed between those dates, giving an overall circa five-year period. The 1st January 2015 was chosen to ensure all agency communication was captured since Louise commenced her relationship with Paul[2], who was still her partner at the time of her death.

1.14. It was agreed by the Panel that should any issues of concern be identified by any person involved in the DADR, which fell outside of the agreed timescales, then these could be brought to the Panel for discussion, in relation to relevance. During this Review no additional issues were identified which fell outside the agreed timescales.

1.15. No immediate, urgent interventions or actions were identified by Panel members and timescales were set for submission of the Chronologies. Full minutes were recorded, and an Action Tracking system put in place to monitor actions to be completed. This process was applied to all subsequent meetings.

[2] Pseudonym given to Louise's partner at the time of her death

1.16. Once all Chronologies were received, a second Panel was convened and took the opportunity to comprehensively discuss the information that had been collated. As a result of these discussions and the analysis conducted, Individual Management Reviews (IMR) from those agencies who had contact with either Louise or Paul during the Review framework were commissioned.

1.17. A number of Agencies then compiled IMR's and submitted these to the Chair and Panel for discussion at the subsequent Panel meetings. Each of these IMR's were compiled by an independent Author. After analysis of the IMRs, an initial draft of the overview report, which set out the narrative, was considered at the Panel meeting on 26th January 2022.

1.18. A finalised report was agreed on 19th January 2023 by the DADR Panel.

Point of Note;

1.19. Due to the COVID 19 Pandemic, National Lockdown and safeguarding procedures, all Panel meetings were conducted virtually, via Internet enabled video conferencing.

1.20. The majority of Panel Members were working from home during this period and general working practices nationally were being customised to meet safe working guidelines.

1.21. The impact on certain Panel members was clear to see and it is important to acknowledge that the national vaccination programme increased the pressure on those working within the National Health Service in a way never before experienced.

1.22. The author is grateful for all efforts made to meet timescales and attend panel meetings.

CONFIDENTIALITY

1.23. All submitted documentation was password protected from the outset and passwords were only issued to those directly involved in the Panel process.

1.24. The chronologies and IMR's are confidential. Information was available only to participating officers/professionals and their respective line managers. Where possible the Criminal Justice Secure email (CJSM) was used to transfer documentation between parties.

1.25. The Government Protective Marking Scheme (GPMS) was adopted throughout with a rating of 'Official-Sensitive' for shared material. Secure networks were used to transmit documents and where this was not possible, password protection added an appropriate level of security to the documents being shared.

1.26. For ease of reference, all terms suitable for acronym will appear once in full, and also in a glossary at the end of the report.

1.27. The deceased will be referred to herein as Louise. Her partner will be referred to as Paul, in line with the notes section on page 4 of this report.

TERMS OF REFERENCE

1.28. Following discussion of a draft at the first Panel meeting, Terms of Reference (ToR) were issued the following week (Appendix 1) with chronology and IMR templates for completion being shared with partners to aid consistent reporting.

1.29. The ToR was Reviewed at every subsequent Panel meeting.

METHODOLOGY

1.30. Under s9 Domestic Violence, Crime and Victims Act 2004, a Domestic Homicide Review was initially commissioned by Huntingdon District Council Community Safety Partnership, and in February 2021, Helen Collins was appointed Independent Chair of the Panel. Tony Hester supported her throughout in the role of Manager of the process.

1.31. This review was commissioned under Home Office Guidance issued in December 2016. Close attention was paid to the cross-government definition of domestic violence and abuse and is included in the ToR (Appendix 1). The following websites, policies and initiatives have also been used as reference documents;

- HM Government strategy for Ending Violence against Women and Girls 2016-2020[3]
- Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews published by the Home Office December 2016[4]
- Domestic Homicide Reviews: Key Findings from analysis of domestic homicide reviews published by Home Office December 2016[5]
- Huntingdonshire District Council web site[6]

[3] https://www.gov.uk/government/consultations/violence-against-women-and-girls-vawg-call-for-evidence/violence-against-women-and-girls-vawg-strategy-2021-2024-call-for-evidence

[4] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/575273/DHR-Statutory-Guidance-161206.pdf

[5] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/575232/HO-Domestic-Homicide-Review-Analysis-161206.pdf

[6] https://www.huntingdonshire.gov.uk

- Cambridgeshire Police website[7]

1.32. At the first panel meeting a discussion was had to identify any prior Domestic Homicide Review (DHR) reports within the CSP area which may contain lessons learnt pertinent to this review. CSP records were examined, and no repeat lessons or trends were identified which had a bearing on this review. This agenda item remained throughout the panel meetings and was regularly reviewed. It was at this meeting that the title of the Review was changed to that of a Domestic Abuse Death Review (DADR), in line with current professional thinking.

Note

1.33. A DADR is not a formally recognised term within the associated legislation, but recent best practice has emerged to suggest in circumstances such as these, where there is no formal judicial outcome and no offence of Homicide has been identified, it is still appropriate to conduct a 'lessons to be learnt' review. It was from this point of principle that the Panel focused its work.

CONTRIBUTORS TO THE REVIEW and PANEL MEMBERS

1.34. This overview report is an anthology of information and facts from the organisations represented on the Panel, many of which were potential support agencies for Louise and potentially Paul;

Name	Organisation and role
D H (initials only for anonymity)	Mother of Louise
Mandi George	Lead officer for Domestic abuse and safe accommodation for Huntingdonshire District Council
Claudia Deeth	Community Safety Team Leader · Huntingdonshire District Council
Vickie Crompton	Cambridgeshire County Council -Domestic abuse and sexual violence partnership manager
Jenni Brain	Cambridgeshire Constabulary - Police* Review Officer
Alex Dopadlik	Cambridgeshire Constabulary – Police* Investigator
Pushpa Guild	Bedfordshire/Hertfordshire/Cambridgeshire Major Crime Unit – Review Officer, Investigation Review Team

[7] https://www.cambs.police.uk

Linda Coultrup	Named nurse safeguarding adults primary care* - Cambridgeshire and Peterborough CCG
Susie Talbot	Cambridgeshire County Council – Senior Health Improvement Specialist, Drugs and Alcohol Team Manager
Nicky Vidgeon Paul Collin	Joint Heads of Adult safeguarding – Cambridgeshire and Peterborough NHS Foundation Trust
Joseph Davies**	Suicide Prevention Manager for Cambridgeshire and Peterborough, Public Health Directorate
Helen Collins	Independent Chair and report author
Tony Hester	Independent Manager
Kathryn English	Panel Administrator and Secretary

* Agencies providing IMR's
** Co-opted Panel member as required, contributing to the report learning and action plan.

Note

1.35. Overall, Panel contribution was robust and communication between attendees flowed easily, despite the challenge of running the panel in a time of Covid Lockdown and unusual working circumstances. Members embraced the need to keep Louise central to the discussions, and on many occasions (referenced in the minutes) attendees held each other to account, with robust exchanges taking place.

1.36. The Authors of the IMR's were confirmed to the Panel as completely independent of the those involved in any interactions relating to this case.

Author of the overview report

1.37. Helen Collins is the author of this overview report. She is a former senior police officer who had never worked within the HDC area.

1.38. She was appointed as the independent Chair of the DADR Panel having not been involved in policing since retirement from service in 2019.

1.39. Set out for reference in Appendix 2 are the full respective backgrounds and 'independence statements' for Helen Collins and Tony Hester who managed the Review process and conducted liaison with the CSP and Panel. They have jointly been involved in 11 DHR/DADR Reviews in the last 12 months.

1.40. Both have conducted the Home Office DHR online training and attended numerous Advocacy After Fatal Domestic Abuse (AAFDA) events between them, including the recent monthly update events.

Parallel reviews/investigations/court proceedings

1.41. At the first Panel meeting the Chair asked for disclosure of all current, pending or completed Reviews in relation to the death of Louise.

1.42. No information of a similar case was found which had a bearing on this case.

1.43. There were no Criminal or Judicial processes to complete before the Chair was appointed and it was confirmed there was no necessity for a Safeguarding Adult Review under points 6 and 7 of the ToR.

1.44. There were also no misconduct investigations pending, in relation to any participating organisations.

1.45. Unfortunately, it was identified early on in the process that the local Coroner had not been informed of the review being commissioned and had already progressed to setting a date for inquest in October 2021. An intervention was made, and contact established with the presiding Coroner. After discussions, facilitated by the designated Coroner's Officer, the date for the Inquest was suspended to allow both processes to run concurrently, and smoothly. This was communicated to Louise's mother who although disappointed, was fully supportive.

1.46. Once the final version of this Review report is agreed, a copy will be shared with the Coroner and the Inquest date will be set.

1.47. HM Coroner has been kept informed throughout this process.

1.48. In relation to Louise's partner Paul, although interviewed by police at the time of the death being investigated, he has refused to co-operate with any review or inquest. He did not respond to letters, phone calls or text messages. Louise's mother has no contact with him, nor her youngest grandchild and was also unable to facilitate contact.

1.49. Friends of Louise and relatives of Paul, who attended her house the night before her death spoke to the Coroner's Officer and brief accounts of the evening were obtained, but no detail of previous incidents of concern within the family were recorded. In total the three statements obtained amounted to less than one side of A4 paper.

1.50. The Chair thanks the Coroner and their Officers for their support and assistance in this Review, particularly in relation to sharing the accounts they had gathered from Louise's friends.

EQUALITY AND DIVERSITY

1.51. Consideration has been given to the nine protected characteristics under the Equality Act 2010 in evaluating the various services provided, and have been regularly revisited throughout the Review. The below is a synopsis for each category:

1.52. Age – Louise was a 29 year old woman, at the time of her tragic death. Louise had three children, two with her previous husband and one with Paul. These children were all under the age of 10 years at the time of the Panel sitting. From this information no age-related issues were identified.

1.53. However, research suggests that age difference can be seen to create a further power imbalance[8] and this was classed as insignificant in this case. Louise was of the average age of women to be more likely to be victims of any domestic abuse in the last year of her relationship[9]. Statistically, an estimated 28.4% of women aged 16 to 59 years have experienced some form of domestic abuse since the age of 16 years[10] (Office of National Statistics, 2019).

1.54. Disability – The Equality Act 2010 defines **disability** as: “A physical or mental impairment that has a 'substantial' and 'long-term' negative effect on a person's ability to do normal daily activities.” There is no information to suggest Louise fell into this definition relating to physical disability and this was discussed with and confirmed by her mother.

1.55. Louise’s mother stated that she had suffered from mental health issues during her teenage years, and at the time of her death, she was receiving treatment for low mood.

1.56. Gender reassignment – Not Applicable to this review

1.57. Marriage and civil partnership – Louise had previously been married to the father of her two eldest children and had remained in an amicable relationship with him post their divorce. There was no formal civil partnership in place with Paul.

1.58. Pregnancy and maternity – During their relationship Louise became pregnant by Paul. As part of her maternity care Louise should have been asked about any abuse within her relationship. Louise’s pregnancies were uneventful and she attended anti-natal appointments.

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[8] Barter, C., McCarry, M., Berridge, D. and Evans, K. (2009). *Partner Exploitation and Violence in Teenage Intimate Relationships*. London: NSPCC

[9]https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/domesticabusevictimcharacteristicsenglandandwales/yearendingmarch2019

[10] https://www.womensaid.org.uk/information-support/what-is-domestic-abuse/myths

1.59. Race – Both Louise and Paul were of White British Heritage.

1.60. Religion or belief – The couples’ religious beliefs are unknown and are not believed to have had a bearing on the events being reviewed.

1.61. Sex – Louise was female, and Paul is male. Records show that the majority (74%) of victims of domestic homicide were female and that 80% of that number were killed by a partner or ex-partner.[11] Percentages for persons taking their own life can be found on the Samaritans web site for 2020[12] and show the male suicide rate was 15.3 per 100,000* compared to the female suicide rate of 4.9 per 100,000[13]. For Louise’s age range the following statistics are recorded by the Samaritans.

1.62.

England	**2018**			**2019**			**2020**		
Number of deaths for persons aged 10+	Overall 5,021	Male 3,800	Female 1,221	Overall 5,316	Male 4,017	Female 1,299	Overall 4,912	Male 3,682	Female 1,230
Number of deaths by age group **25-29 yrs.**	391	294	97	464	349	115	393	288	105

[redacted]

1.63. There is currently no published data for 2021.

1.64. Sexual orientation – the sexual orientation for each is believed to have been heterosexual.

Other factors discussed of Note

1.65. The Panel have discussed whether there is evidence of differential service or ‘conscious/unconscious bias[14]’ from any public body for anyone subject of this report. There is nothing obvious, but stereotypical assumptions can never be ruled out completely. Any intersectionality of the applicable protected characteristics will be explored further in the report.

1.66. Victim blaming has in recent years been increasingly researched and is now understood in a much wider context within society and professional organisations.

1.67. Victim blaming can be identified[15] as the following,

[11] Office for National Statistics, Homicide in England and Wales - year ending March 2018, www.ons.gov.uk
[12] https://www.samaritans.org/about-samaritans/research-policy/suicide-facts-and-figures/latest-suicide-data/
[13] It is important to note, that these deaths didn't all happen in 2020, and we will not know how many did until all deaths are officially registered- this can sometimes take a year or more.
[14] https://www.qualityinteractions.com/blog/unconscious-bias-in-healthcare
[15] http://psychology.iresearchnet.com/social-psychology/social-cognition/blaming-the-victim/

> *Blaming the victim occurs when people hold the victim responsible for his or her suffering. When people blame the victim, they attribute the cause of the victim's suffering to the behaviours or characteristics of the victim, instead of attributing the cause to a perpetrator or situational factors.*
>
> *Ironically, victim blame often stems from a desire to see the world as a just and fair place where people get what they deserve. This belief in a just world lets people confront the world as though it were stable and orderly.*
>
> *By derogating victims and blaming them for their negative outcomes, people can maintain the belief that the world is a fair place after all.*

1.68. This concept was fully discussed by the Panel at the outset of the Review. It has been held as a core challenge point by members from a position of internal and personal challenge, in both the information they received and the discussions which took place. The Chair was keen to avoid victim blaming at all cost and can report that there was no evidence this took place either within the Panel meetings or in the documentation submitted.

Coercive control – in this case

1.69. Coercive control is a strategic form of ongoing oppression used to instil fear and self-doubt. The alleged abuser, in this case Paul, will use tactics, such as monitoring all communication and movements, as a controlling effort, to manipulate the relationship.

1.70. There are a number of indicators that are recognised by health professionals as indicators of coercive control, in the case of Louise and Paul the following examples apply.

1.71. Monitoring activity – Friends clearly state that Louise was scared of staying out too late away from Paul and that he would constantly call and text her while she was away from him.

1.72. Isolating from support system – Louise and Paul separated on numerous occasions, in the eight years they were together however, Louise appears to have been so isolated and dependent on Paul, she often took him back.

1.73. Controlling behaviour – Paul appears to have removed access to Louise’s car keys and vehicle from her on regular occasions to stop her leaving the location of her home. Also in relation to this category is the fact that Paul would bombard Louise with emails and text messages (information provided by Louise’s mother) when they were separated.

1.74. Financial control – Paul did not contribute financial support to the family and used Louise's income to supplement his own.

1.75. Getting out – There is evidence further on in this report of Louise being monitored by Paul in terms of her movements and actions. This links to Paul monitoring Louise's activity.

1.76. Given previous information regarding controlling behaviour by Paul towards Louise the Chair of the Panel asked to see the internal review of the information held by Cambridgeshire Constabulary into the death of Louise, in order to ensure that all criminal justice options had been explored. This was received and had been conducted by the responsible Detective Chief Inspector. This demonstrated a comprehensive review by the Senior Investigating officer into offences of coercive and controlling behaviour after Louise's death. This internal review deemed that there was insufficient evidence to pursue any criminal offences.

1.77. This behaviour is further explored in the report under the section relating to friends and family.

Alcohol as a coping mechanism in abusive relationships

1.78. During their time together Louise and Paul appear to have been regular drinkers of alcohol[16]. In 2006 the World Health Organisation (WHO) published a paper on 'Intimate partner violence and alcohol'[17] In this paper they state that frequent heavy drinking can create an unhappy, stressful partnership that increases the risk of conflict and violence. On page three of this report there is a clear assertion that,

Experiencing violence within a relationship can lead to alcohol consumption as a method of coping or self-medicating

1.79. In terms of the impact of alcohol in relation to intimate partner violence, including coercive controlling behaviour, these can be wide ranging, including,

for the victim, health effects include physical injury (which for some women may lead to pregnancy complications or miscarriage), emotional problems leading to suicide, suicidal ideation and depression, and alcohol or drug abuse as a method of coping

1.80. In terms of policy this report states that,

Both the harmful and hazardous use of alcohol and intimate partner violence have recognised internationally as key public health issues requiring urgent attention.

[16] Confirmed by Louise's mother
[17] https://www.who.int/violence_injury_prevention/violence/world_report/factsheets/fs_intimate.pdf

1.81. It is widely accepted that excessive drinking can exacerbate financial difficulties within a family setting and so begins a potential negative spiral of behaviour.

1.82. It is evident from all of the documentation provided to the Author, and the accounts of Louise's mother, that both Paul and Louise drank alcohol regularly, however it appears that this is seen as nothing unusual or concerning for Louise by the agencies providing information to this review, not potentially as a coping mechanism in relation to Paul's behaviour towards her.

1.83. In their paper, 'Roles of Alcohol in Intimate Partner Abuse'[18], Alcohol Change published a very important key finding,
There were clear indications of intertwined cultural, sub-cultural, familial and contextual influences on gender and alcohol use, such that when women were drinking, they were held more accountable for any relationship conflict (victim blaming), whilst if men were drinking, they were held to be less accountable (accused excusing).

1.84. The Author would draw the attention of the reader to this finding whilst reading the information which is contained in the section of this report relating to what was known by agencies.

1.85. Also of note is the current guidance from the Chief Medical Officer (UK), which states,

- The recommended maximum alcohol intake in the UK is no more than 14 units a week for both men and women, with two or more drink-free days in the week.
- This was the recommended guidance during the timescale of this DADR.
- Problem drinking is defined as regular consumption of alcohol above recommended levels.

1.86. Due to the fact that alcohol was clearly mentioned by all parties at the gathering the night before Louise's death, this issue was looked into by the Panel. There was no indication that Louise abused alcohol at chronic levels, however it can be asserted that alcohol was used by Louise in order to help her cope with her relationship with Paul. This issue was discussed with Louise's mother who concurred with this assertion.

Further contextual information

- On average victims at high risk of serious harm or murder live with domestic abuse for 2-3 years before getting help
- 85% of victims sought help five times on average from professionals in the year before they got effective help to stop the abuse

[18] https://alcoholchange.org.uk/publication/roles-of-alcohol-in-intimate-partner-abuse

- Women are much more likely than men to be the victims of high risk or severe domestic abuse: 95% of those going to MARAC or accessing an IDVA service are women[19]

INVOLVEMENT OF FAMILY, FRIENDS, WORK COLLEAGUES, NEIGHBOURS AND WIDER COMMUNITY

1.87. Prior to the Panel meeting in February 2021, Cambridgeshire Constabulary (CC) had deployed officers to the family of Louise, in line with the College of Policing guidance documents[20]. Although not a formal Liaison officer (due to the circumstances of Louise's death) this is good practice in all such incidents and allowed the panel to have an initial view into the family thinking.

1.88. Once the first Panel had sat, the details of family members were passed to the Chair and Louise's mother was contacted. Regular dialogue between Louise's mother and the Chair took place, and in this way, Louise was heard at the Panel through the voice of her mother who was willing to let her conversations with the Chair be fully shared.

1.89. The Chair and Louise's mother have been in contact throughout the period of the review and have met via Zoom internet meetings, as well as communicating on the telephone and via email.

1.90. Louise's mother has been thoroughly supportive of the review process. The Panel would like to formally thank her for engaging so fully with the process and being candid in her disclosures. She has acted as a conduit into her wider family and has enabled a wider and richer picture of Louise to be obtained. It is acknowledged how difficult this must have been for her and the Panel passes on their thanks for her engagement throughout the Review.

1.91. Advocacy information, counselling services in the local area and appropriate personal support has been shared with Louise's mother throughout, and this included local support services for her grandchildren.

1.92. Louise's mother was asked if she wished to participate in the panel process and/or attend any of the panel meetings. After deliberating on this she decided that she did not wish to attend any of the meetings or contribute in person, other than through the Chair.

1.93. Once the final draft of this report was completed a meeting between the Author and Louise's mother was held in December 2022. At this meeting the report was gone through in detail, any questions were answered, and the next steps of the process explained in detail. Louise's mother expressed her gratitude to the Panel for their work

[19] SafeLives - https://safelives.org.uk/
[20] https://www.college.police.uk

and was supportive of the findings. During this meeting no further information came to light.

1.94. Friends and colleagues of Louise contributed to the Review after contact by her mother and gave permission for the Author to use the information provided by them, these contributions can be found can be found at page 24 and page 25. They did not wish to speak to the author so all communications were facilitated through Louise's mother. The Home Office leaflet was supplied to Louise's mother to pass on to these contributors. They did not request advocacy.

11. DISSEMINATION

1.95. Initial dissemination of documents was restricted to Panel Members. The draft report was circulated for factual accuracy and proofing to the Panel.

1.96. The intended recipients of copies of the final, agreed report, once approved by the CSP and Home Office Quality Assurance Panel, are listed at the end of the review after the glossary. See Page 50.

2. BACKGROUND INFORMATION (THE FACTS)

2.1 Louise was from a white British family and was born in 1991. She had 3 siblings, two older and one younger, and with them she attended local schools. It was during her schooling that Louise started to strike out on her own and is described by her mother at this time as 'strong willed'.

2.2 On leaving school she attended a local college to study Beauty, on leaving college Louise went straight into the workplace and worked at a property agency. Louise is described as being very hard working and having a strong work ethic.

2.3 Louise married her husband in 2014, at the age of 23yrs. During the marriage Louise and her husband (Brian) had 2 children but the relationship came to an end and Louise and her ex-husband had joint care of the children by mutual agreement. Since Louise's death, Brian has full custody of his children and both he and they have a full and meaningful relationship with Louise's family.

2.4 Louise met Paul through a mutual friend, and they began a relationship in 2016, after she had separated from her husband. Together they had a further child, a girl. It appears that this relationship started to show signs of strain from the outset. Louise and Paul did not live together at the time of her death, but had previously co-habited intermittently.

2.5 In terms of employment, at the time of her death, Louise was employed as an assistant at a local General Practice surgery and was well thought of by all the staff. Due to the Covid Pandemic, which was prevalent at the time, Louise had been furloughed and had only recently returned to work after the easing of Lockdown 3 restrictions when she died.

2.6 In the weeks before the tragic loss of Louise, she had been described by friends as happy and very excited about moving into her new home with her children. On the night before her death a gathering/party had been held at her house. Present at this event were her partner Paul, and three friends/relatives of Paul. It would appear that Louise did not know the guests very well.

2.7 From enquiries made and accounts taken by the Police, during this evening Louise became agitated and went upstairs. Sometime later she contacted Paul by text message and he reportedly went to her son's bedroom where he found her with a length of electrical cord around her neck, threatening to harm herself.

2.8 Paul removed the cord, and assisted her to her own bed, where he reassured her after she apologised for her actions. Paul then removed all of the extension leads from the upstairs of the house as a preventative measure.

2.9 No further interventions were made with Louise by the attendees at the gathering. No Calls were made to her family to inform them of her state of mind and no professional agencies were contacted.

2.10 At some stage Paul left the house with his daughter leaving Louise alone in the premises, this is believed to have occurred the following morning.

2.11 On 10th August 2020, Police were contacted by Louise's mother reporting welfare concerns for her daughter after she had failed to attend work that day. On Police attendance Louise was found deceased, along with a note stating 'He' had ruined her life and had taken her phone and keys.

INFORMATION FROM FAMILY, FRIENDS and OTHER AGENCIES

Louise's Mother and children

2.12 On speaking to the Chair of the Panel, Louise's mother provided a comprehensive account of events leading up to her daughter's death. These mirrored the information collated by Cambridgeshire Constabulary. She had a number of unanswered questions surrounding her daughter's death and the purpose and scope of the review was explained to her in order to manage any expectations in relation to a reinvestigation. It was clarified that this report is a review of what was known at the time of her daughter's death, and not a reinvestigation in any way. The impact on Louise's children was discussed at length with Louise's mother and she strongly felt that the children should not be spoken to as part of this review. This view was relayed to the panel and it was agreed unanimously that there would be no benefit in speaking to Louis's children and that contact could re-traumatise them inappropriately having taken advice from Children's services.

2.13 Louise's mother also supplied the Chair with several documents she was in possession of, relating to her daughter's health.

2.14 The extra context she gave is summarised in the following points,

- Louise's mum describes Louise as funny, kind, caring and always helping others before herself whilst being very hardworking. She went on to say she was a brilliant mother who always put her children first.
- Louise was one of three siblings.
- Louise and her ex-husband were described as being childhood sweethearts, and when the relationship broke down, Louise moved away with her two children at that time.
- Whilst working at an estate agency Louise suffered a period of mental ill health for which she sought treatment. This is confirmed in medical records.
- In 2015 when Louise threatened to take her own life and suffered from suicidal ideation, she was found by Police, returned home, and received two sessions of counselling, but was not placed on a Mental Health Section. (This is corroborated from information received from both the Police and the NHS)

- Louise was admitted to Lincoln hospital on one occasion after taking too many tablets (type unknown by mother), and on returning home was visited by her mother who found her to be untruthful in her account of events. As a result, Louise's mother watched her around the clock for a period of approximately one month and hid all her medication and knives in the house. At this point Louise was diagnosed as having a mental health crisis. (This is confirmed in the NHS records)
- Louise's mother disclosed that Paul was not fond of Louise's two children (Years of Birth - 2011 and 2014), but that Louise loved him, and that the relationship could be described as 'on-off' for a significant period.
- There had been no suicide attempts by Louise since 2015.
- Paul was out of work for long periods of time, although employed at the time of Louise's death, this must have caused financial strain, as he never paid any household bills or for food as far as she was aware.
- Louise's mother stated she believed Paul had a problem with Cocaine, she had personally seen evidence of this in Louise's house, and she had seen text messages to Louise about him taking drugs. Both Paul and Louise liked to gamble on their phones as a hobby, however Paul took this further and used all of his wages on gambling and having a good time, for example at Christmas in 2019 Louise's mother is aware that Paul had earned over £2000 but stated he had no money and did not buy Christmas presents for the children.
- During lockdown, it was discussed between Louise and her mother that she wished to move and rent a bigger house. As a result, her mother acted as guarantor for the rent of £700pm on a three bedroomed house and spent £6000 on fixtures and fittings. It was agreed Paul would not move in and Louise viewed this as a fresh start for herself and her children.

2.15 Overall, Louise's mum described the relationship between the parties as follows,

Their relationship was a nightmare, she wouldn't listen to me and they fell out hundreds of times. Every time he left her, she took him back, and even though, when I got a new partner and moved to Nottingham, she would still ask to borrow money from me. This was because he controlled her money and she was heavily in debt. On occasions he would not let her leave the house, or if he did it would only be for an hour or so.

When they fell out, which was all the time, they blocked each other, so he would always send an email to Louise.[21]

2.16 Louise's mum is firmly of the view that Paul was a controlling individual and had some sort of hold over Louise. She shared a note she had found on Louise's phone after her death, which is undated. This note says,

"He makes me out to be the worst person. In the world and all I ever did was try. All because I didn't want to be with him anymore. Im sorry mum" (Exactly as written)

Paul – Louise's partner

[21] Emails provided by Louise's mother directly from Louise's account – see email chain as example of communications Appendix 2

2.17 Attempts were made by the Chair to contact Paul by email. When he did not respond the Chair asked the Coroner, via the appointed Coroners Officer, to help in arranging contact and/or to attempt to mediate a meeting. This was unsuccessful. In May 2021 the Coroners Officer made a further attempt to gain contact on the Chair's behalf and again this was unsuccessful. The Chair is incredibly grateful for all the attempts and assistance provided by the Coroner in this matter.

Relationship history – coercive and controlling behaviour

2.18 The panel sought to gain an understanding of the relationship between Paul and Louise from all of the information gathered. Below is the account Paul gave to police on being interviewed after Louise's death via video recording.

2.19 In this interview Paul confirmed he had previously lived with Louise and was fully aware that she suffered from depression. He stated Louise had recently had her anti-depressant dosage increased. After Louise moved to her new address, he was no longer living with her, but he was still trying to support her, so they agreed to spend the weekend of 7th - 9th August 2021 together, so he could assist with setting up the home. He confirmed they had shared care of their daughter.

2.20 On the night before Louise's death, Paul's brother and cousin were invited to attend the address for a housewarming celebration. He confirmed Louise's two older children were not present and were with their father, Brian, for the weekend. He went on to say that the group all consumed alcohol and were in good spirits. At some point in the evening, Paul states he received a text message from Louise (after she had gone upstairs) where she threatened to kill herself. He went to find her and found her on her son's bed with an extension cable around her neck which she was pulling. All cables were then removed by him and he confirmed there had been no argument or altercation to precipitate this behaviour. He stated he did not consider it necessary to seek medical assistance for Louise at this time.

2.21 In his account Paul states Louise had consumed a bottle of wine and some Gin that evening. The following morning, Paul alleges Louise was hysterical and erratic, shouting and insisting he left the property with their daughter. Paul states Louise had packed a bag for her daughter and Paul took this with him, on checking the bag he stated he found Louise's mobile phone. On leaving the address Paul stated he went to his mother's address and stayed there until he attended work on 10th August 2021.

2.22 This account appears to paint a significantly different picture to that which the Panel formulated about Paul from the information gathered. It is a very bland account and gives little context to the events surrounding Louise's death.

2.23 What was clear to the Panel was that Louise was the subject of coercive and controlling behaviour[22] at the hands of Paul.

[22] How to recognise coercive control https://www.healthline.com/health/coercive-control

2.24 Coercive control is a strategic form of ongoing oppression used to instil fear and self-doubt in the victim. The abuser, in this case Paul, will use tactics, such as monitoring all communication and movements, as a controlling tactic.

There are a number of indicators that are recognised by health professionals as indicators of coercive control, in the case of Louise and Paul the following applied.

2.25 Monitoring activity – Both Louise's mother and friends confirmed that Paul was constantly monitoring Louise's activity by both email and phone call/text message. Numerous emails and text messages were found after Louise's death which suggest this behaviour was excessive and these electronic communications were abusive and threatening – these text messages were seen by Louise's mother. Examples include, ‘’you can run but you can't hide' and 'you will never leave me' – (Messages sent from Paul to Louise)

2.26 Isolating from support system – this is evidenced by the accounts given by Louise's friends and her mother. If Louise did go out with friends, she was constantly monitored by Paul through phone calls and text messages. If Louise did not reply to his text messages immediately Paul became angry and therefore, she would have to leave early to get back to Paul. Louise lived some distance from her family and through Paul's controlling behaviour, it appears she was not able to build strong friendship groups near her home.

2.27 Paul and Louise separated on numerous occasions, but Louise appears to be so isolated and dependent on Paul, she often took him back, which is a frequent indicator of controlling behaviour.

2.28 Controlling money – although the father of Louise's youngest daughter, Paul appears to have contributed little to the family in terms of financial support. When moving into her new home, Louise borrowed money from her mother to make her new home comfortable for her family. Paul gambled (there is no evidence addiction) and appears to have kept his money to himself. Paul often took money from Louise, which left her short of financial resources and she would have to ask her mother for assistance. For example, he insisted she paid his car tax, insurance and loan. This means of controlling Louise's ability to be independent financially had significant consequences for her and her children. Without access to money and the things that money can buy, it is difficult to leave an abuser and access safety. Someone experiencing this type of abuse can become trapped in a relationship with the abuser, unable to resist the abuser's control and at risk of further

2.29 Independence – On at least one occasion it was recorded that Paul had taken Louise's car and therefore had stopped her going about her normal business. On the day of her death, he left Louise's house and took her car keys with him along with her mobile telephone, he states this was an accident, but in the tragic note Louise left at the time of her death, she specifically comments on this fact and that in taking these items he

had caused her distress. She also indicates that this had happened before. By taking such items, this can be viewed as showing a 'powerplay', where Louise had to contact Paul to retrieve them to carry on her day-to-day life. Something Louise's mother stated was a common tactic for Paul to use.

2.30 The removal of her car and car keys affected not only Louise but also significantly her son, who suffered from rheumatoid arthritis, which meant he could not get to school on occasions. Louise's mother also stated that Paul would regularly remove her car keys so she could not leave the house.

2.31 Overall, Louise made specific reference to Paul's controlling behaviour in February 2020 after she reported a verbal domestic incident with Paul. In reporting this incident to the Police, she described him as both controlling and manipulative. She also stated he had the potential to become violent. It is also relevant to note that Louise was at her happiest (as stated by her friends) when Paul was not living with her.

Guests at Louise's house

2.32 In trying to gain a greater understanding of the events of the night prior to Louise's death and the context of her relationship, the friends who were in attendance at Louise's home the night before she died were contacted to see if they would be agreeable to engage with the review. When no responses were received the Chair requested to examine any police statements that were available, as well as contacting the Coroner, to see if subsequent contact had been made with these parties in preparation for the inquest.

2.33 The statements gathered by the Police were made available to the panel immediately, however it became very apparent that the attendees that night were not willing to engage in any formal process.

2.34 The Coroner had also found it extremely difficult to gain contact and had no traction with any of the guests at the gathering. After providing very scant information in March 2021 to a Coroners officer no further contact was established. The information gathered is summarised below.

Attendee 1 (female)

2.35 This account is seven lines long, stating she arrived at Louise's house on the night in question and found Louise to be very excited to show her around as she had only recently moved to that address. She spent time with Louise putting furniture together, they had a few drinks and were having a 'giggle' together. Louise then went upstairs and she went to sleep in the lounge.

Attendee 2 (male)

2.36 This account is eight lines long and states he attended Louise’s address in company with Attendee 1. He confirms that flat pack furniture was built and at some point, the 3rd attendee arrived, this being a cousin of himself and Paul. He confirms Paul’s presence and that alcohol was consumed by the group. He went on to state ‘Louise seemed her normal self it was no different to other evenings we have spent together’.

Attendee 3 (female)

2.37 This account comprises of thirteen lines and confirms the accounts of attendees 1 and 2. However she gives a little more insight into Louise’s state of mind stating, ‘Louise was keen to show me around the house that she had just moved to. She seemed very proud. Louise talked to me about her kids and work whom she also seemed very proud of. We all was in good spirits having not seen each other for a while.’ This attendee did not stay the night.

2.38 Overall, it is interesting to note that none of the guests that night mention Paul having to assist Louise, after he reportedly found her with the cord around her neck. It seems implausible that this could have happened, given he had reportedly removed all of the electrical flexes from the first floor of the house and this was not mentioned/discussed when he returned to the group. These accounts are at best perfunctory and at worst highly sanitised.

Friends and work colleague

Friend 1

2.39 This friend describes Louise as being excited to move into her new house and states she kept in touch with her through WhatsApp, which was a particularly good way of staying in touch during lockdown. On moving into her new house Friend 1 assisted Louise and talked to her extensively about future plans including Christmas. She describes Louise as the happiest she had ever seen her just before her death. She confirms Louise did not see Paul as part of her future life but gives no indication of the state of their relationship.

Friend 2

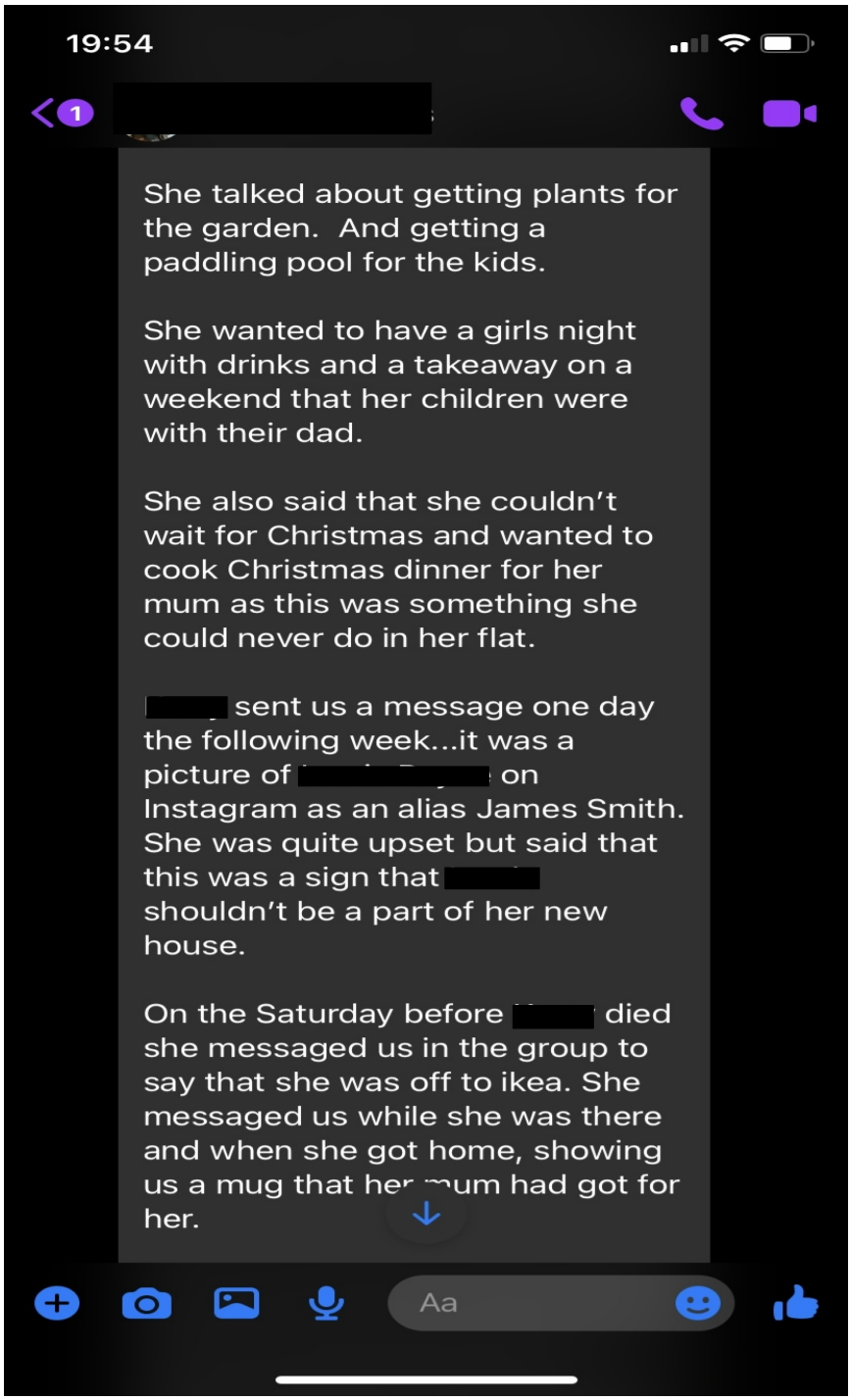
2.40 This friend describes how she met Louise through their children and being pregnant together. She describes Louise as hard working and loving her job at the GP surgery because it allowed her to look after her children, as she didn’t have much support from her on / off partner Paul. This friend describes Louise as doting on her children and stated that she was trying to make her relationship with Paul work for the sake of the youngest child, however Paul was not able to grow up and take responsibility.

2.41 Friend 2 describes 'girls' nights out' where Louise was always the life and soul of the gathering, but that she would receive constant text messages from Paul if she met her friends and would leave early.

2.42 Friends 1 and 2 met with Louise in the Park after the initial lockdown period and Friend 2 describes her as raving about her new house and going to IKEA to buy furniture, she had never seen Louise so happy.

Friend 3

2.43 This friend describes in a text message to a mutual friend (permission obtained to share/publish) Louise's excitement for Christmas and the move to her new house. This text message (redacted) is reproduced in full below.



Work colleague and friend

2.44 This colleague first met Louise when she started working at a local Doctors Surgery as a receptionist 2019.

2.45 Louise was described as a firm favourite with a lot of the patients as she was very bubbly and would do anything to help anyone. She was reliable and very hardworking.

2.46 Louise would be very vocal with regards to her relationship with Paul, one day she would express how in love she was and he was perfect, but a day later that could change and they would be intentionally trying to hurt each other with words.

2.47 Louise did tell her and others that they would both say they had met new partners just to hurt one another.

2.48 On occasions Paul would come into the surgery whilst Louise was working, they seemed very happy on these occasions laughing and joking.

2.49 As a friend she found Louise a lost, beautiful soul who was quite emotional, but put on a hard front to cover this. Louise would be happy one day and crying the next day. If she was happy, she was bouncing around loud and with a constant smile on her face, but if she was sad, it showed, and Louise would seem withdrawn. When asked if she was ok Louise would just say she felt down.

2.50 She went on to describe Louise’s children as being her world and that she would talk proudly of them daily. Everyone would comment on how polite and well-mannered the children were and what a fantastic job she had done raising them.

Other agencies contacted

2.51 In order to gain a holistic view of the relationship between Louise and Paul it was decided to try to approach other agencies who could potentially help give an insight into the relationship.

- The Department of Work and Pensions were contacted and although having records on both parties had no insight to give.
- Refuge and Peterborough Women’s Aid could offer no information or insight.

Suicide prevention and services available

2.52 At the third Panel meeting, a discussion took place about the circumstances of Louise’s death and the current Suicide Prevention Strategy that was being written by the local council. As a result, a meeting was held between the Panel Chair and the leads for this work, Kathy Hartley and Joseph Davies.

2.53 At this meeting, it was apparent a large amount of work was being conducted in terms of suicide prevention and a copy of the final strategy was requested upon completion, along with any other supporting documentation.

2.54 The 'Joint Cambridge and Peterborough Suicide prevention Strategy 2022-2025 Summary' document is about to be published soon, followed by a full strategy which is currently in draft format but will cover themes such as,

- Collaboration between services and joined up working.
- Information sharing and the development of a learning culture.

2.55 The conclusion of the Summary report states,

"This summary outlines our ambition for suicide prevention work in Cambridgeshire and Peterborough in 2022-2025. The priority areas and accompanying recommendations will ensure that the mental health system, wider community and individuals are suicide aware and well equipped to keep everybody, including themselves, safe".

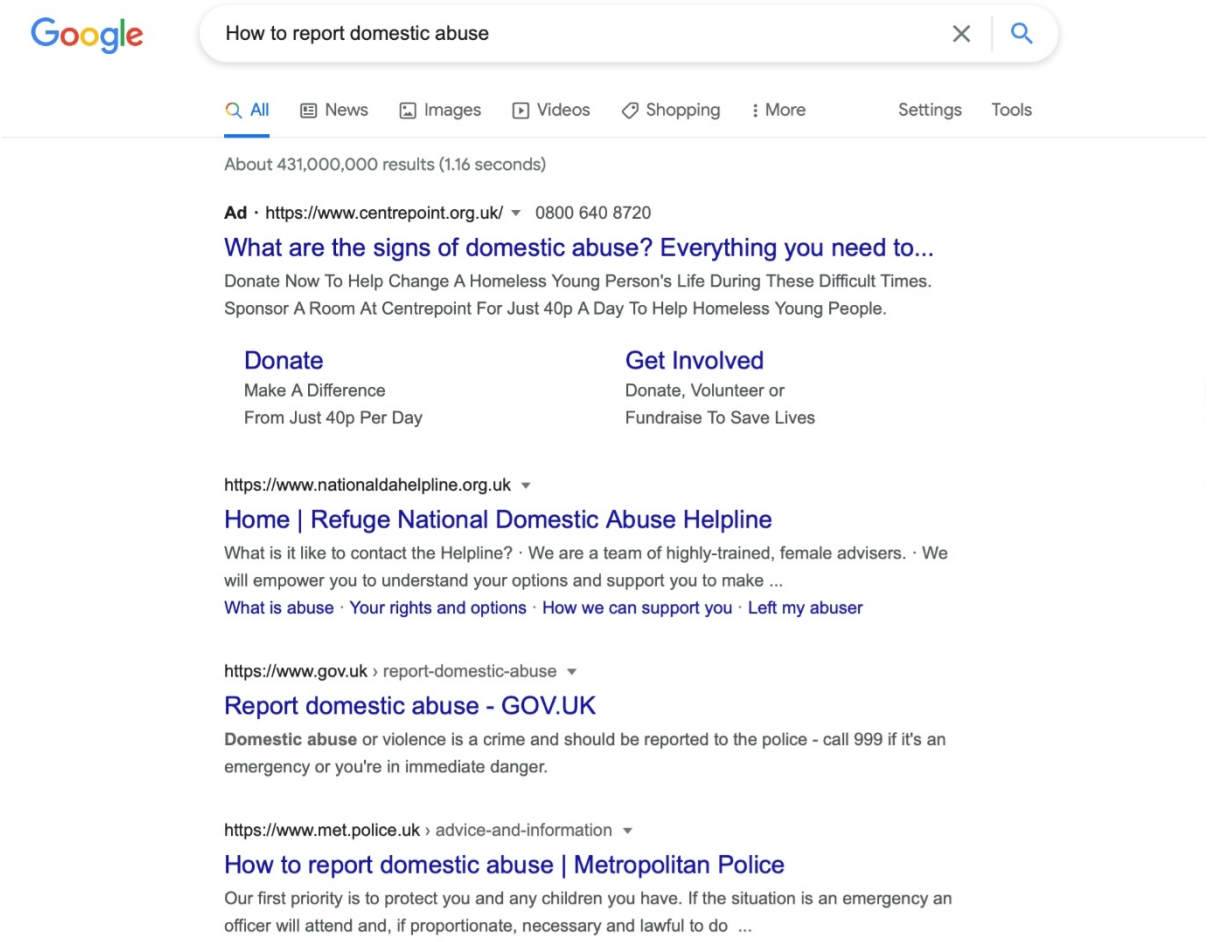
2.56 This indicates a desire and drive in the field of suicide prevention for joined up working and should be seen as good practice.

INFORMATION ACCESSIBILITY

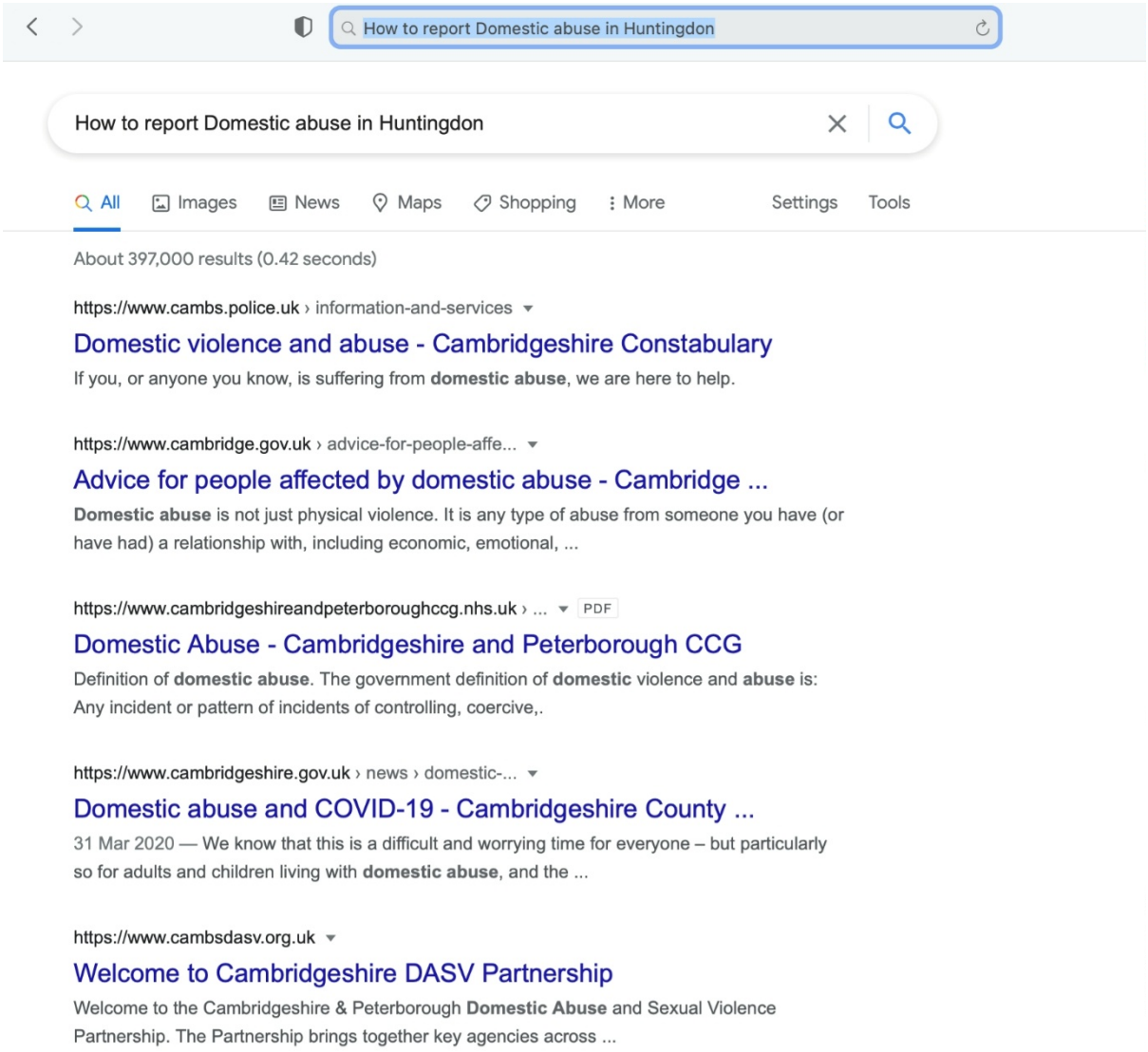
2.57 Having heard the account of Louise's mother and referencing the ToR put in place for this report, the Author conducted open source searching in order to establish if, should

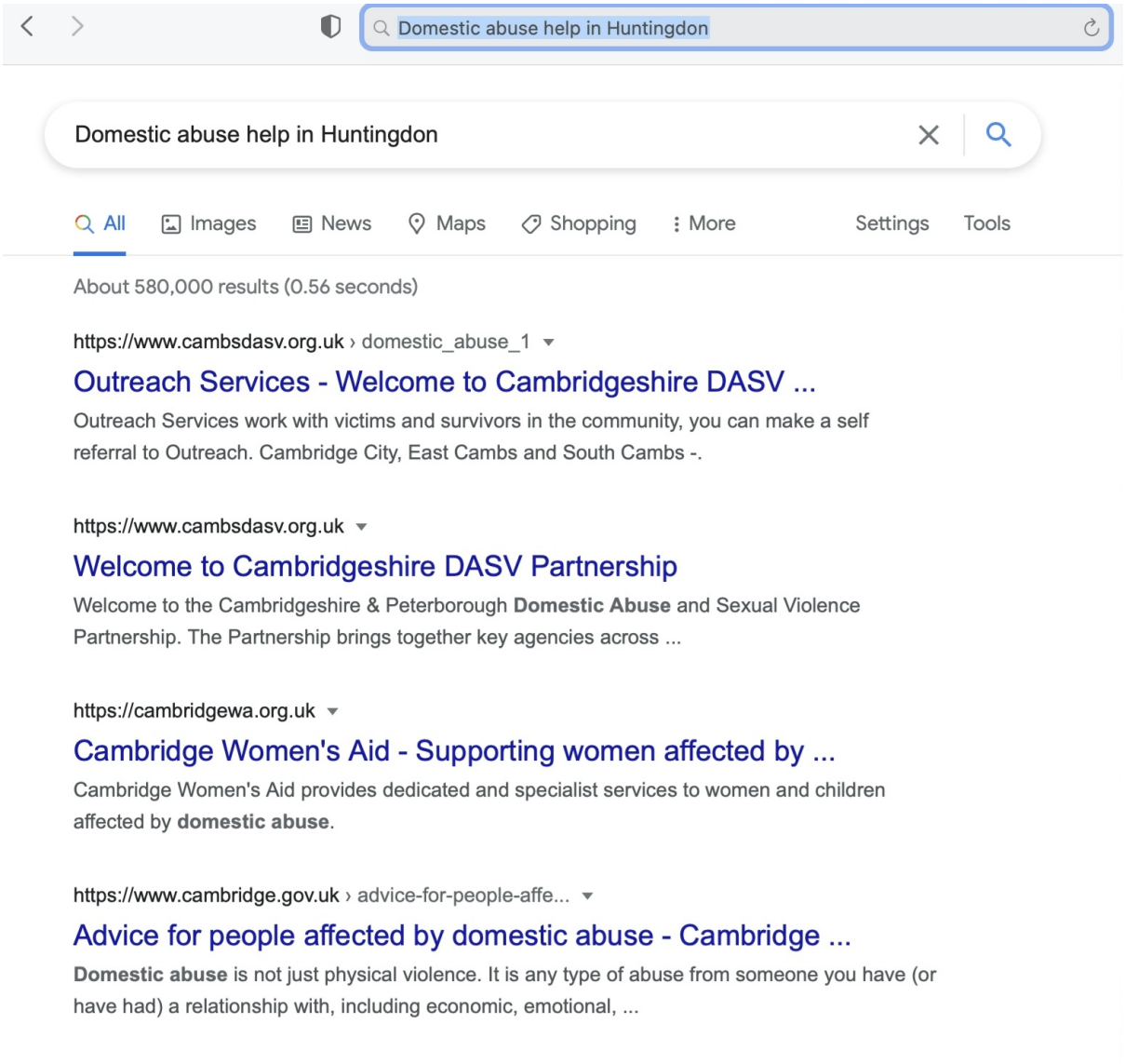
the same situation occur, family and friends could easily access information on how to report suspected Domestic Abuse within the Huntingdonshire area. It should be noted that these searches were not conducted in the run up to, or at the time of Louise's tragic death, but that the below screen shots taken shortly afterwards should be viewed as a window into the information available.

A basic google search shows;

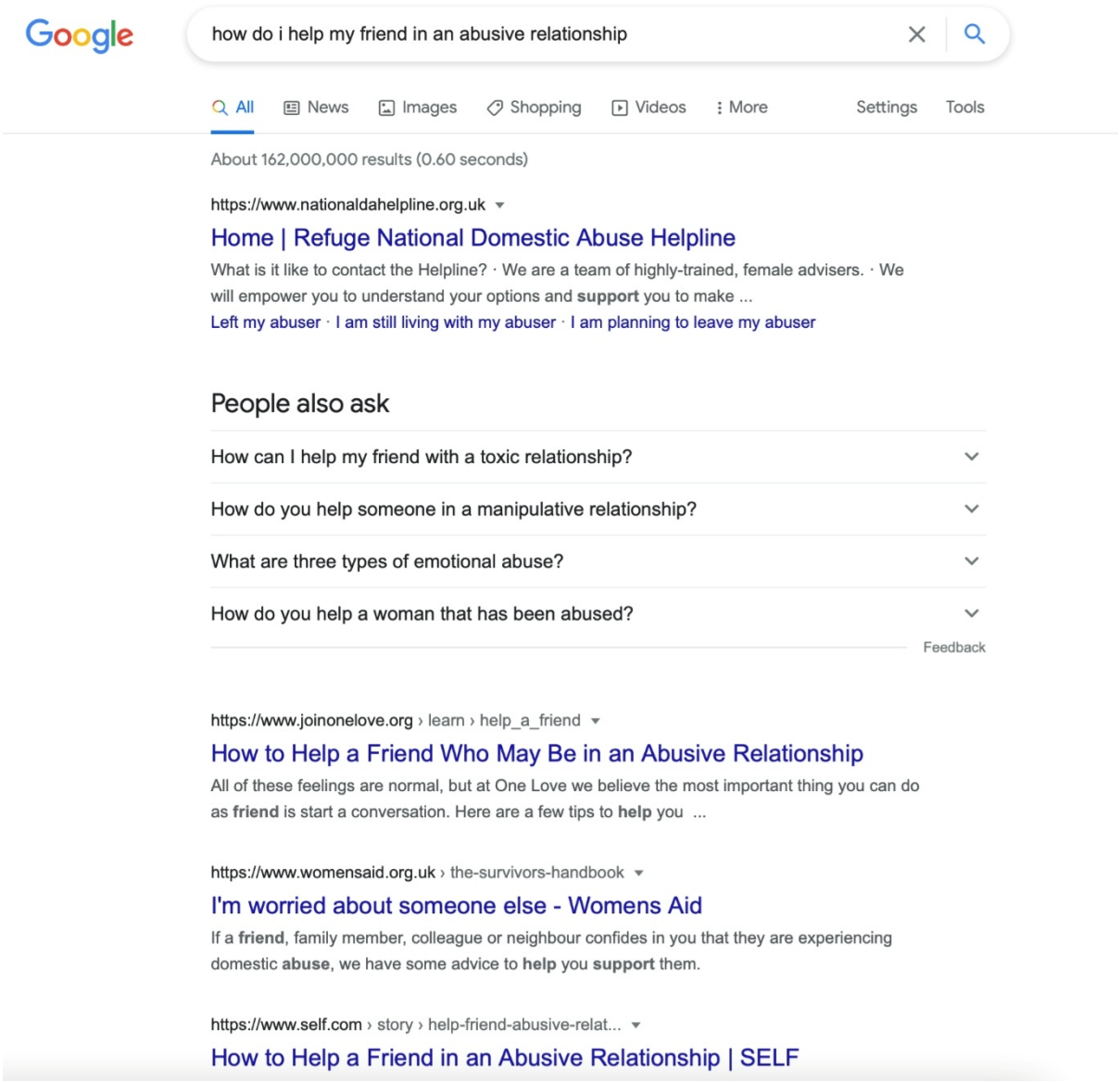


On specifically searching local assistance the following was found;


How to report Domestic abuse in Huntingdon
How to report Domestic abuse in Huntingdon
All
Images
News
Maps
Shopping
More
Settings
Tools
About 397,000 results (0.42 seconds)
https://www.cambs.police.uk › information-and-services
Domestic violence and abuse - Cambridgeshire Constabulary
If you, or anyone you know, is suffering from domestic abuse, we are here to help.
https://www.cambridge.gov.uk › advice-for-people-affe...
Advice for people affected by domestic abuse - Cambridge ...
Domestic abuse is not just physical violence. It is any type of abuse from someone you have (or have had) a relationship with, including economic, emotional, ...
https://www.cambridgeshireandpeterboroughccg.nhs.uk › ... PDF
Domestic Abuse - Cambridgeshire and Peterborough CCG
Definition of domestic abuse. The government definition of domestic violence and abuse is: Any incident or pattern of incidents of controlling, coercive,.
https://www.cambridgeshire.gov.uk › news › domestic-...
Domestic abuse and COVID-19 - Cambridgeshire County ...
31 Mar 2020 — We know that this is a difficult and worrying time for everyone – but particularly so for adults and children living with domestic abuse, and the ...
https://www.cambsdasv.org.uk
Welcome to Cambridgeshire DASV Partnership
Welcome to the Cambridgeshire & Peterborough Domestic Abuse and Sexual Violence Partnership. The Partnership brings together key agencies across ...


Domestic abuse help in Huntingdon
Domestic abuse help in Huntingdon
All
Images
News
Maps
Shopping
More
Settings
Tools
About 580,000 results (0.56 seconds)
https://www.cambsdasv.org.uk › domestic_abuse_1
Outreach Services - Welcome to Cambridgeshire DASV ...
Outreach Services work with victims and survivors in the community, you can make a self referral to Outreach. Cambridge City, East Cambs and South Cambs -.
https://www.cambsdasv.org.uk
Welcome to Cambridgeshire DASV Partnership
Welcome to the Cambridgeshire & Peterborough Domestic Abuse and Sexual Violence Partnership. The Partnership brings together key agencies across ...
https://cambridgewa.org.uk
Cambridge Women's Aid - Supporting women affected by ...
Cambridge Women's Aid provides dedicated and specialist services to women and children affected by domestic abuse.
https://www.cambridge.gov.uk › advice-for-people-affe...
Advice for people affected by domestic abuse - Cambridge ...
Domestic abuse is not just physical violence. It is any type of abuse from someone you have (or have had) a relationship with, including economic, emotional, ...

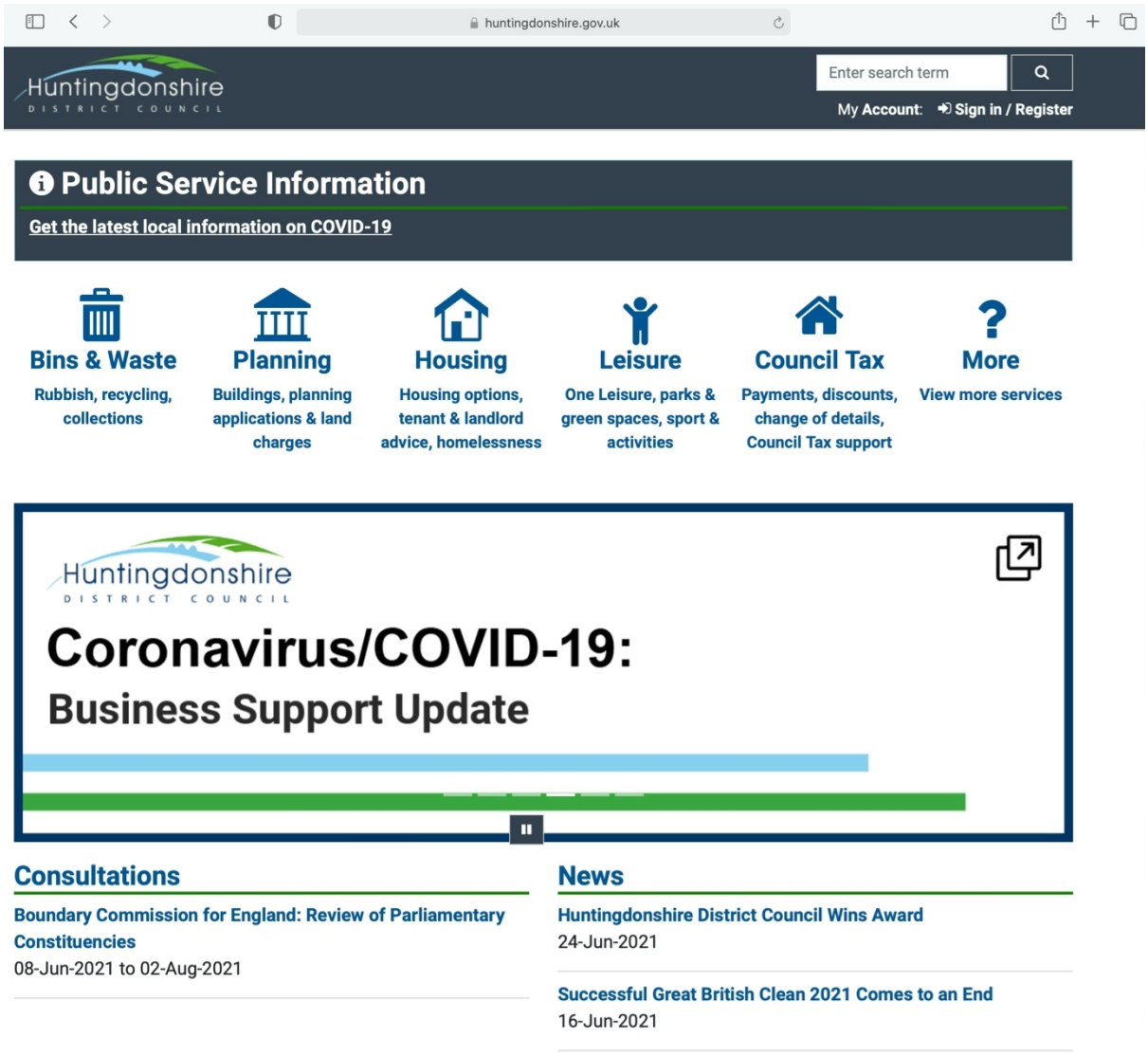
On specifically searching how to help a friend the following is accessed;



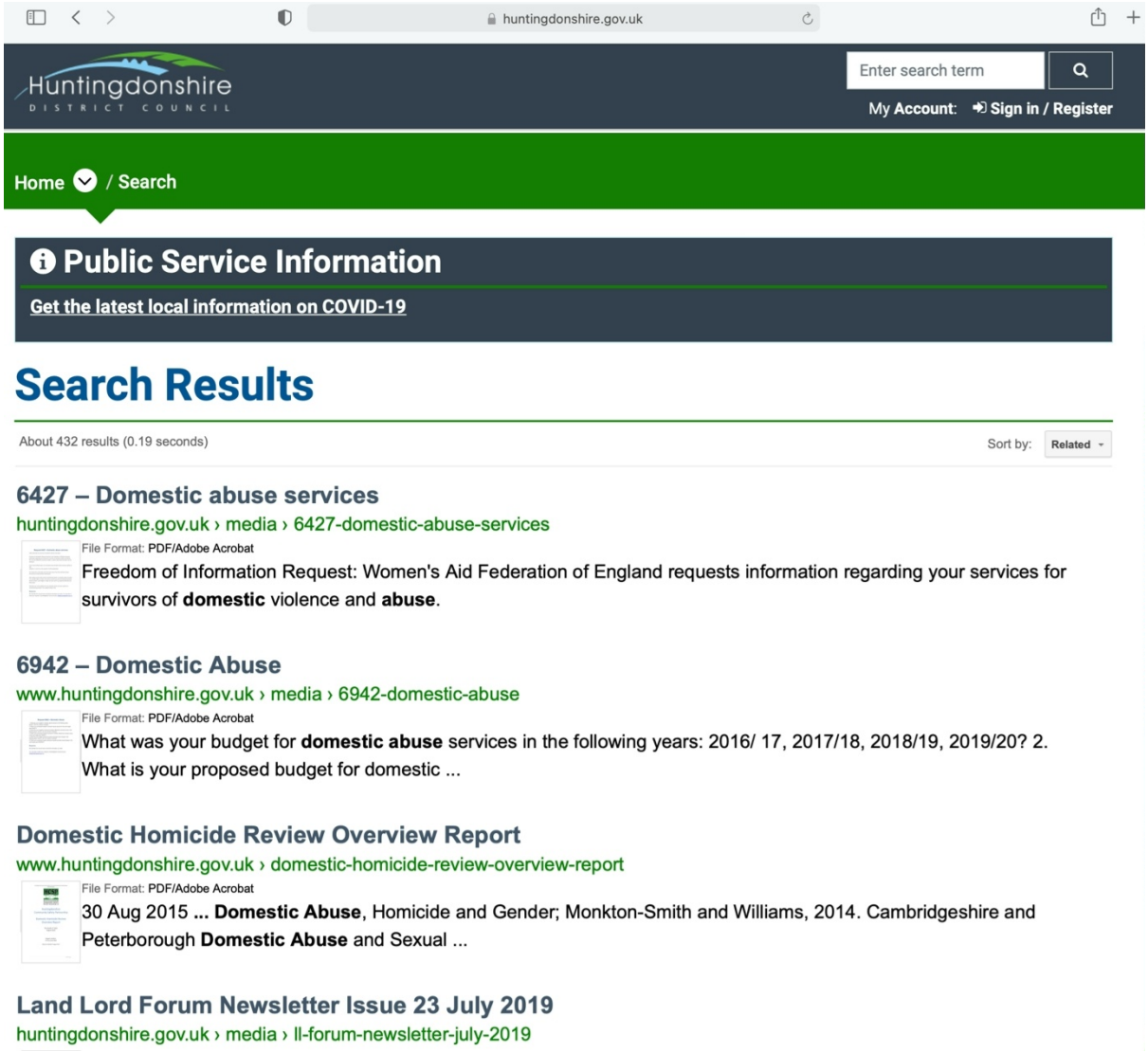
2.58 In summary it is felt that there is a significant amount of information, both locally and nationally, in relation to the subject of Domestic Abuse, which is easily accessible through search engine research.

2.59 The difficulty is in finding a website which makes it very clear what an individual should do (friend or family) once suspicions are aroused.

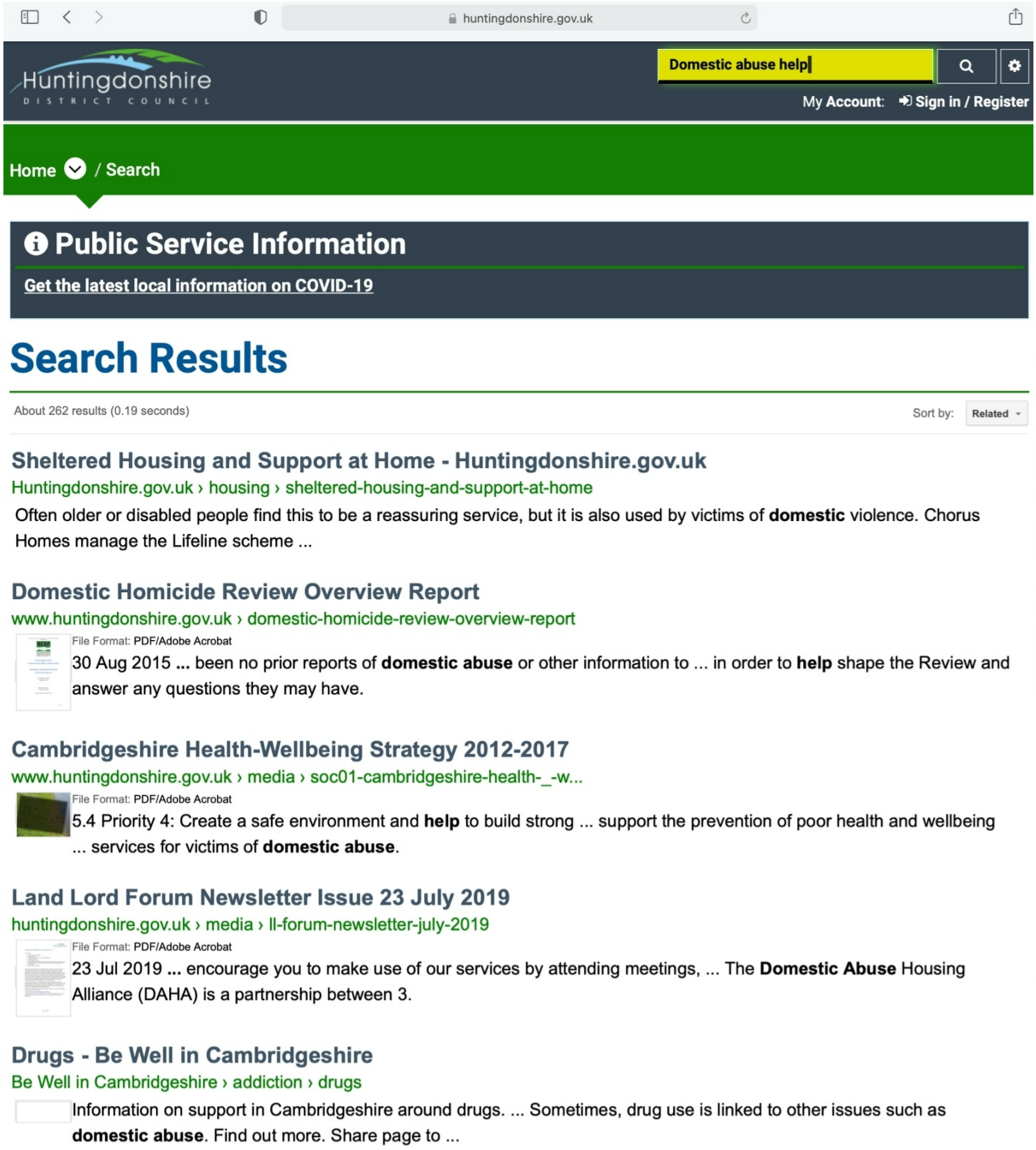
2.60 For example, if one takes the search specifically related to Huntingdonshire, the first link takes the reader to the below Homepage. This offers no quick actionable advice on Domestic abuse.



2.61 Once in the Council site, if one uses the search box and types in domestic abuse the below screen is displayed which again only shows links to documents.



2.62 On searching DA help the below screen is shown, which mentions housing, reviews and Wellbeing but no assistance is offered at all.



2.63 To summarise, there is a plethora of information available to anyone who wishes to search for it, however it is not easily navigable for an average member of the public.

WHAT WAS KNOWN TO SAFEGUARDING AGENCIES

2.64 The information below was obtained by way of commissioned IMR's.

2.65 In the below section, where there is no record relating to either Louise or Paul held by the agency, or unrelated records with no bearing on this Review, a statement has been made to clarify this as 'no records'. This has been included to show that full research was conducted.

2015 to 2020

2.66 In 2015 Louise had three interactions with Police. The main interaction being a report in December where Louise's mother reported safety concerns relating to depression and stated that Louise had attempted to take her own life two weeks previously. This incident meant Louise was reported as a missing person. Louise was found in her car, on the same day as the report, in a semi-conscious state and transferred to Lincoln hospital.

2.67 In July of the same year, Louise reported she had been assaulted by her then husband but was unwilling to report the matter fully. A Domestic Abuse Stalking and/or Harassment Risk Assessment (DASH) was completed, and an investigation commenced. Having applied the evidential full code test to this case a decision was made by the Crown Prosecution Service (CPS) to take no further action.

2.68 Louise had 12 separate interactions with her GP surgery in 2015 regarding issues ranging from tonsilitis and low mood to contraception. These appointments include telephone follow ups. In addition to this, Louise had convinced herself she had cervical cancer – increasing the number of attendances, however, this was not proven.

2.69 On 7th October Louise attended the surgery complaining of low mood and stated she had a 'black cloud' over her which she could not shake. This coincides with the break-up of her marriage, an admission of financial problems, and the change in her circumstances. She was prescribed medication (Sertraline) and this was reviewed in November 2015, when it was increased slightly from the starting dose, and a short supply of sleeping tablets were also given (short supply being good practice). The GP at this time noted there was 'good eye contact' with Louise, she was 'well kempt', articulate and had no suicidal thoughts. It was also recorded that Louise was well supported by her family and friends, and it was documented that her children were safe and well.

2.70 On 10th December Louise once again attended the GP surgery where she stated she felt low but would never try suicide due to her two children, the children being deemed as a protective factor. Although the previous day, she had attempted suicide following

a crisis at work. A health visitor was allocated to the family after concerns were raised about this by the daughter’s headteacher.

2.71 Her prescription is shown to have been changed to an alternative medication, based on the effectiveness of her current medication, following a patient health questionnaire (PHQ – 9)[23] this is used to score the levels of depression and Louise scored a 16, which is moderately severe and was referred to a primary care mental health gateway worker. She was also referred to Advice & Referral Centre (ARC) and was given a crisis plan. By the 17th December, Louise was recorded as feeling much better and sleeping better, she also confirmed she had an appointment booked with the mental health team.

2.72 The last relevant record of 2015 shows Louise receiving input from the Crisis team and feeling reassured about this intervention and referral for counselling.

2.73 2015 saw no interactions with agencies for Paul.

2.74 During 2016 Louise had 16 interactions with her GP surgery. These include regular prescription requests, a review of her medications, physical health appointments but no appointments linked to her mental health

2.75 In 2017 Louise was pregnant with her third child and reported an incident with Paul to Police which related to the ownership of a vehicle, after their recent breakup. This was deemed to be a civil matter, but a DASH form was completed in line with policy. This was assessed as low risk and no further action was taken.

2.76 Her only other contact with relevant agencies were the 18 interactions she had with her GP surgery and in July of 2017 she was recorded as being nearly 12 weeks pregnant. All her interactions centre around her pregnancy and her physical health, there is no reference to depression, anxiety, or suicidal thoughts.

2.77 In 2018 Louise had 11 GP surgery interactions, these included routine post-natal checks and no concerns were raised.

2.78 In July Louise presented with mixed anxiety and depressive disorder, she confided that she was anxious about going out and felt somewhat paranoid. She went on to say that Paul was not as supportive a father as she had hoped and that she had experienced one suicidal thought in the past two weeks. A Patient Health Questionnaire (PHQ9)[24], was completed with Louise on 31st August which scored low, with only 2 positive answers in her responses. This resulted in a review of her medication and a new medication strategy. The antidepressant medication that had previously been effective in successfully managing Louise’s symptoms were recommenced, namely Fluoxetine 20mgs. At this time there were no concerns for Louise recorded.

[23] https://patient.info/doctor/patient-health-questionnaire-phq-9
[24] This questionnaire asks nine questions of the patient, ranging from if they are suffering from poor appetite to if they are suffering from ‘thoughts that you would be better off dead, or of hurting yourself in some way’.

2.79 August appears to have been a difficult time for Louise, her new baby was also teething, but it seems clear that Louise was keen to keep on top of her symptoms.

2.80 Louise is also recorded in August as being anxious about her youngest child being removed from her, the cause of this anxiety is unknown, but records indicate that she was reassured.

2.81 During 2019 Louise had 19 interactions with her GP and these included requests for repeat prescriptions, she also changed GP practice in July. Although not recorded this is assumed to be consequent to a change of address.

2.82 On the 26th March Louise confided in her GP that her mood was worsening and that she had split from Paul, leaving her with 3 children. She further disclosed traumatic events during her childhood and stated she had received counselling as a teenager and was keen to pursue further counselling help. These notes state she was able to care for her children and had no suicidal thoughts, demonstrating this issue was clearly explored by the GP. Louise's medications were also discussed as she had previously found some of the medications unhelpful. A different medication was started, venlafaxine 75mg, and she was encouraged to self-refer to the Psychological Wellbeing Service.

2.83 In April Louise's medication was again reviewed, and Louise reported that she had noticed a positive difference within one week of starting the new medication. There were no side effects and no negative thoughts, this medicine was added onto her repeat prescriptions.

2.84 May, June and July saw no issues being reported and it was at this time she changed GP practices.

2.85 In August her medication was again reviewed by her new practice, and this was repeated monthly until the end of the year with no issues being recorded.

2.86 It is unclear from the notes if Louise was ever asked about any abuse within her current relationship during these interactions

2.87 In February of 2020 Louise reported a verbal domestic incident with Paul where she described him as controlling and manipulative. She also stated he had the potential to become violent. Police attended and it was recorded that this incident related to attempts by Paul to gain his property from her premises. A DASH assessment was completed (recorded as medium risk) and a referral was made to the Multi-Agency Safeguarding Hub (MASH), this was also shared with children's services due to the presence of the children in the household.

2.88 At the same time Louise again changed GP practice and this coincides with her move to a new home.

2.89 Between March and July Louise had nine interactions with her surgery which were predominantly medication requests, however in April, a telephone consultation occurred. (Due to the implications of the Covid pandemic and lockdown most consultations occurred over the phone at this time). During this consultation, Louise disclosed she was beginning to feel symptomatic again and that her tablets were not working as well as they had been. Consequently, her medication was increased from 75mg to 112.5mg.

2.90 In May Louise had a further telephone consultation and stated she was tired and suffering from a general lack of energy. She went on to explain that she was still experiencing bad days and that when she was having these, they were ‘really bad’. She added that she was feeling emotionally unstable and tearful. Her medication was again increased from 112.5 mgs to 150mgs. Some blood tests were also requested to exclude any physical reason for her tiredness/lethargy. All her blood results were assessed as normal, apart from a low Vitamin D result and she was issued a prescription to correct this.

Note

2.91 Medication increases are based on clinical assessments, if a dose is not working and it is felt there is some merit, it can be increased. This occurred on 10th April 2020 taking Louise’s medication from 75 mg to 112.5 mg.

2.92 A further dose increase can then be applied (usually one month apart) if there was no noticeable improvement and on 14th May, nearly 5 weeks after the previous dose increase, her medication was increased from 112.5mg to 150 mgs.

2.93 Any dose variation will occur after a minimum four-week interval, up to the maximum permitted dose. This is a clinical decision based on speaking to the patient and assessing their symptoms, which was the case with Louise.

2.94 A referral for Mental Health intervention is based on the clinician’s assessment at that time but its basis can include - no improvement in mental health, patient continues to be of low mood, has suicidal thoughts, self-harm is considered/occurring. Any individual or combination of these factors may warrant an onward referral. None of these symptoms were reported to the clinician after the medication dose was finalised.

2.95 There is no documentation indicating any further mental health concerns after 14th May.

2.96 Louise had no further interactions with her GP before her death, other than in relation to her repeat medication.

3. ANALYSIS

3.1 Louise and Paul had been in an on/off relationship for approximately eight years at the time of her tragic death, separating regulalry. It was well known to family members that the relationship was not stable, but it did result in a further child for Louise whom she loved dearly.

3.2 What is not in doubt is that Louise loved and doted on all her children. To emphasise this fact, the night before she died, she was telling friends how proud she was of her children.

3.3 It is apparent that the move to her new house was seen as a new start by Louise and, although Paul stayed over with her and helped her move in, he was not in permanent residence there. This was a conscious decision by either the couple jointly or Louise on her own, but when considering all the information, it was most likely Louise who made this decision.

3.4 The picture that has unfolded from the information provided from the IMRs and other sources to this review shows Louise as a hard-working mother striving to provide for her family whilst dealing with her own personal troubles on an ongoing basis.

3.5 It is clear that alcohol played a part in Louise's life and those that she socialised with, but the review has found nothing to suggest any dependence on alcohol or of problematic alcohol abuse in the period before her death.

3.6 There is substantial research[25] conducted into why individuals take their own lives. On their website 'The Samaritans' clearly lay out some of the reasons about why people attempt and succeed in ending their lives. In the section referenced in footnote 11 of their report they observe,

> *People who kill themselves have often told someone that they do not feel life is worth living or that they have no future. Some may have actually said they want to die.*
>
> *It's possible that someone might talk about suicide as a way of getting attention, in the sense of calling out for help.*
>
> *It's important to always take someone seriously if they talk about feeling suicidal. Helping them get the support they need could save their life.*

3.7 The report further states that it is factually correct that,

> *1 in 5 people have thought about suicide at some time in their life. And not all people who die by suicide have mental health problems at the time they die.*
>
> *However, many people who kill themselves do suffer with their mental health, typically to a serious degree. Sometimes it's known about before the person's death and sometimes not.*

[25] https://www.samaritans.org/how-we-can-help/if-youre-worried-about-someone-else/myths-about-suicide/

3.8 It is not this Review’s purpose to establish the circumstances of Louise’s death. Paul’s account suggests suicidal ideations the night before Louise’s death, but all other persons present at the house suggest she was very happy and excited about her new life ahead, prompted by her residence relocation. Her friends also describe her mood as the ‘best’ they had ever seen her.

3.9 Unlike many domestic homicides, sometimes suicides can be completely spontaneous, but this does not appear to be the case with Louise as there is some documented evidence that she had experienced suicidal ideation previously.

3.10 Each of the IMR authors were invited to conduct analysis of their IMR findings. Limited or single encounters with Louise were common across agencies interactions and on face value, there is not a clear and obvious ‘trail of abuse’. However, the IMR’s showed a distinct lack of general ‘routine enquiry’ along with a deficiency in the curiosity of those who came into contact with Louise, as described in section two when comprehensive notes were not completed and information was accepted on face value and not probed fully. All agencies have basic requirements to conduct routine enquiries when victims of Domestic Abuse present themselves, however with the backdrop of Covid these ‘routines’ were revised and contracted in some cases.

3.11 This longitudinal and cross-discipline, intersectional perspective does provide a small window into Louise’s life and her experience of domestic abuse both with her ex-husband and with Paul.

3.12 At the time of her death Louise was the mother of three young children aged nine, six and two years. She was surrounded by a loving family including her mother and 2 siblings, but had moved away and was living in a different county to her maternal family.

3.13 From the information gathered Louise was diagnosed with Depression in 2015 and had been prescribed anti-depressants to be taken on a daily basis.

3.14 In 2013 (outside of the parameters of this review but deemed significant by the Panel) Paul was previously the subject of an allegation of Domestic Related Criminal Damage with a previous partner. This resulted in a Restraining Order being granted by the Court (valid until 2015) with a compensation and Community Order also imposed for 12 months.

3.15 Clare’s Law[26] and the aligned Domestic Violence Disclosure Scheme (DVDS) came into being in 2014 in England and Wales. Cambridgeshire Police have a dedicated link[27] to assist in accessing information for those who require it. There is no evidence that this was pursued by Louise, or that she was aware of this option. It would appear that this is not unusual, in the case of victims of domestic abuse being fully aware of Clare’s law and associated protective measures available to them, but the Author could find no national statistics for 2020/2021 on public access to the disclosure scheme to give context to this issue.

[26] https://www.gov.uk/government/publications/domestic-abuse-bill-2020-factsheets/domestic-violence-disclosure-scheme-factsheet
[27] https://www.cambs.police.uk/information-and-services/Domestic-abuse/Clares-law

3.16 DVDS was rolled out to all forces in England & Wales in March 2014, following the success of a pilot and a review which was completed in 2015. This resulted in an extension of the scheme to cover ex-partners and reports of coercive and controlling behaviour. Any disclosure under the scheme to Louise would have been required to meet the criteria under the scheme i.e., necessity, proportionality, legality and reasonability, in accordance with the Human Rights Act. However, the DVDS guidance was changed to be placed on a Statutory footing in 2021 in order to gain improvements in the volume, speed and quality of disclosures.

3.17 The decision to disclose should be discussed and ratified at a MARAC. In relation to Paul, the Cambridgeshire MASH was aware of the existence of a Restraining Order. In addition, Paul's Police National Computer (PNC) record was flagged with a VIOLENT marker dating back to 2006. This was as a result of an assault on a male in 2006. Consequently, the option to pursue the "right to know" under the DVDS scheme was available to Louise had she known about it and chosen to explore this.

3.18 Furthermore, the "right to ask" option was also available to Louise and her family and friends, due to their concerns regarding Paul's alleged controlling/coercive conduct towards Louise throughout their relationship. However due to the lack of publicity to the general public neither Louise, her friend or family had any knowledge that they had this right to ask about Paul's background.

3.19 It appears from the review documentation, and questions directly asked of Louise's mother by the Chair/Author, that neither of these options were pursued. On exploring this issue with Louise's mother, it seems clear that 'Clare's law' was not familiar to Louise or her mother and that neither of them had any understanding of what their rights were in relation to this scheme.

3.20 The panel discussed concerns as to how familiar the public of Huntingdonshire are with their rights under the scheme, subsequent to this discussion, the Panel requested statistics to show recent uptake. These are recorded in Appendix 3.

3.21 The panel noted that initially take up levels of the scheme were low, and this caused some concern. It is also unclear how well the scheme is understood within the Cambridgeshire Constabulary. On exploring this further in Panel it was explained that understanding in the Constabulary was increasing but it is felt that further work needs to be undertaken to fully embed not only understanding but also appropriate implementation of the options available associated with Clare's law.

3.22 In terms of Police contact with Louise and Paul, the review has found that Louise was clearly the subject of Domestic Abuse related events – including coercive control.

3.23 Attending officers failed to fully record Louise's account of events, and this is a failure to observe best practice in terms of securing and preserving evidence. There is also no record of the officer deploying their body worn camera to record Louise's account. Even though it is a mandatory requirement for all officers responding to a domestic abuse related incident, and is clearly stated within Cambridgeshire Police Domestic Abuse policy and National guidance.

3.24 It is also uncertain why a referral was not made to MARAC and why a victim care contract was not put in place with Louise. In this case the Crown Prosecution Service

(CPS) deemed there to be insufficient evidence to provide a realistic prospect of conviction, with their rationale referring to their Domestic Violence Policy.

3.25 All other Police interactions with Louise are clearly within policy, legal frameworks and guidance requirements relating to the investigation of Domestic Violence. These include the appropriate use of ‘Flags’ or markers on the command-and-control system, the use of DASH and appropriate supervision and oversight of cases.

3.26 The police have no further record of Louise being the subject of Domestic Abuse, violence or coercive control at the hands of Paul. That is not to say it did not occur, rather that the police were afforded no opportunity to intervene on any reported events and therefore no opportunities materialised or were missed.

3.27 From Louise’s medical records, it is clear that she was willing to engage with her GP practices and happy to report issues and concerns. Mood assessments were conducted by health care professionals on a number of occasions and it was always felt that her children created a protective factor for her, which she articulated herself.

3.28 Louise’s son suffers from rheumatoid arthritis and was medicated for this with immunosuppressants, and on occasions this led to mobility issues for him, which must have been challenging for both Louise and her son. It was for this reason that the removal of her vehicle/vehicle keys by Paul caused significant stress to Louise, as Luke required transportation to and from school and for other activities.

3.29 In synopsis, Louise was attempting to manage her low mood / fatigue, three children (one of whom was unwell and one a toddler) with her employment and all whilst receiving little support from Paul. This is likely to have caused substantial strain and significant challenges and would have done so even for the most resilient of individuals.

3.30 There is no evidence of any unexplained injuries, or evidence of coercion/control or any obvious suggestion of abuse in Louise’s medical records. That is not to say this did not occur just that it was not recorded, probed, or looked into. It could be asserted that a lack of professional curiosity allowed risk factors to be overlooked, the rationale for this assertion being the increase in Louse’s attendance at medical appointments, increasing medication and her increasing explanation of low mood.

Covid as a factor

3.31 In the months prior to Louise’s death and all through the Covid Pandemic Lockdown periods, Louise’s appointments with her GP were conducted by telephone. She had no face-to-face interactions with healthcare professionals, and, during this period, her medication was increased from 37.5mgs to 150mgs over a three-month period.

3.32 In effect, her medication increased by approximately 400% which is not uncommon but given the history of Louise and the Pandemic impacts, it is believed that there was an opportunity for video calls with Louise and this could have provided better opportunities for exploration of the position she was in, and an assessment of eye contact and body language.

3.33 Due to these remote telephone appointments, it appears that there was no investigation by health practitioners into the ongoing causes of Louise's depression/mental illness, which could have been assessed and aspects of those causes resolved to reduce her symptoms, without resorting to increased medication in isolation.

3.34 An article in the British Medical Journal[28], 2021, entitled '*How COVID-19 has affected general practice consultations and income: general practitioner cross-sectional population survey evidence from Ireland'*, gives an insight into the implications of Covid on GP interactions. One of the objectives of the report was to gain an insight into *'How general practice is delivered in many countries has drastically changed due to the COVID-19 pandemic'.*

3.35 The principal findings of this study include: -

- A shift to telemedicine was observed from 10.5% of all GP consultations and 17.6% of practice nurse consultations pre-COVID-19 to 57.0% and 32.4%, respectively during the COVID-19 response.

- More than half of practices saw decreases in non-COVID-19 related consultations with vulnerable patient groups. In particular, non-COVID-19-related visits from patients under 6 years and over 70 years—who receive free GP care—decreased, despite these groups usually being more frequent users of health services.

3.36 It is accepted that this data refers to Ireland, but a similar statistic is found when researching England and Wales where, **Face-to-face appointments decreased from 87.3% to 41.0% of all GP consultations** and, consultations by telemedicine increased from 10.5% to 57.0% of reported consultations.

3.37 The British Journal of Medical Practice[29], also conducted a study in 2021 entitled, '*Challenges of safeguarding via remote consulting during the COVID-19 pandemic: a qualitative interview study'.* This study concluded,

> *The GPs interviewed raised important concerns about how to identify and manage safeguarding in the context of remote consultations. Current guidance recommends face-to-face consultation for safeguarding concerns, but pressure to use remote forms of access (within or beyond the pandemic) and the fact that safeguarding needs may be unknown makes this an issue that warrants urgent attention.*

3.38 In the body of the study is a very telling and insightful passage which is quoted in full below, from a GP who was interviewed as part of the research,
However, GPs remained concerned that triage approaches that required patients to state in advance the reason for contact could deter patients and GPs from exploring any other reasons for consultation, reducing safeguarding opportunities: '***That's not how consultations work. It starts off with a headache and you end up talking about alcohol and DV*** **[domestic violence]*, that's the bread and butter of the conversations that we have; bullying at work or whatever the thing is, because there are things that are legitimate to go to your doctor with and there are things that really aren't.'*(GP3)**

[28] https://bmjopen.bmj.com/content/11/4/e044685
[29] https://bjgp.org/content/72/716/e199

3.39 This DADR would never be in a position to state if Louise would still be alive had GP consultations taken place in person during the period before her death, but the issue of what ‘normal’ GP services should and could look like post Pandemic is a topic that is clearly hotly debated in medical circles.

4. CONCLUSIONS AND LESSONS LEARNED

Conclusions

4.1 Overall, the analysis of data collated, the assessment of the evidence obtained by the police and the subsequent panel research has shown that there were no major intervention opportunities which could have been made, which in themselves would have changed the outcome of events for Louise.

4.2 Nonetheless, the review has highlighted some learning opportunities for those agencies involved with Louise and Paul in the run up to Louise’s death.

4.3 There has been no significant failure in service identified throughout this review in relation to any agency which in itself could have changed the outcome for Louise. However, failure by police to use Body Worn Video appropriately and a lack of medical professional curiosity may have had a bearing on the treatment of Louise.

4.4 Additional strategic learning points have been identified by the panel and will form the basis of an action plan, for example;

- Domestic Abuse awareness accessibility on both the Council website and partner agencies access points should be highlighted and clear options for action prominent

Good practice/innovation

4.5 Currently there is a significant amount of work being undertaken by Cambridgeshire and Peterborough local authorities in terms of suicide prevention[30], this is due to be published soon. This work has been approved and is due to be published by the end of February 2023.

4.6 This three-year strategy has an ambition of; every person in Cambridgeshire and Peterborough having access to the right care and support, from both the mental health system and their communities, to ensure they do not die by suicide.

[30] https://www.cambridgeshire.gov.uk/residents/adults/adults-services-strategies-and-policies/suicide-prevention-strategy

4.7 In being able to achieve this ambition the strategy looks at consistency of service, joined up working, community engagement and resources so as to provide a collaboration of services.

4.8 Of course, this is post the death of Louise but demonstrates a desire to improve services.

5. RECOMMENDATIONS

5.1 A number of improvements in service have already been undertaken by the agencies involved with Louise and Paul. The below is a list of outstanding Actions to be taken in relation to lessons to be learnt, through a local action plan as per Appendix 4.

5.2 A deep dive review of training relating to the need for professional curiosity, record keeping, rationale recording and holistic problem solving should be conducted and should pay close attention to Statutory partners training programs complimenting each other to ensure seamless transition between partners.

5.3 The new suicide prevention strategy should be embedded in all partner agencies working in the domestic abuse field. This should specifically relate to vulnerable persons suffering from suicidal ideation and should work towards end to end and seamless partnership working to keep those most vulnerable safe.

5.4 Exploration at Partnership level should take place, in relation to the use of Alcohol by those struggling with suicidal ideation as a potential coping mechanism. This should link with the Suicide Prevention strategy and embedded in any updated version. Further work should be commissioned to enable appropriate support training to be delivered to professionals working in this field.

5.5 Further work should be commissioned to enable appropriate support training to be delivered to professionals working in this field. Although the strategy deals with self-harm and healthy coping strategies, this is not a topic of research in its own right, and conversations with partners should be ongoing in relation to this. This issue goes to link with the need for professionals for example the police to fully investigate the circumstances around any call to a domestic situation and to be curious in relation to all the presented information.

5.6 Common myths exist that children are a preventative factor in relation to suicide, but on this occasion Louise had also tried to take her life the day before once her children were away from the premises.

5.7 Specific training for staff working within the GP surgery where Louise was registered geographic implemented to further embed ‘professional curiosity’ within general day to day practice – this relates particularly to telephone GP consultations which appear perfunctory based on the notes recorded. This is over and above the generic

recommendation at point 1 above. Telephone appointments make it difficult for GPs to assess who is listening to the call and pick up on other cues. The percentage of cases cleared by telephone as opposed to face to face should be reviewed.

5.8 The use of Clare’s Law and the embedding of the principles held within the legislation should form part of DA training for all agencies dealing with victims and potential victims of coercive control and DA. The use of the legislation should be reviewed by Cambridgeshire Constabulary to ensure continuation of the trajectory they are already on, and this should be combined with the use of the DVPN legislation.

5.9 In conjunction with the above at point 5, there is a requirement to increase the public’s understanding of their rights to pursue disclosures under this legislation. A wide-reaching communications strategy across all associated partnerships should be considered and monitored/published by the CSP.

5.10 The use of Body Worn Video and adherence to both local and National guidance should be consistently reinforced by Cambridgeshire Constabulary, monitored, and regularly reviewed through performance monitoring processes. The author has been informed that since this incident this takes place regularly, but the CSP must ensure that this does not slip in the future.

5.11 Information access relating to Domestic Abuse and action to be taken in the reporting of such within the Huntingdonshire area is difficult to navigate from the Huntingdonshire website. This should be reviewed, simplified and provide improved clarity. Although already addressed in some ways, e.g. the CSP adding Clare’s law to their web page this should be fully reviewed to ensure accessibility for all no matter what their needs and be compliant with the ‘plain English’ ethos.

Note

5.12 In relation to point 8 Huntingdonshire is not alone in this regard and the lack of accessibility and clarity of Domestic Abuse advice and guidance on local authority websites has been highlighted previously in reviews at a National level.

5.13 Nationally, there is also the issue of accessibility of information in relation to the reporting of suspicions relating to persons suffering from Domestic Abuse. This is not something this local council can contend with, and it is the recommendation of this panel and author that this issue is looked at from a more holistic view point and not just through individual reviews. For example, is it possible for the Government to publish a flow chart of potential action which would be the first thing people see on searching DA through all Search Engines?

5.14 The recommendations discussed by the panel and identified as needing further work are to be found in the Action Plan set out in Appendix 3 at the end of this report.

Author

Helen Collins BA (Hons) PGCE (PCET)
May 2021

Glossary

ASC	Adult Social Care
CCG	Clinical Commissioning Group
CC	Cambridge Constabulary
CSC	Children's Social Care
CJSM	Criminal Justice Secure email
DA	Domestic Abuse
DV	Domestic Violence
DADR	Domestic Abuse Death Review
GP	General Medical Practitioner
IMR	Individual Management Review
MASH	Multi Agency Safeguarding Hub
NHS	National Health Service
ToR	Terms of Reference

Name references used

Louise	Deceased
Paul	Current partner of deceased at time of death
Brian	Ex-husband of Louise
Claire	Louise's eldest daughter
Luke	Louise's son
Jayne	Louise's youngest daughter

DISTRIBUTION LIST

Agency
Family of Louise
HM Coroner
Chair CSP
Contributing Panel Members
Police and Crime Commissioner
Managing Director at Huntingdonshire District Council

APPENDIX 1

Terms of Reference for Review

1. To identify the best method for obtaining and analysing relevant information, and over what period prior to the death, to understand the most important issues to address in this review and ensure the learning from this specific homicide and surrounding circumstances is understood, and systemic changes implemented. Whilst checking records, any other significant events or individuals that may help the review by providing information will be identified.
2. To identify the agencies and professionals that should constitute this Panel and those that should submit chronologies and Individual Management Reviews (IMR) and agree a timescale for completion.
3. To understand and comply with the requirements of any criminal investigation, any misconduct investigation and the Inquest processes and identify any disclosure issues and how they shall be addressed, including arising from the publication of a report from this Panel.
4. To identify any relevant equality and diversity considerations arising from this case and, if so, what specialist advice or assistance may be required.
5. To identify whether the victims or perpetrator were subject to a Multi-Agency Risk Assessment Conference (MARAC) and whether the perpetrator was subject to Multi-Agency Public Protection Arrangements (MAPPA) or a Domestic Violence Perpetrator Programme (DVPP) and, if so, identify the terms of a Memorandum of Understanding with respect to disclosure of the minutes of meetings.
6. To determine whether this case meets the criteria for a Serious Case Review, as defined in Working Together to Safeguard the Child 2018, if so, how it could be best managed within this review.
7. To determine whether this case meets the criteria for an Adult Case Review, within the provisions of 44 Care Act 2014, if so, how it could be best managed within this review and whether either victim or perpetrator(s) were 'an adult with care and support needs'
8. To establish whether family, friends or colleagues want to participate in the review. If so, ascertain whether they were aware of any abusive behaviour to the victim prior to the homicide (any disclosure; not time limited). In relation to the family members, whether they were aware of any abuse and of any barriers experienced in reporting abuse, or best practice that facilitated reporting it.
9. To identify how the review should take account of previous lessons learned in Huntingdonshire and from relevant agencies and professionals working in other Local Authority areas.
10. To identify how people in Huntingdonshire gain access to advice on sexual and domestic abuse whether themselves subject of abuse or known to be happening to a friend, relative or work colleague [Research will be undertaken].

11. To keep these terms of reference under review to take advantage of any, as yet unidentified, sources of information or relevant individuals or organisations.

Panel considerations

1. Could improvements in any of the following have led to a different outcome for [redacted], considering:

a) Communication and information sharing between services with regard to the safeguarding of adults and children

b) Communication within services

c) Communication and publicity to the general public and non-specialist services about the nature and prevalence of domestic abuse, and available local specialist services

2. Whether the work undertaken by services in this case are consistent with each organisation's:

a) Professional standards

b) Domestic abuse policy, procedures and protocols

3. The response of the relevant agencies to any referrals from 1st January 2015 relating to [redacted]. It will seek to understand what decisions were taken and what actions were or were not carried out, or not, and establish the reasons. In particular, the following areas will be explored:

a) Identification of the key opportunities for assessment, decision making and effective intervention in this case from the point of any first contact onwards with [redacted]

b) Whether any actions taken were in accordance with assessments and decisions made and whether those interventions were timely and effective.

c) Whether appropriate services were offered/provided, and/or relevant enquiries made in the light of any assessments made.

d) The quality of any risk assessments undertaken by each agency in respect of [redacted]

4. Whether organisational thresholds for levels of intervention were set appropriately and/or applied correctly, in this case.

5. Whether practices by all agencies were sensitive to the ethnic, cultural, linguistic and religious identity of the respective individuals and whether any specialist needs on the part of the subjects were explored, shared appropriately and recorded.

6. Whether issues were escalated to senior management or other organisations and professionals, if appropriate, and completed in a timely manner.

7. Whether, any training or awareness raising requirements are identified to ensure a greater knowledge and understanding of domestic abuse processes and/or services.

8. Identify how the resulting information and report should be managed prior to publication with family and friends and after the publication in the media.

Operating Principles

a. The aim of this review is to identify and learn lessons as well as identify good practice so that future safeguarding services improve their systems and practice for increased safety of potential and actual victims of domestic abuse (as defined by the Government in 2015 – see below).

b. The aim is not to apportion blame to individuals or organisations, rather, it is to use the study of this case to provide a window on the system.

c. A forensic and non-judgmental appraisal of the system will aid understanding of what happened, the context and contributory factors and what lessons may be learned.

d. The review findings will be independent, objective, insightful and based on evidence while avoiding ‘hindsight bias’ and ‘outcome bias’ as influences.

e. The review will be guided by humanity, compassion and empathy with [redacted] ‘voice’ at the heart of the process.

f. It will take account of the protected characteristics listed in the Equality Act 2010.

g. All material will be handled within Government Security Classifications at ‘Official - Sensitive’ level.

Definition of Domestic Abuse

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

- psychological
- physical
- sexual
- financial
- emotional

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.

APPENDIX 2

From: [redacted] > Louise
Sent: 01 August 2020 07:40
To: I [redacted]Paul
Subject: Re: Wtf

You turn up I will call the police

Get Outlook for iOS

From: [redacted] < Louise
Sent: Friday, July 31, 2020 9:39:52 PM
To: [redacted] Paul
Subject: Re: Wtf

Loose ya shit do what the Fuk you want bye bye □□

Get Outlook for iOS

From[redacted] Paul
Sent: Friday, July 31, 2020 9:38:30 PM
To: [redacted] Louise
Subject: Re: Wtf

I don't think your thick at all..... you've so lost me with all this shit seriously □ will you call me please

Sent from my iPhone

On Jul 31, 2020, at 9:34 PM, [redacted] Louise wrote:

You think I'm so thick! Good luck with that!

Get Outlook for iOS

From: [redacted] Louise>
Sent: Friday, July 31, 2020 9:33:27 PM
To: I [redacted]Paul
Subject: Re: Wtf

No you fuking int!!!! You having a fuking laugh the girl is thick as shit and playing dumb! End of end of us for good now

Get Outlook for iOS

From: [redacted] Paul
Sent: Friday, July 31, 2020 9:32:01 PM

To: [redacted] Louise
Subject: Re: Wtf

What the fuck [redacted]? I don't know what your going on about..... where has this come from? It's like your just trying to find a reason to have a pop at me your not having someone round at all because we're sorting things out I thought? I honestly don't have a clue what your on about on [redacted] life I am coming Chessington as well and that will help sort us out!

Sent from my iPhone

On Jul 31, 2020, at 9:23 PM, [redacted] Louise wrote:

It's over and I'm having someone round tonight!!! You int coming chessington

Get Outlook for iOS

From[redacted] Paul
Sent: Friday, July 31, 2020 9:22:53 PM
To: [redacted] Louise
Subject: Wtf

What the actual fuck now [redacted]? You've flown off the handle again over what? I've done nothing wrong once again..... what do you mean watch this space? You trying to say your going to get with someone else

Sent from my iPhone

APPENDIX 3

Cambridgeshire Constabulary Statistical information

Statistics connecting to Clare's Law for 2019-20 and 2020-21

Statistics for Clare's Law applications made to Cambridge Constabulary from 2016 -2021.

Year	Number
2016	60
2017	101
2018	76
2019	179
2020	253
2021	350

These show a slow uptake until 2019 but are now increasing year on year. This increase is possibly due to better officer awareness resulting in members of the public being offered the service at scene, improved promotional campaigns through the force Facebook page. There is also an improved online portal for making the requests through the force website.

Word of mouth and national media are also believed to have contributed to the increased applications.

It is still very unclear if the opportunity to invoke Claie's Law is still widely enough known within communities and all partner agencies should seek to signpost adults towards this provision if they feel they ought to know.

Statistics for the number of DVPNs applied for from Force Superintendents to illustrate where officers were (or not yet) considering this safeguarding measure.

Year	Number
2016	34
2017	19
2018	25
2019	26
2020	30
2021	172

The force was slow compared to other forces nationally to use the DVPN/DVPO as a protective measure but since the introduction of the Vulnerability Focus Desks (VFDs) in 2021, there has been a significant increase in their use. The VFD offer bespoke safeguarding advice to frontline officers dealing with domestic abuse and have been supporting them in applying for the orders. They are sought in high risk cases.

APPENDIX 4

Independence statements

Chair of Panel and Review Author

Helen Collins was appointed by Huntingdonshire District Council CSP as Independent Chair of a DHR Panel and is the author of this report. She is a former police officer with 30 years operational service. She served mainly as a detective in both specialist (Public Protection and Major Crime) and generalist investigation roles and was head of Crime for Surrey Police.

As Head of Public Protection, she oversaw the introduction of both MARAC and MAPPA processes within Surrey.

As Head of Crime, she was responsible for the deployment of some 1500 police and civilian staff on a daily basis dealing with all serious and specialist crime investigations and operations in Surrey including homicide, armed robbery, kidnap, fraud and abuse. She also has a background in counter terrorism operations from a Firearms Command perspective.

As Temporary Assistant Chief Constable in Surrey she was also responsible for all matters pertaining to Community Policing and customer service and sat on the Corporate Parenting Board for Surrey County Council.

Helen has since set up her own company to provide public service consultancy and investigative expertise in relation to complex and historic investigations within the public sector.

During and since her policing service she has had no personal or operational involvement within Huntingdonshire District Council, or Cambridgeshire Constabulary.

Overseeing manger

Tony Hester has over 30 years Metropolitan police experience in both Uniform and CID roles that involved Borough policing and Specialist Crime investigation in addition to major crime and critical incidents as a Senior Investigating Officer (SIO). This period included the management of murder and serious crime investigation.

Upon retirement in 2007, Tony entered the commercial sector as Director of Training for a large recruitment company. He now owns and manages an Investigations and Training company.

His involvement in this DVHR has been one of support to the Independent Chair.

Secretary to the Panel

Kathryn English's involvement in this DVHR has been one of administration and support to the Independent Chair, her remit being to record the minutes of meetings and circulate documents securely as well as to act as the review liaison point for the Chair.

She has no business or personal relationships with anyone involved in this review.

APPENDIX 5

Consolidated internal lessons learned and recommendations from agency IMR's and Panel Research

Rec No	Agency	Action required	Outstanding action, outcome of action, what has been achieved and date of completion as appropriate
1	Statutory Partners	A deep dive review is needed of training relating to the need for professional curiosity, record keeping, rationale recording and holistic problem solving should be conducted and should pay close attention to Statutory partners training programs complimenting each other to ensure seamless transition between partners.	**S**pecifically - Review Training of these subjects **M**easured - through appropriate training taking place – reporting to CSP Chair **A**ttainable – through information sharing and reviewing all training currently delivered **R**elevant - in terms of need to show complimentary and not contradictory training to improve service delivery **T**ime – initial review should be conducted within 6 months by statutory partners and consolidated in 9 months by CSP
2	Suicide Prevention Lead	The new suicide prevention strategy should be embedded in all partner agencies working in the domestic abuse field in Huntingdon. This should specifically relate to vulnerable persons suffering from	**S**pecifically – To embed the suicide prevention strategy in all partner agencies in Huntingdon **M**easured – update report to CSP Chair

		suicidal ideation and should work towards end to end and seamless partnership working to keep those most vulnerable safe.	**A**ttainable – through information sharing and reviewing all training currently delivered **R**elevant – to aid the delivery of the strategy **T**ime –should be completed within 6 months
3	Huntingdon District Council	Exploration at Partnership level should take place, in relation to the use of Alcohol by those struggling with suicidal ideation as a potential coping mechanism. Further work should be commissioned to enable appropriate support training to be delivered to professionals working in this field.	**S**pecifically – research to be commissioned into local use of Alcohol in such circumstances to give a specific local view **M**easured - through greater insight gained **A**ttainable – through information sharing and research functions **R**elevant - in terms of need to understand the current position within Huntingdon to allow appropriate allocation of resources **T**ime – initial review should be conducted within 12 months
4	Suicide Prevention lead	Further work should be commissioned to enable appropriate support training to be delivered to professionals working with those experiencing Domestic Abuse. Although the suicide prevention strategy deals with self-harm and healthy coping strategies, this is not a topic of research in its own right, and conversations with partners should be ongoing in relation to this. This issue goes to link with the need for professionals, for example the police to fully	**S**pecifically – commissioning of specific training in relation to the identification of risk relating to those experiencing suicidal ideation **M**easured - through appropriate training taking place or deemed not necessary

		investigate the circumstances around any call to a domestic situation and to be curious in relation to all the presented information.	**A**ttainable – through information sharing and further research **R**elevant - in terms of identifying those in most need and at greatest risk **T**ime – initial training should be identified and conducted within 6 months
5	GP surgery	Specific training for staff working within the GP surgery where Louise was registered geographic implemented to further embed 'professional curiosity' within general day to day practice – this relates particularly to telephone GP consultations which appear perfunctory based on the notes recorded. This is over and above the generic recommendation at point 1 above. Telephone appointments make it difficult for GPs to assess who is listening to the call and pick up on other cues. The percentage of cases cleared by telephone as opposed to face to face should be reviewed.	**S**pecifically – GPs and practitioners to review current practice in relation to non-face-to-face appointments and the embedding of professional curiosity **M**easured – Audit of appointments and training **A**ttainable – through current record keeping and training logs **R**elevant - in terms of need to show exemplary service provision and understanding of those suffering from domestic abuse **T**ime – initial review should be conducted within 9 months and reported back to CSP
6	Cambridgeshire Constabulary	The use of Clare's Law and the embedding of the principles held within the legislation should form part of DA training for all agencies dealing with victims and potential victims of coercive control and DA. The use of the legislation should be reviewed by Cambridgeshire Constabulary to ensure continuation of the trajectory they are already on, and this should be combined with the use of the DVPN legislation.	**S**pecifically - review training of this subject and monitor performance **M**easured – general performance management reports **A**ttainable – through existing performance management structures

			Relevant – to continue to see the appropriate use of the mechanisms available to victims **T**ime – monthly internally to Cambridgeshire police for a minimum of 6 months and fed to regular CSP meeting for exposure to partners
7	CSP	In conjunction with the above at point 6, there is a requirement to increase the public's understanding of their rights to pursue disclosures under this legislation. A wide-reaching communications strategy across all associated partnerships should be considered and monitored/published by the CSP.	**S**pecifically – to improve public access and understanding of Clare's law **M**easured - general performance management reports of uptake within Cambridgeshire Constabulary area **A**ttainable – through performance reporting **R**elevant - in terms of need to show complimentary and not contradictory service provision by all partners **T**ime – ongoing reporting to CSP to be established within 3 months
8	Cambridgeshire Constabulary and CSP	The use of Body Worn Video and adherence to both local and National guidance should be consistently reinforced by Cambridgeshire Constabulary, monitored, and regularly reviewed through performance monitoring processes. The author has been informed that since this incident this takes place regularly, but the CSP must ensure that this does not slip in the future.	**S**pecifically – adherence to local and national guidance/policy **M**easured - general performance management within Cambridgeshire Constabulary area **A**ttainable – through performance reporting

			Relevant - in terms of need to show compliance **T**ime – ongoing reporting to CSP to be established within 3 months
9	CSP	Information access relating to Domestic Abuse and action to be taken in the reporting of such within the Huntingdonshire area is difficult to navigate from the Huntingdonshire website. This should be reviewed, simplified and provide improved clarity. Although already addressed in some ways, e.g. the CSP adding Clare's law to their web page this should be fully reviewed to ensure accessibility for all no matter what their needs and be compliant with the 'plain English' ethos.	**S**pecifically – to improve public access and ease of understanding by those seeking assistance **M**easured – completion of review of current communications and any changes made **A**ttainable – through performance reporting to CSP **R**elevant - in terms of need to show complimentary and accessible advice and assistance to all members of the community. Including adherence to plain English guidance, along with relevant translations for the demographic **T**ime – ongoing reporting of progress to CSP to be established within 6 months and communications to be reviewed on a yearly basis in future to ensure relevance