PENNINE LANCASHIRE COMMUNITY SAFETY PARTNERSHIP

DOMESTIC HOMICIDE REVIEW OF

"Matilda"

October 2019

Independent Chair and Author: Kathy Webster

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Home Office Quality Assurance Panel: November 2024

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In memory of Matilda.

Matilda was bright, beautiful, funny, usually chaotic but often kind and caring. She was jokingly described as on occasions being "mad as a box of frogs" which reflected her energy and her fun outlook on life.

As a child, Matilda was subject to a Child Protection Plan before she was even born regardless of which she went on to be systematically abused within her family, experiencing neglect, physical, emotional and sexual abuse until she was removed from her parents age 7 years.

From this point she lived with experienced Foster Carers who worked hard to support Matilda and meet her needs. It was recognised that her traumatic start in life had a massive negative impact on Matilda in many ways. She struggled with school and relationships with her peers and became at risk of being sexual exploited when she was teenager.

Matilda was very much loved by her foster family who eventually became her legal guardians and Matilda changed her named by deed pole to reflect their family name. She showed love and care to her "parents" in many ways and is truly missed by them.

Matilda was only 23 years old when she died in a way which was cruel, prolonged and meaningless. Sadly, her only child had already been removed from her care because she did not have the capacity to keep the child safe from Carson's criminal predatory behaviours. There was nothing to suggest that Matilda had been anything but a caring, loving mother who was trying her best.

Matilda's legacy is her child whom she loved deeply and would have done anything to protect.

There is a family memorial close to where the family live which is visited daily and is tendered with love and care, one of the memorials read "The gates of memory shall never close we miss you more than anyone knows."

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1. Introduction

1.1. This domestic homicide review (DHR) examines agency responses and support given to Matilda who was 23 years old at the time of her death in October 2019. Condolences and sympathy are extended to the family and friends of Matilda on behalf of Pennine Lancashire Community Safety Partnership who commissioned this review.

1.2. In addition to agency involvement, the review will examine the couples past history to identify any relevant background or trail of abuse before the homicide, whether support was accessed within the community and whether there were any barriers to accessing support.

1.3. The key purpose of a DHR is to enable lessons to be learnt following the death of a person as a result of domestic violence and abuse. In order for these lessons to be learnt as widely and as thoroughly as possible to identify what needs to change in order to reduce the risk of such tragedies happening in the future.

1.4. The catalyst for this DHR was that Matilda was deliberately given a lethal amount of controlled medication over a number of days by her partner Carson. Carson was convicted of her murder and at the same trial was also convicted of the murders of two of his children and the attempted murder of another child. He was initially imprisoned for 40 years but this was later overturned by the Lord Chief Justice and his jail term extended to 48 years.

1.5. The review considers the contact and involvement by different professionals and organisations with Matilda from August 2017 when Matilda first started having a relationship with Carson up until the date of her death in October 2019.

2. Timescales

2.1. There has been a significant delay in producing this DHR which was in part due to the joint decision made between Pennine Lancashire Community Safety Partnership and Blackburn with Darwen, Blackpool and Lancashire Children's Assurance Partnership (CSAP) in 2020, to complete a Child Safeguarding Children Review (CSPR) relating to the murder of Carson's two children and the attempted murder of a third child to be completed first.

2.2. The rational for this decision was to allow the CSPR to establish the circumstances of the children's death and to fully understand the nature of Carson's previous relationships prior to conducting the DHR. The CSPR was highly complex and was eventually published in November 2022.

***Domestic Homicide Review (DHR) -** is a multi-agency review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by a person to whom he or she was related, or with whom he or she was or had been in an intimate personal relationship; or a member of the same household as himself or herself

***Community Safety Partnership –** has a role to focus on community safety and to bring local agencies together to deliver multiagency solutions to local problems by pooling resources and experience

***Children Assurance Partnership –** local multiagency arrangements committed to improving safeguarding knowledge, understanding and expertise across the wider children's workforce.

***Child Safeguarding Practice Review (CSPR)** – are statutory reviews which are undertaken when a child dies or has been seriously harmed and there is cause for concern as to the way agencies worked together.

2.3. This DHR commenced with the first meeting of the Panel members in September 2022 and was completed in December 2023.

2.4. The review has taken longer than the required six months to complete due to the nature and complexity of the review which has involved sixteen organisations. A further delay was due to a request being made at the latter stage of the reviewing process for the Crown Prosecution Service (CPS) to further review their role in "Operation XX" (operation name anonymised and was the investigation into the suspected murder of Carson's children) with that of the Police in relation to any delay in charging Carson who murdered Matilda whilst on police bail.

3. Confidentiality

3.1 The findings of the DHR are confidential as far as identifying the subjects, their families or professionals. Information has been made available only to the officers/professionals and their line managers who participated in the DHR. Pseudonyms agreed with Carson and Matilda's family are used in the report to protect their identity. Professionals are referred to by their roles for example GP, police officer or probation officer. The services that were involved are described in section seven.

4. Methodology and Terms of Reference

4.1. The circumstances of Matilda's death were reported to the Chair of Pennine Lancashire Community Safety Partnership in February 2021. It was agreed that the criteria under the Domestic Violence Crime and Victims Act 2004 for a domestic homicide review were met.

4.2. The purpose of a DHR is to review the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from domestic violence, abuse or neglect by a person to whom they were related or with whom they were or had been in an intimate personal relationship, or been a member of the same household as themselves.

4.3. The methodology of this review complies with national guidance described in *multi-agency statutory guidance for the conduct of domestic homicide reviews (December 2016).* This included identifying a suitably experienced and qualified independent person to chair the panel and to provide the overview report for publication.

4.4. The decision was taken to commission the same independent reviewer as the CSPR which relates to Carson's two murdered children and the attempted murder of a third child. The rational for this was that the timeline of the CSPR conjoined with the timeline of Matilda. Agencies who had significant contact with Matilda and her family and with Carson provided Individual Management Review (IMR) reports to address the Terms of Reference. Agencies with minimal contact were asked to share a summary review.

4.5. The timeline for the detailed collation and analysis of information is from when Matilda first started having a relationship with Carson up until the date of her death in October 2019. Historical background was shared to provide context to the situation.

***Independent Management Review (IMR) -** is a report detailing, analysing and reflecting on the actions, decisions, missed opportunities and areas of good practice within the individual organisation.

Key Terms of Reference:

1. To establish the circumstances surrounding the homicide
2. To establish whether there are any lessons to be learned from the case about the way in which professionals and organisations work together and carried out their duties and responsibilities and to identify areas of good practice.
3. To identify clearly what those lessons are, how they will be acted upon and what is expected to change as a result.
4. To establish whether the concerns and responses by professionals and their organisations were appropriate both historically and, at the time, leading up to the homicide.
5. To establish whether organisations have appropriate policy and procedures to respond to the circumstances identified in this case and to recommend any changes as a result of the review process, with the aim of better safeguarding victims and their families.
6. All enquiries was restricted to a period of no more than 2 years prior to the date of the domestic homicide and until the review has concluded. Historical information or convictions of domestic abuse, outside of this timeframe was included to provide context.
7. To provide details of additional records concerning domestic violence and medical Issues including mental health or physical injury or disability that may have a relevant impact on the review.
8. To consider any cultural or environmental issues which may have contributed to barriers faced by the victim in accessing protection and examine why any targeted interventions were not effective.

5. Scope of the review

5.1. The review takes account of national guidance and identifies the specific issues of relevance and include the following areas:

1. Impact of past childhood trauma on Matilda's decision making and actions.
2. Background of a criminal investigation into Carson's past history of suspected murder of his children and coercive control of their mother.
3. The protection of Matilda's young child.
4. The complexity of the police criminal investigation examining the suspicious deaths of two of Carson's children which took place during a Covid pandemic.
5. The effectiveness of the police, probation and judiciary services in managing Carson's future offending and promoting the safety of Matilda and Carson's ex-partner.
6. The role of domestic abuse services and MARAC in keeping Matilda and ex-partner safe
7. The role of women's refuge and supportive housing in establishing a safe environment for Matilda.

5.2. The review panel considered how any family members, friends or other support networks could contribute to the review with all persons identified being invited to take part.

6. Contribution of family and friends

6.1. The panel is grateful for the assistance provided by the Victim Support Practitioner who had provided leaflets from Advocacy After Fatal Domestic Abuse (AAFDA) and other relevant support materials to the family and supported the Independent Reviewer in arranging a face-to-face meeting with Matilda's "parents." (Parents are ex-Foster Carers with Special Guardianship Order who Matilda viewed as being her parents).

6.2. Special thanks go to Matilda's parents who gave their time to share their many fond memories of Matilda with the Independent Reviewer and Domestic Abuse Co-ordinator. The family were invited to comment on the terms of reference for the review at this first meeting. The parents were kept up to date throughout the reviewing process through their Victim Support Practitioner.

6.3. The parents have provided significant insight into the circumstances which led to their daughter's homicide and supported the Independent Reviewer in having an impromptu telephone conversation with one of Matilda's best friends who provided their reflections into Matilda and Carson's relationship which was most helpful.

6.4. A feedback meeting has taken place following completion of the final draft report which involved Matilda's parents, Independent Reviewer, Community Protection Manager and supported by their Senior Caseworker (Victim Support). The parents clarified a number of points made in the report which have since been addressed. Overall, the parents agreed with the learning identified within the report and recognised the complexity of the issues raised. It is a credit to them that despite their disagreement with Matilda over the relationship with Carson, they remained a constant source of love and support to her.

6.5. The panel is also grateful for the assistance of HMP Wakefield who facilitated a virtual interview between the Independent Reviewer, Community Safety Manager for Blackburn and Darwen Borough Council and Carson. A list of questions was provided in advance of the meeting to reassure Carson of the nature of the information being requested. The panel thank Carson for his attendance at the meeting and for sharing his recollections.

6.6. Other interested parties approached by letter have included Matilda's ex-partner, who is the birth father of Matilda's child and Carson's close family members. There has been no response from these parties and their right not to participate in the DHR process has been respected.

7. Contributors to this DHR

7.1. There were sixteen organisations who confirmed their involvement with Matilda and Carson. Twelve organisations were requested to provide IMR's with the remaining four organisations providing a summary of their involvement. The panel confirmed that authors of the IMR's had no prior knowledge or engagement with the subjects of the review to ensure their independence.

Organisations involved in this DHR and have provided an IMR include:

Blackburn with Darwen Borough Council Children's Services – Matilda was the mother of a young child and Children Social Care became involved as a response to child protection concerns at the start of Matilda and Carson's relationship in July 2017. Their involvement was based on information they held from a previous case and involved extensive child and family assessment resulting in Matilda's child being placed under a Full Care Order with the child's birth father and the case closed in September 2019.

Blackburn with Darwen Borough Council Adult Service – Carson received two short interventions from an Approved Mental Health Professional (AMHP) who conducted a Mental Health Act (MHA) assessment in May 2018 and June 2019. The first MHA assessment concluded that Carson did not have a mental health disorder. The second MHA assessment found Carson to have chronic depression and was awaiting a mental health in-patient bed when he was arrested by the police for failing to attend court for a sentencing hearing. Further information was provided on a short intervention in March 2018 for the ex-partner of Carson who was at serious risk of suicide and had become an in-patient on the mental health unit.

Lancashire & South Cumbria Integrated Care Board (ICB) – Medical record information provided by the GP practice relating to Carson commenced from when he was 2 years old up to October 2019 which highlighted a number of mental health and behavioural issues. GP information relating to Matilda revealed a past history of childhood abuse, low mood and behavioural issues raised in 2010. Matilda was seen in 2018 for low mood for which she was assessed and treated. The GP was aware of two pregnancies but was only informed of one termination of pregnancy which took place in 2017.

East Lancashire Hospitals NHS Trust (ELHT) – Patient notes for Matilda dating back to May 2010 provided information relating to childhood issues around learning difficulties and concerns of early sexualisation. Matilda had attended the hospital for maternity care commencing June 2016 with the birth of her child in 2017. Matilda was referred to the hospital gynaecological service and was seen on a number of occasions until December 2018. Both Carson and his ex-partner attended the hospital Emergency Department on separate occasions during 2018 – 2019 relating to minor injuries and mental health crisis.

Lancashire & South Cumbria NHS Foundation Trust (LSCFT) – Children and families 0-19 services became involved when Matilda became pregnant in 2016 and remained involved until 2018 following the child being placed with the birth father.
There were seven brief interventions between 2018 and 2019 relating to Carson having contact with the mental health service.
Carson's ex-partner was seen on a number of occasions for mental health issues between 2018 to 2019.

WISH Centre (Blackburn & Darwen District Without Abuse Ltd) – WISH is a commissioned specialist domestic abuse service to which Matilda was referred in January 2018 by children social care to attend AIM programme and there were multiple contacts with Matilda up until April 2019 at the point she appeared to disengage from the service.
Carson's ex-partner was also known to WISH from October 2016 and they continued to provide support on an intermittent basis throughout the scoping period.

Domestic Abuse Support Services in South Lakeland – Matilda moved from Chorley Refuge to resided at the refuge in South Lakeland for single women from April 2018 to July 2018 from where she was evicted following disclosure of her whereabouts to Carson.

Together Housing Association (THA), Matilda had a tenancy (flat) with THA, a Supported Housing Scheme from August 2018 at which point Matilda was known to be a victim of domestic abuse and in a relationship with Carson for which there was a non- molestation order granted by the courts to prohibit Carson from contacting Matilda. The tenancy was held up until her death. **(Additionally, a total review of the service was undertaken and shared as part of this DHR).**

Lancashire Constabulary – Carson was known to the Police from 2003. In 2016 Carson was arrested for the attempted murder of a four-month-old child resulting in the Senior Command Assistant Chief Constable holding a "Gold Command" meeting to consider the deaths of Carson's previous children in 2013. A serious crime investigation was commended under 'Operation XX' and the Senior Investigation Officer (SIO) immediately engaged with the Complex Case Team of the Crown Prosecution Service (CPS).

This was an extremely complex investigation which eventually led to Carson being charged with the murder of two children and the attempt murder of a third child. During Operation XX Carson remained on Conditional Police Bail and it was within this period that Carson murdered his partner, Matilda.

The Police Protection Unit was involved in safeguarding Carson's ex-partner and Matilda as known victims of serious coercive control by Carson. Three referrals to Multiagency Risk Assessment Conference (MARAC) were made by them on behalf of Matilda during the review period of the review. **(Additionally, the independent reviewer was able to conduct a face-to-face interview with the SIO for the case).**

Crown Prosecution Service (CPS) – Carson had several previous convictions starting from 2013. CPS had detailed involvement with Carson and Matilda commencing August 2018 up until October 2019 and covers the breach of the terms of a Non-Molestation Order, suspended sentence, breach of police bail terms and Carson's initial custodial sentence for a battery offence on Carson's younger sibling which was appealed. Throughout this period CPS dealt with the charging decisions and prosecution in Operation XX. **(Additionally, a review report of CPS actions during Operation XX was requested and provided).**

Probation Service. At the time of Matilda's death Probation Services were split into two organisations, the National Probation Service (NPS) and Community Rehabilitation Companies (CRCs). In June 2021 the NPS and CRCs were disbanded and the Probation Service was formed. Carson was not managed by the NPS until after Matilda's murder.

Lancashire and Cumbria Community Rehabilitation Company - were involved from July 2019 when Carson was sentenced to 12 weeks imprisonment for offences of Breach of Non-Molestation Order and Section 39 Assault against a sibling. These offences placed him in breach of a stand-alone Suspended Sentence Order (SSO) originally imposed in December 2018 for Breach of a Non-Molestation Order (imposed July 2018 by the Family Court) and possession of a knife. The SSO imposed in December 2018 did not require contact with Probation Services. Similarly, when Carson was sentenced for the initial breach of his Non-

Molestation Order in August 2018, he received a Community Order with a stand-alone Curfew which did not require contact with Probation Services.

HMP Preston – Carson attended Magistrates Court in July 2019 and found guilty of breach of non-molestation order, assault of his teenage sibling at the family home and possession of a weapon. Carson was remanded for six-weeks out of a twelve-week sentence.

8. The Review Panel membership

8.1. The panel was chaired by Kathy Webster who is the author of this report and is independent of all organisations participating in the review.

8.2. The work of the panel was administrated and supported by the Community Protection Manager from the Community Safety Team of Blackburn and Darwen Council. Panel confirmed that panel members had no prior knowledge or engagement with the subjects of the review to ensure their independence.

8.3. Panel member names have not been given. This is because there has been significant television coverage about this case prompting caution in naming individuals practicing locally.

8.4. The role of panel members was to represent their organisation by providing an IMR and additional information on request. Other tasks involved the determination of the scope for the terms of reference for the review, provide respectful challenge around the analysis presented and to quality assure the content of the report.

8.5. The first panel meeting took place in September 2022 and there were three further panel meetings to receive and consider the IMRs prior to writing the report. During the report drafting period, there was a further nine panel meetings due to the panel requesting additional information from Police, Probation and CPS. Also, owing to the vast amount of information available, several meetings overran necessitating additional meetings.

Membership of the review panel

JOB TITLE	**ORGANISATION**
Independent Chair and Report Author – Kathy Webster	Safeguarding Consultant
Community Protection Manager	Pennine Lancashire Community Safety Partnership
Head of Social Work & Specialist Services	Blackburn with Darwen Borough Council Children's Services
Service Lead – Specialist Services	Blackburn with Darwen Borough Council Adult Services

Deputy Designated Nurse for safeguarding and children in care.	Lancashire & South Cumbria Integrated Care Board
Adult Safeguarding Team Nurse	East Lancashire Hospitals NHS Trust
Named Nurse for Safeguarding	Lancashire & South Cumbria NHS Foundation Trust
Chief Executive Officer	Blackburn & Darwen District Without Abuse Ltd (WISH)
Chief Executive Officer	Springfield Domestic Abuse Support Services
Assistant Director of Supported Housing and Neighbourhood Safety	Together Housing Association
Safeguarding Manager	Together Housing Association
Lead Review Officer	Lancashire Constabulary
Deputy Chief Crown Prosecutor	Crown Prosecution Service
Senior Probation Officer	Probation Service

Statement of independence and experience on behalf of the Independent Chair and author review.

8.6. Kathy Webster has not been directly concerned with the subjects of this review or any of the family members or professionals involved, or given any professional advice on this case at any time. Kathy has over forty years' midwifery and children nursing experience working in a variety of settings in the NHS. The final eighteen years in the NHS was working in specialist safeguarding roles including Designated Nurse Safeguarding and Looked After Children. Kathy has a number of nursing and midwifery qualifications including BMedSci in clinical nursing (child) and MSc in Healthcare Education (safeguarding) and has completed the AAFDA course on Domestic Homicide Reviews.

8.7. Kathy has completed a number of published Serious Case Reviews/Child Safeguarding Practice Reviews, Serious Adult Reviews and has been involved in the production of a number of Domestic Homicide Reviews. Kathy completed three Serious Case Reviews within Lancashire between 2019 and 2020 and was the author of the Child Safeguarding Practice Review published in 2022 which relates to the children murdered by Carson who is the perpetrator in this DHR.

9. Parallel Reviews

9.1. The criminal trial for this case was completed in December 2021. Carson was found guilty of the murder of his partner Matilda and of the historical murders of two of his

children in 2013 and for the attempted murder of a third child (2016) who cannot be identified for legal reasons.

9.2. Carson received a forty-year prison sentence which was overruled by the Lord Chief Justice who concluded that the sentence was too lenient and a further eight years was added onto the sentence. Carson made an appeal against his convictions in February 2023 which was dismissed by three Court of Appeal Judges in London who concluded that the "trial proceeded fairly".

Further reviews have included:

- **Coroner's Inquest** did not take place into the death of Matilda. H.M. Coroner sent a form 121 to the Registrars in May 2023 to explain that they did not intend to conduct an inquest as there had been a conviction of murder and the family had not requested for this as was their right.
- **Independent Office for Police Conduct (IOPC)** which found no reason for disciplinary proceedings and no organisational learning for improvement.
- **Police Professionals Standards** relating to Police practice in this case, which resulted in no required further action.
- **A Serious Further Offence Review** conducted in May 2021 by the CRC has not been shared with the Review Panel although key findings identified have been shared and addressed by the new unified Probation Service (NPS).
- **Child Safeguarding Practice Review (CSPR)** CSPR Child C, D & E - The murders and attempted murder of the three children highlighted in this DHR were the subjects of a published CSPR. Carson's coercive controlling behaviour was not recognised until after his arrest for attempted murder in 2016, the understanding of which predates this DHR. A copy of the Child C, D & E CSPR can be requested in writing to SafeguardingPartnerships@blackburn.gov.uk.

Areas of learning from the CSPR most relevant to this DHR:

1) Coercive Control - Carson had demonstrated coercive controlling and manipulative behaviours with his long-term partner who was unaware of the toxic nature of the relationship at the time. When the relationship was strained, he was adamant that his partner would not leave the relationship and used their two children as "tools" to prevent the relationship from ending.

2) Fabricated or Induced Illness of a child (FII) - Carson was found at a Finding of Fact hearing to be a cruel and manipulative individual who was guilty of having caused Fabricated Induced Illness in two infants and one toddler by non-fatal smothering requiring hospital admission following reports of a brief resolved unexplained episode (BRUE). He later went on to murder (by smothering) two of his children and attempted to murder a third child.

Fabricated Induced Illness of a child (FII) - is a rare form of child abuse. It happens when a parent or carer exaggerates or deliberately causes symptoms of illness in the child.

3) Manipulation of professionals - Carson was seen to take centre stage following the children's hospital admissions / deaths and was found to be a skilful liar, able to manipulate professionals by providing very plausible explanations about the events which at the time were believed.

10. Equity and Diversity

10.1. Section 4 of the Equality Act 2010 offers protection from discrimination in respect of the protected characteristics under the Act. Importantly, the Act prohibits any protected status for domestic abuse and violence. Public authorities have an additional duty to eliminate discrimination and to promote equality of opportunity called the public sector equality duty.

Consideration of the protected characteristics:

- **age** – the subjects were both adult with a five-year age gap which held no significance in terms of their relationship.
- **disability** –none of the subjects of the review had any diagnosed physical or mental impairment, which would have defined them as disabled.
- **gender reassignment** – no issue found in this review.
- **marriage and civil partnership** – the subject couple were not married or engaged.
- **pregnancy and maternity** – there were two pregnancies none of which related to employment matters.
- **race** – both subjects identified as "White British." There were no issues of racial discrimination.
- **religion** – Carson described himself as being Roman Catholic and Matilda did not identify with any religion – no religious discriminatory issue was found in this review
- **sex** – the subjects were in a heterosexual relationship. It is recognised that Domestic homicide, and domestic abuse in particular, is predominantly a crime affecting women; with women by far making up the majority of victims, and the vast majority of perpetrators being male.
  On average, two women are killed each week by their current or former partner in England and Wales, a figure that has remained unchanged for a number of years. It impacts on women's health and independence, reduces their ability to work and creates a cycle of economic dependence. Women's inequality limits their ability to escape from abusive relationships; it can make it more difficult for them to enforce their rights and more likely to experience sexual harassment and violence.
- **pregnancy** – in this case, the victim became pregnant on at least two occasions but opted from termination of pregnancy rather than having a baby linked to the abuser. As a victim of physical and coercive controlling abuse Matilda took the option to conceal the truth from Carson and told him she had miscarried. This was seemingly a strategy used to prevent a volatile reaction from Carson and keep herself safe. However, the impact of these acts would have been significant in terms of increased stress levels and emotional distress. It is known that pregnancy can be used by men to entrap women by increasing the women's level dependency and vulnerability.

- **additional context -** this complex homicide is unusual in that it involved coercive control by a male, who was under police investigation for the murder of children, went on to murder a partner by deliberately administrating lethal amounts of illegally obtained prescribed medications and then tried to manipulate professionals into believing that the death was a suicide.

11. Dissemination of this DHR report

List of recipients who will receive the report:

- The Home Office.
- Domestic Abuse Commissioner
- Family members involved in the review
- IMR authors
- DHR8 Panel members
- Pennine Lancashire Community Safety Partnership
- Blackburn with Darwen Domestic Abuse Partnership Board
- Blackburn with Darwen Child Safeguarding Assurance Partnership (CSAP) & Blackburn with Darwen Safeguarding Adults Board

12. Background to this DHR

Summary of the incident which was the catalyst for this DHR

12.1. One evening in October 2019, Matilda was found unresponsive in bed at the home of her partner's (Carson) aunt and uncle where Matilda and Carson had been intermittently staying. Matilda was found by the auntie who raised the alarm and a 999-ambulance call was made. The call handler gave advice on resuscitation until the paramedic arrived at the scene who then maintained resuscitation for a time but was unsuccessful following which Matilda was pronounced dead at the scene. The police were requested to attend in line with local protocol.

12.2. The story given by Carson to the police was that Matilda had been unwell for a week and over the past two days she had been complaining of sickness, diarrhoea, weakness, feeling sleepy and appeared unwell. Matilda had remained in bed for most of the time and was said to have been taking Paracetamol and Night Nurse for flu symptoms. Carson said Matilda had been seen by a GP earlier in the day which was later found to be untrue.

12.3. Carson alleged that Matilda had sent him a text saying that she was going to *"take a load of drugs because I don't want to be here anymore"* but then she had apparently denied taking any drugs when he went to check on her. Matilda was said to have become drowsy after taking one sleeping tablet (Zopiclone) which had been prescribed for Carson. Prior to Matilda' being found unconscious, Carson had been away from the premises for three hours with Matilda in the care of the auntie and uncle who had returned home from work before he left. When the auntie had first checked on Matilda she appeared to be snoring and asleep, but was later found to be unresponsive at the point Carson returned to the property.

The findings of the pathologist

12.4. The post mortem found that Matilda had died as a result of Tramadol and Diazepam toxicity, both of which are prescribed drugs and none had ever been prescribed to Matilda.

- **Zopiclone** is a drug prescribed in the treatment of insomnia.
  Side effects - include gastrointestinal disturbance including nausea and vomiting, dizziness and drowsiness.
- **Diazepam** is a drug prescribed in the treatment of anxiety related disorders and known to be subject to usage abuse.
  Side effects - include drowsiness, light headedness, confusion, muscle weakness and gastrointestinal disturbances.
- **Tramadol** is an opiate analgesic drug prescribed to treat moderate to severe pain.
  Side effects - include nausea and vomiting, constipation and drowsiness. Signs of overdose of Tramadol include severe drowsiness, weak or floppy muscles, cold and clammy skin and seizures. Tramadol in excessive dosage acts on the central nervous system and can lead to unconsciousness, coma and death.

12.5. The conclusion of the post mortem was that the mechanism of death was due to central nervous system depression. It was noted within the report that there were a number of small circular bruises on the inner aspects of both arms which were superficial and could possibly have been grab marks although this is not speculated on further within the report.

12.6. Carson was convicted of her murder in December 2021 and the prosecution case stated that Carson had killed Matilda by giving her repeated doses of prescription only medications which he had obtained illegally over a period of days before her death.

Events leading up to the death

12.7. At the time of Matilda's death, she had a flat at THA but was spending most of her time at different family addresses and locations with Carson. As previously stated, Carson remained under police investigation (Operation XX) and was on police bail throughout the timeframe.

12.8. When Carson met Matilda, he had recently split from an ex-partner shortly before a Family Court Hearing held in May 2017. The court hearing had been to consider possible Fabricated Induced Illness in a child who had been cared to him. At this time Matilda had her own young baby in her care, but following Children's Social Care assessment, the child was eventually placed with the birth father due to Matilda continuing a relationship with Carson who had been assessed as being a serious risk to children.

12.9. Eight months into their relationship Children's Social Care referred Matilda to WISH for domestic abuse services where she later disclosed that she was a victim of domestic abuse (coercive control) by Carson. Matilda stated that she was afraid that he would harm her child and the child's birth father if she tried to leave the relationship.

12.10. Matilda made a Police statement and was provided with a place of safety at a Women's Refuge and Carson became subject of a Non-Molestation Order as part of her safety plan. However, Matilda continued to see Carson and in 2019 Carson served a prison term for breaching his Non-Molestation Order, assault of his teenage sibling and for

possession of a weapon. He was sentenced to twelve weeks imprisonment which was reduced on appeal.

12.11. Just prior to Carson being imprisoned the Non-Molested Order which was in place to protect Matilda had expired and a stand-alone Restraining Order was issued by the court to protect Matilda and Carson's teenage sibling. This was withdrawn approximately six weeks later at Carson's Appeals Hearing at the request of the younger sibling and Matilda. Ten weeks later Matilda was murdered by Carson.

12.12. The trial relating to Matilda took 10 weeks to complete and included both the murder and attempted murder of the children being investigated through Operation XX. Carson was given a 40-year prison sentence which was increased to 48 years by the Lord Chief Justice who felt that the first sentencing term had been too lenient given the circumstances.

13. Narrative Chronology – Summary information outside the timescale

Historical information – Matilda

13.1. Matilda was known to Children Social Care for periods throughout her childhood due to her family connection with a High-Risk Sex Offender. She was a victim of childhood physical, sexual and emotional abuse until the age of 7 years when she became subject of an Interim Care Order and moved into Foster Care.

13.2. Matilda remained a Looked After Child with the same Foster Carers who were granted a Special Guardianship Order when she was 14 years old and she changed both her forename and surname by Deed Poll to reflect her adopted family whom she regarded as family when she was 17 years old.

13.3. It was recognised that Matilda had suffered significant trauma as a young child which affected her emotional resilience and behaviour throughout her childhood.

13.4. Matilda was 20 years when she gave birth to her child. The midwife recognised Matilda's level of vulnerability and reported a period of non-engagement and missed appointments which were appropriately addressed at the time.

Historical information – Carson

13.5. Carson lived with his birth family who had a long history of domestic abuse. During early childhood he was recognised as having speech delay and behaviour problems. There had been an Education and Health Care Plan (EHCP) for Carson in school and he was accessing the school counselling service. When behaviour issues continued, he was referred to Child Mental and Adolescent Mental Health Services but it is unclear if was taken for assessment by his parents.

***Non-Molestation Order**- is a type of injunction which can be sought by a victim of domestic abuse against their abuser.
***Restraining Order** - is an order used by a court to protect a person in a situation involving alleged domestic violence, child abuse, assault, harassment, stalking, or sexual assault.
***Interim Care Order** - is a short-term court order which means that a child becomes looked after in the care system.
***Looked After Child** – is a child in the care of the Local Authority for more than 24 hours and often referred to as children in care.
***Education and Health Care Plan (EHCP)** – is for children and young people aged up to 25 who need more support than is available through special educational needs support.

13.6. At the age of 12 years Carson was known to be smoking, drinking alcohol and had his first police warning for criminal damage.

13.7. At 13 years Carson was admitted to hospital following cocaine and alcohol use. A referral to Children Social Care was made but it is unclear if this resulted in any intervention by them.

13.8. When Carson was 18 years, he requested support from his GP for anger issues and irritability. He disclosed that he had held his girlfriend's neck to try to strangle her. Criminality and safeguarding were not considered at the time and it has been recognised that this is an historical account and practice has improved since that time. Later that year he was arrested by the Police for the assault (throwing an ashtray) at his girlfriend (ex-partner).

13.9. During Carson's adult life he was said to be employed on construction sites and at some point, he was said to have set up his own construction company with several building sites involved. In 2013 Carson experienced the sudden unexpected death of his child age 23 days who at the time was thought to have died with bronchopneumonia. The second child was 21 months when they suddenly and unexpectedly died at home. This death was recorded by the coroner as unascertained.

13.10. Carson reported to the police that he was a victim of domestic abuse by his partner (ex-partner), which he later admitted was a lie. He was arrested later that year (2016) for the suspected attempted murder of a child of 4 months. At this point his relationship with his ex-partner had ended although Carson continued to remain in contact with her.

History of ex-partner

13.11. The ex-partner met Carson when she was 10 years old and became pregnant with Carson when she was age 19. She provided an historical account that Carson was extremely controlling throughout their relationship and he had debt problems due to gambling.

13.12. Following the deaths of her two children the ex-partner was treated for significant mental health issues and was supported by local specialist domestic abuse services (WISH) who helped her to finally break free from Carson who continued to try to manipulate and control her including during his relationship with Matilda.

14. Information within the timescale of the review.

Relevant information pre-dating Matilda's relationship with Carson. (February 2017 and June 2017).

14.1. Matilda was living with her partner, who was the birth father of her first child. Their relationship became under pressure following the birth and Matilda was looking to end this relationship and move out of their home with the baby.

14.2. Between March and May 2017, Carson and his ex-partner briefly reconciled which had been despite Police bail conditions being in place for Carson to have no contact with her.

14.3. Later in May 2017 there was a Family Court Hearing where it was found that Carson was on the *"balance of probability"* responsible for causing the collapse of an infant known

to him by deliberately obstructing the child's airway. Carson was described by the Judge as being a *"dangerous man"* and *"convincing liar."* The Finding of Fact findings were reported directly to Lancashire Police who followed this up with a Gold Command meeting which in turn resulted in a serious crime investigation under the name Operation XX.

14.4. Operation XX involved the attempted murder of the 4-month-old child (2016) and reopened the historical investigation into the deaths of Carson's two young children who had both died in his care during 2013.

Information relating to Matilda's early relationship with Carson and initial safeguarding arrangements for Matilda's child. (July 2017 – October 2017)

14.5. In July 2017 Children Social Care became aware that Carson was seeing Matilda and there were concerns for her child (5 months) with regard to the information they held about the significant risk Carson posed to children. Matilda had met Carson at the pub where she worked at a time when her relationship with the birth father of her child had broken down and she was about to move into her own property with her child.

14.6. Matilda and the child's birth father were alerted by a Social Worker of the risks to children posed by Carson. Matilda agreed not continue the relationship and the birth father agreed to inform the Social Worker if Matilda continued the relationship with Carson. In light of the agreement the case was closed.

14.7. Carson's ex-partner informed Children Social Care of an altercation in the bar where she worked which had involved Carson and Matilda. Matilda was reported as being pregnant by Carson confirming their relationship. This information was noted on the ex-partner's file and therefore did not trigger a Multiagency Safeguarding Hub (MASH) referral on behalf of Matilda's child.

14.8. Matilda's ex-partner informed the Social Worker that Matilda was still seeing Carson although Matilda denied that this was the case. Matilda was requested to sign a "Schedule of Expectations" (contract) confirming that her child would not have any contact with Carson. The child remained open to Children Social Care on a Child in Need (CIN) plan.

14.9. A CIN meeting took place in September 2017 and was held in respect of Matilda's child who was still felt to be having contact with Carson and had recently missed a health appointment for a scold on their arm. Matilda admitted that she was pregnant with Carson's baby but reported she did not want a relationship with him. A child protection strategy meeting on behalf of the child and unborn baby was indicated at this point but did not occur.

14.10. There was a further sighting reported to the Police of Carson and Matilda being together at Matilda's home which was shared with Children Social Care. A further sighting was indicated when the pair were involved in an altercation with a taxi driver over the fare resulting in Carson receiving minor injuries.

***Multiagency Safeguarding Hub** - is a partnership of different agencies that enables fast information sharing and decision making to safeguard vulnerable children.

***Child in Need (CIN) Plan** – is a multiagency plan to help children and families who need extra support or services to enable children to achieve their full potential

14.11. A Child Protection strategy meeting was convened in October 2017 and the conclusion was to hold an Initial Child Protection Conference (ICPC) which was planned to take place later that month. However, Social Workers witnessed Carson at a meeting being volatile and aggressive which further raised their concern about the safety of Matilda's child. The plan to hold an ICPC was dropped and instead, steps were taken for an Interim Care Order to remove Matilda's child to a place of safety. Arrangements were made for regular supervised contact between Matilda and her child.

Information relating to initial steps to safeguard Matilda and ongoing concern for the ex-partner. (November 2017 – March 2018)

14.12. A Social Worker visited Matilda in November 2017 as part of the ongoing parenting assessment and to read the judgement of the Finding of Fact heard in the family court relating to Carson being suspected of attempted child murder. It is recorded that Matilda could not believe what he had done to a child to save his relationship with his ex-partner who was planning to leave him at the time of the incident. Matilda agreed that Carson may hurt her child to get back at her. Later that day Matilda had a pregnancy scan and requested a consultation around termination of pregnancy because she felt that the baby would always link her to Carson.

14.13. Following the termination of pregnancy Matilda reported to the social worker that she had told Carson that she had lost the child naturally by miscarriage and Carson had shown no emotion around this. Matilda was put in touch with the local specialist domestic abuse service (WISH) for support who were already working with Carson's ex-partner.

14.14. During this period the police received a call from the sibling of Carson's ex-partner stating that Carson had threatened to burn their house down. A fire assessment was completed and police officers issued a Harassment Warning to Carson following this report in late 2017.

14.15. WISH was concerned about the ex-partner's mental health and level of suicide ideation. The potential risk posed by Carson towards his ex-partner was discussed which highlighted the threats made by Carson. These threats were further highlighted during the ex-partner's psychological assessment that reported her saying that *"where ever I go he will find me and make my life hell."* The ex-partner raised concern of Carson sadistic nature towards animals and the abuse he directed towards his children (suffocation) was also discussed. A mental health support and a safety plan was initiated for the ex-partner by the police serious crime team.

14.16. Matilda was referred to WISH by the Social Worker for her to commence the Awareness, Insight, Motivation (AIM) programme in January 2018 and she settled in well. Matilda revealed that the relationship was finished and she had blocked phone and social media contact with Carson but was afraid he would find her new address and try to visit her.

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*I**nitial Child Protection Conference (ICPC) –** is a decision-making meeting to consider if a child requires a Child Protection Plan.
***Interim Care Order** – is a temporary order made by the court that places a child in the care of the local authority or another suitable person.

14.17. Two days later the police were informed that Carson was still in a relationship with Matilda. A joint visit by police and social worker took place at Matilda's home where she denied seeing Carson despite evidence to the contrary.

14.18. WISH confirmed that Matilda had lost contact with them, following which they reconnected with her in March 2018 and she agreed to recommence the AIM programme.

14.19. Also, in March 2018 Carson's ex-partner disclosed to her Mental Health Care Coordinator that she had met up with Carson around five times since Mother's Day after bumping in to him at their children's grave and he had been *"really nice"* to her. She disclosed that Carson had told her that he was still seeing Matilda and they were trying for a baby and planned to move away so they could keep the baby, *'he said the system is f***ed and he thinks he can beat it'*.

14.20. The ex-partner was remorseful and concerned over disclosing this information to the police. This resulted in the ex-partner being moved to a new location for her own safety. A short time following this move, the ex-partner was admitted to hospital for an attempted suicide by drug overdose.

Information relating to the assessment and management of the risk posed to Matilda. (April 2018 – July 2018)

14.21. WISH made a police referral in April 2018 following a disclosure made by Matilda that Carson was threatening to burn down the home of her child and the child's birth father if she ever tried to leave him. This resulted in Matilda being found a placement at Chorley women's refuge for her own safety.

14.22. In Police interview Matilda stated that she had left him that day and he threatened to "hurt the baby" (her child) and he was repeatedly ringing her. She reported that Carson had not physically hurt her but there have been incidents when she had been backed up against a wall and he would be screaming in her face and this was happening 2-3 times per week.

14.23. Matilda stated that when she had tried to end the relationship, he had threatened to hurt her child and the child's father. Matilda felt the only way to keep them both safe was to continue the relationship. She said *"I got it, it just got to the point where I have to stay, stay with him to keep my child safe because I know he won't hurt my child as long as I stay as I am with him."*

14.24. Matilda appeared very afraid of Carson and was concerned for the safety of her child's father who had recently moved. Matilda was aware the Carson had followed him and knew his new address. A referral to Multiagency Risk Assessment Conference (MARAC) was made which took place in early May 2018. The MARAC risk assessment found that Carson was a high-risk perpetrator but no action log appeared to be completed in recognition of this.

***Multiagency Risk Assessment Conference (MARAC)** – is a meeting where agencies share information and develop safety plans for high-risk victims of domestic abuse

14.25. Coincidently, later on, that same day Carson was arrested by the Police Major Investigation Team and was interviewed for the historical deaths of his two children who died in 2013. At this arrest Carson threatened to commit suicide stating he was depressed.

14.26. The next day Carson was released on police bail with conditions that he should not have any contact with a child under 16 and not to have contact with the witnesses of the case including Matilda and his ex-partner.

14.27. The police risk assessment at the time considered that Carson *"posed a risk to children and vulnerable adults."* His risk to Matilda was initially assessed as being "*low risk because she was a young adult and said to be in a relationship that she was content with*." However, it was recognised that if she *"came to the end of the relationship the review of her risk was to be reconsidered at this point."*

14.28. In Blackburn Family Court a Non-Molestation Order was put in place for Carson not to have any contact with Matilda with a number of reinforcing conditions in place. This Order was to remain in force until the May 2019 unless revoked by a further Order of the Court before this date.

14.29. Within a few days of Matilda staying at the Chorley women's refuge she was evicted for breaching the rules around meeting up with Carson and revealing where she was staying. Matilda was collected and returned home by a police public protection officer.

14.30. Matilda disclosed to the officer that she was in fear of Carson, who had been manipulative and controlling and he understood when she was at her most vulnerable and would prey upon that. Matilda was in fear of leaving her house and had no support network around her. WISH supported Matilda to move to another women's refuge in South Lakeland. Matilda was mainly concerned about the distance and how she could keep her weekly supervised contacts with her child.

14.31. Once settled at the second refuge, Matilda attended her new GP with low mood and was diagnosed with "low mood" for which she was prescribed appropriate antidepressant. Matilda continued to see a GP for mental health management on and off throughout the majority of the timeline.

14.32. A few days following Matilda's move to the second refuge, Carson was reported to the police as a missing person. He was found later that evening attempting to jump off a multi-storey car park. Carson was taken to hospital for a Mental Health Assessment which found no evidence of a mental health disorder and he was discharged. The next day it transpired that Carson had emotionally blackmailed Matilda into to speaking to him via a family member to prevent him from jumping off the building. Matilda admitted to speaking to him for 20 minutes until the police arrived. She was very worried about how this would affect her contact with her child.

14.33. South Lakeland women refuge's assessment of Matilda was that she was at serious risk (high risk) from Carson and a safety plan was agreed. Matilda blocked Carson from Facebook which was their usual mode of contact. She was seen by a police officer (public protection team) for welfare check where Matilda explained the situation and said "*I'm*

scared but know he will only hurt me if you get him." She expressed that she did not want to be here (alive) and felt her child was better off without her.

14.34. WISH closed Matilda's case after a Review MARAC transfer was completed because Matilda was felt to be in a safe place. The Independent Domestic Abuse Advisor (IDVA) who was based with WISH continued to be in contact with Matilda for additional support.

14.35. Family Court Proceedings concluded in May 2018 in relation to Matilda's child. It was felt that Matilda's vulnerabilities left her open to persuasion by Carson to resume/maintain the relationship. Assessments of Matilda noted positive aspects of the parenting and noted that she could provide good care for her child but the risks presented by the continuing contact with Carson were too great. The court decided to place the child into the care of the birth father under a Care Order. Arrangements were made for Matilda to have supervised contact with her child once a week at her parents' home. Children Social Care subsequently closed the case in September 2019 after a period of support with contact arrangements.

14.36. There appeared to be a brief period where Matilda and the child's father were back in touch with each other. However, Matilda continued to message Carson every day on WhatsApp and was receiving money from him. She admitted that she was finding it difficult to break from Carson as her feelings were still strong but agreed to block his number. A final warning was given by the women's refuge to Matilda for the ongoing contact with Carson.

14.37. A welfare visit took place in June 2018 between Matilda and her child's Social Worker. Matilda's past childhood history was discussed and Matilda reflected that she wanted to change and get away from Carson to fight for shared care of her child. Matilda denied seeing Carson although intelligence was available that she had been out with him in Wigan. Her mood was low and she was focused on seeing her child the following day.

14.38. A resident at the refuge reported to staff that they had seen a picture of a positive pregnancy test from Matilda. Matilda told staff she was going to spend the weekend with her parents, but was seen going to a hotel with Carson. In relation to this Matilda was visited at the Refuge by Public Protection Police Officers where she denied contact with Carson. She reported to the officers that she was not frightened of Carson and believed that she was not at risk from him. Matilda stated that she '*did not require a high level of safeguarding.'*

14.39. In July 2018 Matilda was evicted from the women's refuge in South Lakeland for disclosing the address of her whereabouts and continuing to meet up with Carson against advice. Matilda was collected by a police officer (public protection team) and taken to Blackburn for an emergency accommodation placement at the Salvation Army.

Information regarding Matilda's continuing risk and the management of Carson's offending behaviour leading to his first imprisonment. (August 2018 – June 2019)

14.40. Contact between Matilda and her child changed to being supervised by the children social care contact team because her family no longer felt able to supervise contact due Matilda's continuing association with Carson. Matilda was seen at the Salvation Army by the child's Social Worker where she reported feeling trapped by Carson and alone. She admitted seeing Carson daily and recognised that if she had her child back, she would not be able to

keep the child safe. She recalled that Carson was insistent that he did nothing wrong to the children he had been accused of murdering.

14.41. Later in August 2018, Matilda moved into THA supported housing scheme, following a referral from the Council's Housing Needs Team. The THA assessment viewed Matilda as being high risk.

14.42. A second MARAC meeting took place in early August 2018 following a referral from the Police around a number of threats made against Matilda's child, the child's birth father and Carson's ex-partner who had been subjected to stalking by Carson. It was confirmed that Carson was a high-risk perpetrator of domestic abuse and there was a non-molestation order in place to protect Matilda until May 2019. It was clarified that Matilda was still seeing Carson but had admitted that she was fearful of him and he was controlling and manipulative towards her.

14.43. Later, in August 2018, Carson was found to have breached the terms of the non-molestation order by being in the company of Matilda in June 2018. Police referred the matter to CPS who agreed the charge was fully met but under the wrong legislation. This was amended to the correct legislation and Carson entered a guilty plea and was sentenced to a Community Order with a six-week curfew between 9pm and 6am daily, to be electronically monitored, costs of £85 and victim surcharge of £85. Matters concluded and there was no further activity on file. The magistrate's court was unable to identify any risk factors so Carson was not seen or assessed.

14.44. Around this time, there were concern about Matilda not turning up to see her child as planned which resulted in supervised contact being suspended for a short period. Matilda's friend reported to staff at THA that they were worried that Matilda may be pregnant (this pregnancy resulted in a termination in December 2019) and that they suspected that Carson might be trying to commit fraud, because he had asked if he could place money into their bank account which was highly suspicious.

14.45. Serious Fraud allegations about Carson were reported to the Police in November 2018 by unrelated third parties. This was followed by Carson making allegations that third parties had threatened to kill him in relation to allegations that he owed them money which he was alleged to have stolen by means of fraud.

14.46. Carson was further arrested in late December 2018 for breach of non-molestation order (second time) and for possession of a bladed article in a public place. This followed Carson threatening to cut his own throat on arrest. Carson appeared at Blackburn Magistrates Court and was sentenced to a 12 month Suspended Sentence Order (SSO) with a period of 12 weeks imprisonment wholly suspended for this period with £85 costs and a victim surcharge of £115.

14.47. A Police Officer (Safeguarding Team) visited Matilda at her THA residence where it was reported that she was seemingly happy that the Mon-Molestation Order preventing Carson from having contact with her had ended. Matilda reported she was happy to continue her relationship with Carson and they did not need to make any further contact with her.

14.48. The conclusion of the Police Officer at the time was to label Matilda as a "compulsive liar." This was in respect of significant evidence that Matilda had on occasions withheld the true nature of her relationship with Carson and had seemingly lied to the staff within the Refuge, Police Officers and other professionals working to safeguard her.

14.49. Carson was arrested in March 2019 and charged with an offence of Battery against his teenager sibling at the family home following an argument over money where Carson had assaulted and tried to strangle the younger sibling.

14.50. During April 2019 the Police (Operation XX) were trying to locate Carson to arrest him. They tried speaking to Matilda at her THA flat and were told by staff that she did not spend much time there and they presumed she was staying with Carson.

14.51. Contact between Matilda and her child at her parents' home was said to be going fine at this point. However, Matilda had missed five sessions with her THA Key Worker and her phone had been switched off which placed Matilda at risk of eviction because she was not using her THA residency as her principal home. It was again recognised that Carson was breaching the Non-molestation Order/ Police Bail Conditions by continuing to have contact with Matilda.

14.52. A third MARAC meeting took place later in May 2019 which was held on behalf of both Matilda and Carson's teenage sibling. This was in response to protecting the younger sibling who lived at the same address as Carson (family home) and for breaching the Non-Molestation Order protecting Matilda which was due to end. It was noted that Matilda was fully aware of Carson's criminal history and on-going criminal investigation into the deaths of Carson's children and attempted murder of a third child.

14.53. Carson was later arrested for the assault on his teenage sibling, (May 2019) and for breaching the Non-Molestation Order. At the arrest Carson took a Paracetamol overdose as Police knocked on his door resulting in hospital admission where Carson claimed he wanted to die and at first refused treatment. He remained in hospital for one week but no formal mental health disorder was found on assessment and it was felt that he was trying to manipulate and frustrate the justice system.

14.54. The case came before the Preston Magistrates Court (sitting at Preston Crown Court) and Carson appeared from custody entering a not guilty plea to both offences relating to the assault and non-molestation with a trial date being fixed for June 2019. Carson was granted bail with conditions to stay at his Auntie's address.

14.55. Police informed Matilda that the non-molestation order against Carson had now expired and Matilda was of the view that she did not want or need this to be reinstated.

14.56. Around this time, Carson's ex-partner complained to WISH that Carson was following her when she visits her children's graves. She was advised to report this to the police. The ex-partner responded that past reports to the police had not been addressed because his behaviour had not been classed as harassment.

Information relating to Carson's initial conviction for assault, Breach of Non-Molestation Order and Breach of his SSO (July 2019 – September 2019)

14.57. Following initial delay Carson appeared at Burnley Crown Court in July 2019 and was sentenced to 12 weeks imprisonment for assault, breach of his SSO imposed in December 2018 and breach of his Non-Molestation Order which had now expired against Matilda. The Magistrates imposed a 12 month Restraining Order to protect Matilda and Carson's step sibling.

14.58. Carson made an appeal against his conviction for the assault on his teenage sibling which was overturned following new information provided by family members and six weeks later Carson was released from custody. Matilda had been in court during the appeal proceedings and insisted that she did not need protection from Carson. In the absence of any Pre-Sentence Report the Restraining Order which was in place was lifted at this point in line with the sibling and Matilda's request.

14.59. On Carson's release from prison, he was subject to licence supervision for 6 weeks, thereafter he remained subject to Post Sentence Supervision until August 2020. Carson was released to his auntie's address with weekly probation officer appointments to monitor his behaviour.

14.60. On release from prison, health professionals had referred Carson to the community mental health team and he was seen by them shortly after his release. The Mental Health Team who had seen Carson contacted the probation officer with concerns about Carson. He was found not to have a mental health disorder however, there were "*concerns about his demeanour which was very arrogant and he lacked any anxiety or empathy"* indictive of a personality of disorder. For example, he stated to the mental health practitioner that "*the police cannot pin the murders on me, and they will not find any evidence."*

14.61. The day following Carson's release from prison a meeting took place between the police and Carson's ex-partner to inform her that Carson was out of prison and to advise her on safeguarding matters to keep herself safe. Carson continued to be investigated by detectives for the deaths of his children for which bail conditions had remained since April 2018.

14.62. On the same day, Matilda was seen by her child's social worker to discuss arrangements following Carson's realise from prison and to assess Matilda's intention to continue her relationship with him. Matilda was asked if she felt scared and apprehensive about Carsons release to which she replied that she *"doesn't want to answer this question."* Matilda said it was difficult for her because she always goes back to him. Matilda was well aware of the risk posed to her child by Carson. The case was closed by Children Social Care in respect of Matilda's child in September 2019.

14.63. A Letter to the GP from the Mental Health Home Treatment Team in September 2019 stated that Carson was confident that his relationship with his partner (Matilda) can now continue as the Non-Molestation Order has been removed.

14.64. At the final Probation Officer appointment that took place with Carson prior to Matilda's death Carson stated that he *"has not yet seen Matilda but will see her tonight*." The probation officer discussed the session from the previous week where he blamed

Matilda for the non-molestation order when she could have stopped it. He said *he would accept things and that he will not hold anything against her.* Again, Carson spoke of the on-going child murder investigation and said *that he has spoken with solicitor and they are adamant that the case will be dropped.* The Probation Officer reflected in their record that they *"struggle to ascertain what the truth is. Carson presents as a bit dramatic and lacks empathy."*

Events leading up to the death of Matilda (October 2019)

14.65. Carson and Matilda plus another couple went on holiday and stayed in a caravan in Blackpool. Carson and Matilda had a violent argument on the first night about Carson texting another woman resulting in him leaving the caravan and returning later that evening. A few days later Matilda and the two friends suffered (unexpected) symptoms of vomiting and diarrhoea and they all agreed to return home. After two days at home the friends' symptoms had disappeared. However, Matilda remained unwell. Carson was seen giving her tablets from a brown unmarked medicine bottle which he said were "anti-sickness" tablets.

Four days prior to Matilda's death, there was a call to NHS 111 reporting Matilda had abdominal pain, vomiting, blurred vision and dizziness for five days. A practitioner tried to call back with no response and a message was left on the answerphone to call back.

Three days prior to Matilda's death, there was a call to the GP at 11.06am that Matilda was unwell. She was reported to be feeling sick and dizzy since last week. The GP attempted to call back and made an appointment for that evening and left a message to ring back. During the day Matilda had been shopping for a present for her child and dropped it off at her parent's house. She was invited in but declined the offer in case she had anything contiguous. At 14:23 the GP spoke to Carson, who said that Matilda was in bed asleep but she was aware of the appointment arranged for 18:30. Carson said he was not with Matilda and he had her phone so was unable to speak directly to her. Matilda did not attend this appointment.

Two days prior to Matilda's death, Carson had a GP appointment reporting poor sleeping pattern and on routine mental health questioning denied low mood. Carson stated that he *'just wants something to help me sleep'*. Carson reported that he falls asleep but then was awake in an hour. A 7-day course of Zopiclone (sleeping tablets) was prescribed but the GP was clear that it would not to be re-issued again.

14.66. Matilda was found unresponsive at the home of Carson's auntie where he had been bailed. Carson appeared to be front and centre of the initial police investigation and enthusiastically appeared to help the police by finding a suicide note from behind a picture frame and he made a number of false claims about Matilda wanting to kill herself. Carson was later arrested for breach of his bail conditions and on suspicion of poisoning offences. He was charged and remanded in custody in January 2021 pending trial which took place in December 2021.

15. Overview

15.1. Matilda was the victim of coercive control and manipulation which was fuelled by her vulnerability, low self-esteem, and relationship breakdown with the birth father of her child. Matilda had experienced high level trauma in her childhood which appeared to have an impact on the way she was able to make good decisions and relationship choices.

15.2. Matilda was warned on a number of occasions that Carson posed a serious risk to children and was not allowed contact with children under 16 years. Despite this, the relationship continued and Matilda's child was eventually removed from her care with a Care Order awarded to the child's birth father.

15.3. Throughout their relationship Carson was under Police investigation by a Major Investigation Team under Operation XX. Carson remained under police bail conditions not to have contact with any witnesses for the case and not to have contact with children under 16 years. He was also ordered to report to Blackburn Police Station twice weekly and it appears that he did so. Police considered Carson to be a risk to children and vulnerable adults and was placed at "medium risk."

15.4. The risk to Matilda was initially viewed as being "low" because she was seen as a young woman wanting to maintain a relationship with Carson. However, as time progressed Matilda was assessed by the police as "medium risk" at which point a Detective Inspector, from East Basic Command Unit with responsibility for public protection was allocated by the SIO of Operation XX to oversee the safeguarding of Matilda.

15.5. During the timeline Carson was arrested on six occasions for offences which included the suspected murders of his children in 2013, breach of the Non-Molestation Order for Matilda, assault on his teenager sibling and failing to attend court for sentencing. In addition, he was charged with possessing a knife on two occasions. On all occasions he took the opportunity to frustrate his arrests by actively manipulating the situation. For example, he claimed to have mental health issues, took an overdose as police broke in to arrest him, threatened to jump off a multi-storey car park and threatened to cut his own throat.

15.6. Carson was additionally alleged to be involved in criminal behaviour around financial fraud involving a number of business people which the police had started to investigate. He claimed to have his own Construction Company which was highly implausible given his personal circumstances.

15.7. The ex-partner (mother of the murdered children) had reported long term coercive control throughout their relationship without knowing or understand that this was the case. It was only after police liaison with specialist officers and the engagement of WISH that the ex-partner was able to recognise the nature of Carson's abusive behaviours. Although Carson and his ex-partner had separated, Carson continued to make unwelcomed contact with her.

15.8. Matilda made a complaint to WISH followed by a Police statement about her relationship with Carson which had become toxic. She disclosed that Carson had not physically harmed her but he would push her up to the wall and scream in her face. The arguments were said to happen around 2-3 times per week. Matilda told Police she was

afraid of Carson and he had made serious threats that he would harm her child and the child's father by setting fire to the house if she did not stay with him.

15.9. This disclosure resulted in Matilda moving to a woman's refuge for her own safety and a Non-Molestation Order was put in place by the family court to prevent Carson from contacting Matilda. However, Carson continued to contact Matilda either directly himself or by using family members to contact her. He made threats to harm himself and others in order to gain Matilda's attention which led to contact with Carson against refuge policy resulting in her eviction from two separate women's refuges. There were examples of Matilda contacting Carson and him giving her money.

15.10. Throughout the review period Matilda denied contact with Carson on numerous occasions until the burden of proof came forth and she would then admit seeing him, but would then try to assure professionals that she wanted nothing to do with him. This led to professionals forming a particular negative view of Matilda in terms of her ability to be truthful and she was labelled a "compulsive liar" at a later point.

15.11. Matilda's mental health was affected by social isolation, the distress of having her child removed from her care and the toxic nature of the relationship with Carson. The realistic concern that Carson would harm her child if she did not stay with him was a matter of fear and concern for Matilda throughout the relationship. Matilda was seen regularly by her GP who appropriately monitored her mental health and prescribed medication. A referral for counselling was made but it is not clear if this was attended.

15.12. Matilda was seen by the GP at the early stages of a pregnancy in 2017 which resulted in termination and a second pregnancy was confirmed at an early stage by the Urgent Care Centre but later found negative. There was a further pregnancy in 2019 which also resulted in termination without GP notification. It was revealing that Matilda admitted to professionals that she *"did not want a child connected with Carson"* but she had told Carson that she had a miscarriage on one occasion with Carson taking Matilda for the second termination due to the understanding that Matilda would not be able to keep a baby with Carson due to the high-level risk he posed.

15.13. Following eviction from refuge, Matilda eventually moved into a flat at THA supported housing scheme where staff tried to support her. After the initial period Matilda spent a great deal of time away from her THA residence and staff struggled to engage with her. Staff felt she was probably spending time with Carson.

15.14. Protection for Matilda was managed by officers in the police child protection team/public protection team and specialist domestic abuse services. The statutory and legal processes in place to promote Matilda's safety involved MARAC on three occasions. The first was initiated by WISH following disclosure of domestic abuse which led to a non-molestation order through the family court which expired after one year and was not reapplied for after then. The second MARAC was initiated by the police following her second eviction from a refuge. The third MARAC, also initiated by police, was mainly in response to the domestic abuse assault by Carson's on his teenage sibling.

15.15. A Restraining Order was issued in respect of both Matilda and Carson's sibling when following Carson's sentencing for assault on his teenage sibling, breach of the Non-

Molestation Order and breach of a Suspended Sentence Order. However, when Carson successfully won his appeal over his twelve-week prison sentence, the Restraining Order was lifted with the support of the sibling and Matilda who had been in court at the time where she promoted the view that she did not need protection from Carson.

15.16. Ten weeks after the lifting of the Restraining Order Matilda was lethally poisoned by Carson using illegally obtained prescription drugs. Carson was on Police Bail Conditions at the time not to have contact with Matilda.

16. Analysis of professional decision making and practice

Safeguarding arrangements for Matilda's child

16.1. Children Social Care became concerned in July 2017 when it was known that Carson had started a new relationship with Matilda who had an infant child in her care. This relationship had commenced less than two months following a Family Court Hearing where it was described that Carson was a "dangerous man" and it was found that on the balance of probability he attempted the murder a 4-month-old child known to him by deliberate airway restriction.

16.2. In considering this premeditated act further it would appear that Carson was motivated to cause serious harm to a child as a direct form of punishment against the child's mother in order to manipulate her into remaining in the relationship against her will. With this additional factor in mind, Carson was viewed as not only a danger to children but also a risk to any new partner who wanted to leave a relationship with him. In reality, it should be considered that anyone suspected of murdering their own child as an act against an adult should be considered as capably of murdering anyone.

16.3. The paramount role of Children Social Care in any situation is to safeguard and protect children and they appropriately visited Matilda and her child's birth father at their earliest convenience to convey to them that Carson was a danger to children. They were clear about their need to intervene should Carson remain a feature in the child's life. Matilda agreed to end the relationship and the birth father assured the Social Worker that he would monitor the situation to keep his child safe which he did on two occasions.

16.4. Following father's alert that Matilda was still seeing Carson, Children Social Care produced a "Schedule of Expectation" (contract) reinforcing that Matilda's child (who was living mostly with her) would not have contact with Carson. Contracts had been used in social work for several years and their effectiveness is debatable and failed to have the desired impact on this occasion.

16.5. There had at this point been a further sighting of Carson with Matilda who was reported to be pregnant. A Multiagency Safeguarding Hub (MASH) referral for a Strategy Meeting with the possible outcome of an Initial Child Protection Conference (ICPC) was to be held on behalf of Matilda's child was relevant at this stage but did not occur. The seriousness of an ICPC and the wider ability for agencies to share confidential information

may have prompted Matilda to take legal steps to end the relationship with Carson before the relationship was too well established.

16.6. There were two additional incidents relating to Carson having contact with Matilda which eventually did lead to a Child Protection Strategy Meeting with a plan to hold an ICPC at the end of October 2017. However, just prior to the date, Social Workers witnessed Carson being volatile and aggressive within the context of a meeting which led to Children Social Care taking immediate steps to protect Matilda's child via an Interim Care Order. It did not however, result in further assessment of Matilda's safety and vulnerability within the relationship as it should have done.

16.7. With the benefit of hindsight, it is probable that a Child Protection Plan may have been ineffective at this stage due to the relationship having already established over a four-month period and it was most likely that Carson would have continued to pursue and manipulate Matilda as he did throughout the whole of the timeline period. Indeed, Matilda admitted later in their relationship that *"if her child was in her care, she would not be able to protect the child".*

16.8. During the Children Social Care assessment of Matilda's ability to parent her child it was found that Matilda showed a level of dishonesty when denying she was seeing Carson. However, she was able to demonstrate positive aspects to her parenting in particular her emotional warmth towards her child. It was concluded that the singular risk to her child was Carson and because Matilda was unable to break free from him, Children Social Care had no other choice than to protect the child through court proceedings.

Key Learning Points:

- Strategy meetings for child protection cases should be held as soon as any child protection concerns arise to ensure ICPCs take place in a timely manner.

Progress - Since 2017, it has been recognised that the key learning areas have been addressed within Children Social Care and multiagency child protection arrangements have improved. There is a new "front door" service known as Children Advice and Duty Service (CADS) for safeguarding services which promotes greater access to qualified social workers and increased management oversight. Further work has been carried out to ensure that Police, Health and Children Social Care attend all strategy discussions with a new escalation process to manage difference of opinion.

Initial safeguarding arrangements for Matilda

16.9. Much of Matilda's past history was not fully available to the Social Workers initially working with her. It was only at the point when care proceedings were in the later stages of completion that information from a neighbouring Local Authority was obtained. Matilda was found to have been subject of a number of serious adverse childhood experiences (ACEs) which had a negative impact on her adult life. Best practice would have been for this information to be requested sooner. The nature of Matilda's ACEs may have highlighted her increased vulnerability and prompted a more proactive approach to providing specialist domestic abuse support and legal involvement sooner.

16.10. When the Independent Reviewer met Matilda's parents (guardians), they explained that owing to Matilda's past trauma she could present as being chaotic and she had found decision making difficult which had impacted negatively on relationships and job opportunities. She did however, manage to do some bar work which was mainly before the birth of her child. There did not appear to have been any psychological assessment or counselling around her traumatic childhood experiences to help her come to terms with her past trauma during her childhood or adolescence as indicated by best practice.

16.11. It is known that adults who survive childhood trauma may have trouble regulating their emotions and have difficulty in relationships, as well as having poor memory and low self-esteem. (Mind: website 2023). There is coincidental learning here about the importance of psychological support and counselling for adolescences who have a history of childhood trauma due to ACEs.

16.12. The protection of Matilda's child was seen as paramount in the early period of this case which was expected practice. The Social Worker working with Matilda was not able to share the full details of Carson's suspected crimes for legal reasons until following the court judgement at the Finding of Fact hearing which took place in November 2017. This was despite there being a number of claims made about Carson's crimes against children already within the public domain via social media.

16.13. Prior to full disclosure being made, Matilda was provided with limited information that Carson was a risk to children and he could not have any contact with children under 16 years. Matilda responded that Carson had told her there were child care proceedings ongoing and he had not done anything wrong.

16.14. It appears that at this early stage the thrust of the social workers intervention was appropriately aimed at keeping Matilda's child safe leaving Matilda to cope alone with Carson's predatory behaviour and his minimising narrative about not causing any harm to children. Whilst social workers were advising Matilda against the relationship with Carson, an early referral to WISH for IDVA services was indicated to promote specialist support. The benefits of this would have been to assess Matilda's level of vulnerability within the relationship and to offer support and counselling to disrupt Carson's coercive controlling behaviour early on in the relationship.

16.15. The local Specialist Domestic Abuse Services (WISH) were already aware of Carson as being a perpetrator of domestic abuse and coercive control through working with his ex-partner and would therefore understand the situation to support Matilda.

16.16. The timing of the social workers full disclosure of the "Finding of Fact" judgement came four months into the relationship by which time Carson may have already been manipulating and controlling Matilda whether she was aware this was happening or not. When Matilda was told that Carson was suspected of murdering his own young children to stop his ex-partner from ending their relationship, Matilda had responded that she *"felt sick to the stomach that he could do such a thing."*

16.17. The DHR panel discussed whether there had been an opportunity for professionals to consider the role of the Domestic Violence Disclosure Scheme (DVDS) known as "Clares Law" which is available to support victims of serial abusers, specifically on the matter of

their “right to know” about a partner’s domestic abuse past where police may consider proactively to inform a victim for their safety. (Gov.UK 2023).

16.18. DVDS (Clare’s Law) pilot scheme commenced in 2014 following a report into the death of Clare Law who was murdered by her ex-partner after experiencing a history of harassment, criminal damage, threats to kill and sexual assault. The report into her death showed that the perpetrator had seriously abused women in the past and the police were aware of his history. The report found that there was a loophole in the Data Protection Act 1988 which allowed domestic offenders to keep their past criminal record confidential.

16.19. Following Clare’s death, the family campaigned to ensure that potential victims have a “right to know” of a partner’s abusive past and to make legal means for the police to warn potential targets. The family belief was that Clare would not have entered into the relationship with her murderer had she known of about his past.

16.20. It was considered that had Matilda been aware of Carson’s past abusive past history at an early point she would have been able to make a more informed choice about the relationship before Carson was able to manipulate her into staying with him.

16.21. The Panel’s conclusion was that a DVDS would not have provided any additional information because of the legal restrictions initially placed on the Finding of Fact verdict in the case of Operation XX. Matilda was made fully aware of Carson’s history once legal restrictions ceased and thereafter was informed of the on-going criminal investigation at all times. Indeed, Matilda was identified as a material witness by the Major Investigation Team under Operation XX and as such was seen as being protected under Police bail conditions.

16.22. There is learning here for professionals to remind them of their responsibility to consider making a DVDS as an early intervention strategy to disrupt the commencement of a relationship in cases where there is a known perpetrator of coercive control.

16.23. As previously identified, the child’s social worker referred Matilda to WISH for support in January 2018 which was following the full disclosure of Carson’s suspected crimes. WISH did not receive any historical background information about Matilda which could have raised their awareness of her past childhood abuse and level of vulnerability.

16.24. Matilda’s risk of domestic abuse from Carson was not fully realised until she made a disclosure to WISH in April 2018. This led to a police referral and interview where she was clear about her fear of Carson and the level of threat made towards her. During police questioning Matilda stated Carson was not physically harming her, but he would regularly (two to three times per week) force her against a wall and scream abuse in her face if she did not comply with his wishes.

16.25. These actions amounted to physical and emotional assault and although these acts were minimised by Matilda, they would have been very frightening events. It was reported that Carson was making serious threats to harm Matilda’s child and he used this overwhelming rhetoric of fear to control Matilda. Carson had told Matilda the he knew the child’s (and ex-partner’s) new address with threats being made to burn the house down. Matilda believed that Carson made these threats with the intention of carrying them out if she did not stay in a relationship with him.

16.26. At this point Matilda was being supported through WISH and IDVA service to apply for a Non-Molestation Order against Carson via the court to run for twelve months to prevent him from pursuing and harassing Matilda. However, Carson maintained contact with Matilda and despite police advise that this was in breach of the Non-Molestation Order she consistently did not report Carson's contact to the police which may have been due to fear of the consequence.

16.27. Matilda would have had the power to revoke the Non-Molestation Order at any time, which she either chose not to do or she was unaware of her right to do so. The breaches of the Non-Molestation Order where seemingly not taken seriously by professionals because Matilda was known to have regular contact with Carson. However, given that the Order was in place on Carson it was his responsibility to prevent contact with Matilda.

16.28. Matilda initially expressed to professionals that she did not want to carry on the relationship with Carson but her motivation for this does not appear to be well explored. For example, if Matilda said she did not want a relationship with Carson why was she still seeing him? Matilda explained to police in interview and to the Independent Domestic Violence Advisor (IDVA) that Carson was manipulating phone calls to get to her through other people, or by using false names and blackmailing her with threats to harm himself. These are all commonly used tactics by perpetrators of coercive control and stalking.

16.29. There was evidence that Matilda was continuing to meet up with Carson even after moving away from the local area into a Women's Refuge. This provoked the professionals involved to form a view that Matilda wanted to maintain a relationship with Carson rather than considering that Carson was incessantly in contacting her to maintain the relationship. This being said there were times within the timeline where Matilda admitted that she had feelings for Carson and that she did want to be with him making this a confusing picture.

16.30. The level of Matilda's vulnerability from childhood trauma and true nature of the relationship with Carson did not appear to be well understood. Much of professionals understanding about the relationship was seemingly based on **what** was happening rather than **why** it was happening.

16.31. Friends who came forward following Matilda's death said that Matilda had admitted to them that Carson was violent towards her but she had not told professionals because she feared the consequence for herself and her child.

16.32. It is true to say that Matilda was in regular contact with Carson however, victims of coercive control need long term support and safety planning to take account of the "brain washing" and "grooming" nature of coercive control. Research has identified eight reasons women stay in an abusive relationship including,
1. Distorted thoughts - through being traumatised.
2. Poor self-worth - as they are beaten down and humiliated by the perpetrator.
3. **Fear** – the threat of physical and emotional harm is powerful, and abusers use this to control and keep women trapped.
4. Wanting to be a Savior - Many women describe a desire to help, or love their partners with the hope that they could change them.
5. Children - These women put their children first, sacrificing their own safety.

6. Family Expectations and Experience - Many women describe how past experiences with violence distorted their sense of self or of healthy relationships.
7. **Financial constraints** – women experience financial limitations though having funds taken, unable to work and may have debt placed in their name.
8. Isolation - a common tactic of manipulative partners is to separate their victim from family and friends. (Cravens, J. D., Whiting, J. B., & *Aamar, R. (2015).

16.33. Multiagency working practice needs to be resilient when managing long term coercive controlling relationships which can be very difficult to break often with victims being unable to do this for themselves. (Women's Aid)

Key Learning Points:

- Reminder to professionals to make a DVDS on behalf of victims as an early intervention strategy to disrupt relationships being established by coercive controlling offenders.
- Understanding a parent/client past history of Adverse Childhood Experiences (ACEs) early in any domestic abuse or parenting assessment is important so that the appropriate use of trauma informed practice can be should adopted as relevant.
- Robust early intervention and assessment of a victim's vulnerability and circumstances by specialist domestic abuse services is essential when dealing with serial perpetrators of coercive control.
- Hearing, recording and reflecting on the voice of victims is crucial to effective safety planning
- Understanding **why** the victim remains in the relationship rather than focusing on **what** is happening in a relationship is an important part of assessment and safety planning
- Multiagency working with victims is important to maintain long-term engagement and support.

Management of risk to Matilda.

16.34. Carson's ex-partner (mother of the two children who died and had known Carson since their childhood) was appropriately recognised as "high risk" due to her poor mental health, risk of suicide and fear that Carson had said he *"would find her, wherever she goes and make her life hell*." There was a multiagency safety plan in place to meet the ex-partner's needs and Police Bail Conditions included that Carson could not contact her for her protection. Despite these arrangements the ex-partner did experience occasions when she had seen Carson *"hanging about on the street"* where she lived and he had approached her at the children's grave side.

16.35. There was evidence that Carson remained in "arms-length" contact with his ex-partner which was probably a deliberate act to distress her and to enable Carson to keep some form of control over her. This is not uncommon behaviour in perpetrators of coercive control and is behaviour used to convey their power over the victim for their own self-gratification.

16.36. Throughout the timeline the ex-partner was well supported by the services involved and she was helped to move area when Carson became troublesome towards her which was good practice.

16.37. In considering the management of risk to Matilda it was known that Matilda met Carson at the early stage of the police investigation (Operation XX). The risk to Matilda's child had rightly been of paramount concern and led to appropriate intervention by Children Social Care as previously discussed.

16.38. As stated earlier, Matilda's disclosure to WISH (April 2018) that Carson was threatening to set fire to the home of her child and the child's birth father if she ever tried to leave him, led to WISH making an appropriate referral to Police and MARAC. WISH also, supported Matilda in applying a Non-Molestation Order against Carson and help with a move into a place of safety within Women's Refuge in line with good practice.

16.39. Matilda was questioned about the relationship at Police interview which revealed domestic abuse, coercive control and manipulation. She disclosed that she was afraid of Carson and believed that he would carry out the threats he was making against herself, her child and the child's birth father. She reported that the only way she could keep her child safe was to stay with Carson.

16.40. Coincidentally, on the same day as Matilda's Police interview Carson was arrested for the historical murders of his two children. At this point Operation XX was gaining momentum and had gathered substantial medical information towards charging Carson. Following the police interview a risk assessment considered that *"Carson posed a risk to children and vulnerable adults."*

16.41. Matilda was added to the list of witnesses for Operation XX who were protected under Police bail conditions for Carson not to have contact with any child under 16 years, not to have contact with any witness and report to the police station every Friday and Sunday, which was imposed at the time. This was to provide further protection for Matilda by preventing Carson from continuing a relationship with her but was seemingly ineffective.

16.42. In May 2018, Matilda was in a Women's Refuge in South Lakeland where she was seen by a GP with thoughts of harming herself. She stated she would not act on these thoughts because of her child who was seen as a protective factor. The GP assessment found Matilda with "low mood" for which she was prescribed appropriate medication with GP follow up. Low mood and isolation would have further impacted on Matilda's ability to act against Carson and may have increased her vulnerability which did not appear to be fully recognised.

16.43. Matilda was seen by a Public Protection Police Officer in July 2018 following reports of Matilda meeting up with Carson which she denied. Matilda insisted that she did not need protection and that she wanted to continue to see Carson. The Police recorded her request but because Matilda was a material witness in Operation XX, they still continued to maintain a level of safeguarding.

16.44. A few days later Matilda was assessed at THA who regarded her as being an "high risk" victim. The mixed professional messages given to and by Matilda about her level of risk

from Carson may have become confusing over time leading to Matilda seemingly taking the easy option of avoiding contact with supporting services.

16.45. Victims who have issues of past childhood trauma, such as Matilda may often resort to avoidance management as they revert back to how they coped in the past. This is difficult for practitioners working with victims and again needs professional curiosity and trauma informed practice working arrangements in order to understand and intervene in what is making a victim stressed. Avoidance coping is a maladapted form of coping with a stressful situation which is too difficult to deal with. Whilst this is a good way to manage stress at the time it often only increases the stress as the situation causing the stress remains unresolved and can become magnified. (Scott. E; 2022). This behaviour should be viewed as an alert to something more serious happening in the life of the victim which can result in tragedy as seen in this DHR.

16.46. Carson was arrested in December 2018 for breach of the Non-Molestation Order on two occasions and for other offences. Matilda was seen again in January 2019 by a Public Protection Police Officer who she informed that the Non-Molestation Order should be lifted as she was happy with the relationship. The officers informed Matilda that she could not see Carson, if she did Carson would be in breach of his Bail Conditions in having contact with her as Matilda was a Prosecution Witness.

16.47. The Police are often the front line in protecting victims of domestic abuse and coercive control and regularly take the lead in protecting victims with the help of partner agencies. The Police put control measures in place by keeping Carson on bail with strict conditions. His position was regularly monitored even to the extent that he should report to a Police Station outside Lancashire should he be working away from the area. The Major Investigation Team liaised with other Police Forces and shared intelligence, conscious that Carson may be a risk to other women in other parts of the country, which was good practice.

16.48. Matilda's ongoing relationship with Carson was protracted and frustrating given that all relevant interventions had been exhausted without the desired effect of disrupting the relationship. Therefore, when Carson was on remand (for eight weeks) for an assault on his teenage sibling and in breach of the Non-Molestation Order, this should have been a "golden opportunity" for professionals to enthusiastically engage with Matilda to try to break the cycle of Carson's control over her.

16.49. Matilda had been in contact with WISH and was due to start the AIMs programme again. This would have provided an opportunity for those working with Matilda to promote trust and a safe space for Matilda to enable her to reflect on what was happening and explore her fears and hopes for the future. It was unfortunate that Matilda did not engage with the programme and eventually disengaged from the service altogether.

16.50. It is the case that IDVAs work with current risk, which had been significantly reduced for Matilda at the time Carson was on remand. The IDVA actively liaised with the key worker at the supported living accommodation in an attempt to engage Matilda to no avail and the case was closed with golden opportunity being lost.

16.51. It has come to light that during Carson's short period on remand, Matilda had been spending time with her parents. The parents have reflected that the professionals involved had not contacted them to seek Matilda's whereabouts, neither had their views been sought in terms of understanding Matilda 's level of vulnerability. The parents told the Independent Reviewer that although Matilda was in her early twenties she was operating at a much younger level (more like an adolescent) which would have needed to be taken into consideration as part of any safeguarding and intervention plan. The lesson here is for professionals (particular IDVAs) to form a trusting alliance with helpful family members to best support and protect victims.

16.52. The Domestic Abuse Act of 2021 and statutory guidance published by the Home Office in 2022 further advocates for multi-agency working spanning across statutory and non-statutory agencies. It highlights the importance of information sharing between agencies and multi-agency working.

Key Learning Points:

- Risk assessment is a continual process and cannot be left to one agency alone.
- Different agencies have different criteria's for viewing and addressing risk therefore, multiagency assessment, planning and working together arrangements are an essential part of reducing risk.
- When perpetrators are on remand this should be used as a "golden opportunity" to intensify work with victims in order to understand their perspective and to reevaluate risk and safety planning.
- Professionals need to consider the role of parents / helpful family members as part of the safeguarding plan.

Effectiveness of the local MARAC arrangements

16.53. There were three MARACs held on behalf of Matilda. May 2018, August 2018, and May 2019. A MARAC is a meeting where information is shared on the highest risk domestic abuse cases between representatives of the local police, health, child protection, housing practitioners, IDVAs, probation and other specialists and voluntary sector. The meeting focus is to safeguard the adult victim by producing a co-ordinated action to increase their safety.

16.54. The first MARAC followed Matilda's allegation to WISH about Carson's abusive behaviour towards her and his threats to harm her child and the child's father if she tried to leave him. The IDVA safety plan acknowledged that Matilda had moved to South Lakeland Women's Refuge to keep her safe. No action log was completed at the meeting as it should have been. Good record keeping is essential for protecting victims and to provide an evidence trail of information for future consideration.

16.55. The second referral to MARAC (August 2018) was made by the Police in response to Matilda continuing to meet Carson despite threats he made against her child and Carson's stalking against his ex-partner. There was full information sharing of the recent history at the MARAC and a safety plan which confirmed that safety advise had been given. The IDVA was to liaise with the police over the ongoing police investigations and it was noted that there was a Non-Molestation Order in place to protect Matilda.

16.56. The third referral to MARAC (May 2019) was again made by the Police on behalf Matilda for two breaches against her Non-Molestation Order and for Carson's teenage sibling who had been assaulted by Carson. It was known that a criminal court case was pending and Carson was expected to be sentenced to prison. The MARAC notes appear to suggest that all agencies were to look out for Carson and report any sightings to the police who were struggling to contact him. It was reported that Carson was wanted for crimes in Scotland, the full extent of which are not known or relevant to this DHR.

16.57. It was not clear in the MARAC notes if any discussion took place with Matilda about the relationship on this occasion, although the DHR timeline provides information that Matilda was happy for the Non-Molestation Order to be closed when it expired. There was seemingly no detailed safety plan presented at MARAC, although it was known that Matilda was being supported by an IDVA via a victim programme focusing on raising her awareness of domestic abuse, covering safety planning, trauma bonding, ACE's and its impact, power and control, all forms of domestic abuse including coercive control and economic abuse.

16.58. The (multiagency) safety plan is a live changing document which is individualised to take on board the wishes and feelings of the victim and should be available for review at each MARAC. The plan should be clear about who is doing what and by when with clear lines of communication between partners and contingency action when safety plans are failing, with a mechanism for bringing cases back to MARAC to address cases which may have become protracted, exhausted and in need of multiagency evaluation to promote change.

16.59. It was evident within the chronology for the review that not all agencies had the MARAC information within their records as would be expected. The quality of the notes was poor and safety plans limited. Matilda was seen as a woman wanting a relationship with Carson and whilst this may have seemingly been the case there was no evidence to suggest that a quality assessment into Matilda's level of vulnerability and circumstances had been completed. Had there been a continuous key worker or IDVA who could have built a long-term trusting connection with Matilda using trauma informed practice it may have been the case that Matilda's lived experience under the oppression of Carson would have been better understood by all concerned.

16.60. The review found that records of MARAC were not appropriately shared and linked to the victims and perpetrator's record within all the agencies involved. For example, the GP who was treating Matilda for low mood had not been invited to the first MARAC but was invited to the second MARAC. On that occasion MARAC information was appropriately alerted and coded on the patient record system. The GP was not subsequently aware of Matilda's MARAC status as they should have been. Members of MARAC should be invited to all MARAC meetings and understand their role and responsibility to share information within their own agency in the best interest of victims.

Progress – Blackburn with Darwen MARAC (does not cover other surrounding areas in Lancashire) have undertaken a Police led review of the effectiveness of its arrangements and processes. Since January 2022 Blackburn and Darwen initiated the new Multi-Agency Risk Reduction, Assessment and Co-ordination (MARRAC) process as below.

- The new process involves two groups of professionals; 1) a core group of partners including, Children Services, Adult Services, Community Safety, Police, Domestic Abuse Providers, Primary and Secondary Health Providers, and 2) partners that are called “expert pulls” including, Probation, Substance Misuse Service, Housing Providers, Education, Charity Sector, Early Help, MAPPA and other local partnership initiatives are invited for relevant cases.

- Meetings are held twice per week and referrals are heard once information gathering has taken place which takes a minimum of two weeks. Meetings take place virtually (rather than face to face) with the full use of technology to share documents relating to the case and the use of recording and transcripts for the whole meeting to ensure optimum record keeping.

- The focus of MARRAC has been expanded to ensure harm to victims is reduced, reduce risk by perpetrators and safeguard children and other members of the public who may be impacted. MARRAC is underpinned by Value and Enabling steps which a) gather and analyse information; b) analyse and understand risk; c) identify solutions for victim, perpetrator, children and others; d) review cases for outcome.

- The MARRAC Team use the concept of being “Domestic Abuse Aware and “Trauma Informed.” The roles and responsibilities to MARRAC members as clearly defined to ensure high level commitment to the process and robust information sharing within the agencies.

- A number of initiatives have been developed and inform the work of MARRAC. For example, “Operation Provide” is an initiative involving Police and Domestic Abuse Services where IDVAs go out with police response officers to scenes of Domestic Abuse to better source victim evidence and understand the voice of the victim, which is good practice.

- Safety planning can involve weekly catch-up on victims with multiple disadvantage and complex needs to ensure that they remain in sight of the process. In cases where the safety plan if failing to effect change and concern persists the parallel process of an Adult Strategy Meeting can be used to provide a wider focus and time for partners to fully consider the case.

- Further steps to manage repeat and serious perpetrator behaviour can now be taken through Integrated Offender Management, Domestic Violence Protection Orders and additional conditions to probation / sentence licences are considered.

16.61. In conclusion, it relevant that Matilda was the subject of MARAC on three occasions within the space of a year which highlights the high level of risk recognised on behalf of Matilda. Unfortunately, the new MARRAC processes were not available to Matilda and whilst there is no guarantee that there would have been a different outcome, the new arrangements would have promoted a better understanding of her circumstances and a more robust safety plan with more opportunity to consider contingency planning when interventions became ineffective.

Key Learning Points

- Multiagency working and communication are key to protecting victims of domestic abuse and managing perpetrators.
- Repeat perpetrators of domestic abuse need to be linked and cross referenced to their victims and other crimes committed by them in order to consider the full extent of their level of dangerousness.
- The quality of the MARAC/MARRAC is key to multiagency working, understanding, planning and intervening.
- Those who attend MARAC/MARRAC on behalf of their agency have a responsibility to understand their role and function in gathering, recording and sharing information with relevant others in their agency.
- Importance of continuing to monitor safety plans and recognise when contingency is needed to promote change.

Criminal justice arrangements to manage Carson.

16.62. In considering the management of Carson during Operation XX, he was arrested and interviewed in April 2018 for the murders of his children which occurred in 2013 and he was released on Police Bail with the following Bail Conditions:

1. No contact with children under 16yrs unless supervised by Social Services.
2. To sign on at the local Police Station on Friday's and Sundays.
3. Not to contact named persons listed either directly or indirectly.

16.63. During this arrest Carson had threatened to commit suicide stating that he was depressed and had low mood. He claimed to have taken an overdose of prescription drugs six weeks earlier and has suicidal thoughts. This was just one example of a number of implausible stories and actions provided by Carson to try to manipulate and frustrate professionals and control situations.

16.64. There were a number of criminal justice processes playing out to protect both Matilda and Carson's ex-partner throughout the time line for this DHR. As previously stated, there was a Non-Molestation Order in place between April 2018 with a review date for May 2019 which remained in place.

16.65. The purpose of a Non-Molestation Order is to prohibit a person (perpetrator) from molesting the person (victim) who is applying for the order. The aim of the order is to stop an ex-partner from harming or threatening the applicant and to empower the victim with a sense of control in relation to actions which are uncalled for from their abuser.

16.66. Just prior to Matilda's Non-Molestation Order the ex-partner was followed by Carson to the children's grave on Mother's Day where he manipulated her into seeing him again for a short time. The ex-partner reported what had happened to her mental health care co-ordinator and added that he was being very confident and arrogant saying that the *"system was f***ed up and he thinks he can beat it."*

16.67. This statement provided powerful insight into how Carson viewed the criminal justice system and his intention to continue to have power over his ex-partner when he wanted to. Whilst this led to further protection for the ex-partner by the police (police liaison officers),

the information did not transfer across into the risk assessment for Carson's ongoing relationship with Matilda.

16.68. CPS Magistrates' Court Unit prosecuted Carson on three occasions between 2018 and 2019. Carson was convicted for breach of the Non-Molestation Order in August 2018, an offence (having contact with Matilda) for which he was sentenced and tagged with a curfew requirement. Such a sentence did not require contact with a probation officer for regular appointments. There were no reports of Carson being in breach of his curfew which was interesting in that despite his arrogant behaviour he appeared not to want to bring any adverse attention onto himself. He did however, continue to be in contact with Matilda.

16.69. Carson was again convicted for breach of Non-Molestation Order in December 2018 and for possession of a bladed article in a public place with threats to use it on himself. This resulted in a "stand alone" Suspended Sentence Order (SS0), 12 weeks custody suspended for 12 months. The punishment for the breach did not appear to make any difference to the coercive controlling situation with Carson and Matilda continuing to be in contact and meeting up with each other.

16.70. Coercive or controlling behaviour became a crime with the Serious Crime Act 2015. More recently in April 2023 section 68 of the Domestic Abuse Act 2021 widened the offence to include partners, ex-partners and family members. As previously mentioned, there is evidence suggesting that Carson was coercively controlling Matilda throughout their relationship. His behaviours included, taking steps to isolate her from family and friends, he made serious threats to harm her child and birth father if she tried to leave him (context that he was under criminal investigation for suspected murder of his own children). he used a tracking devise on her phone to check where she was, he found ways of contacting Matilda even when she blocked his number and emotional blackmail tactics with threats of harming himself to keep the relationship alive. Carson was a highly manipulative character whose mission was seemingly to keep a hold over Matilda. He had given threatening warnings to Matilda that he would not tolerate her leaving the relationship.

16.71. Despite Carson's activities being known it would have been difficult to make a successful criminal charge of coercive control against him because Matilda came across as a poor historian and as the relationship developed denied any fear of him. This was in contrast to her describing her fears at the early police interview. Carson was never charged for coercive controlling behaviour towards Matilda or his ex-partner.

16.72. Carson was found guilty after a criminal trial in June 2019 for the serious assault of his teenage sibling, breach of Non-Molestation Order with Matilda and for breaching of SSO. The matters were adjourned for sentencing and the court imposed a Restraining Order to protect Matilda and Carson's sibling from further *"conduct which amounts to harassment or will cause fear of violence."* Details of the Order were that "*Carson must not contact directly or indirectly with either Matilda or his sibling."*

16.73. Sentencing was adjourned on two occasions in June 2019 because Carson was in hospital following taking a Paracetamol overdose. This hospital admission was felt to be a malicious act by Carson to delay his sentencing. Then in July 2019 Carson failed to attend

Court and a warrant for his arrest was issued and he was produced to court a few days later. He was sentenced for Adult Custody for 12 weeks which he immediately appealed against as was his right to do so.

16.74. At appeal his conviction for assaulting his teenage sibling was squashed and he was released six weeks into his sentence. Consideration was given to the Restraining Order and Counsel spoke with Matilda to ascertain her views and she was emphatic that the Restraining Order should not remain in place. It was confirmed on the hearing record sheet that No Restraining Order was made.

16.75. The decision of the bench not to maintain the Restraining Order was said to be consistent with case law *(R v Brown (2012) EWCA Crim 1152) "which was based on the rational that a young woman involved in an abusive relationship was entitled to make a decision to reject a Restraining Order no matter how dispiriting this may be"*. It goes on to clarify that there was "*no suggestion that the young woman lacks capacity, or is forced to do this, or that she was in fear of the applicant."*

16.76. R v BROWN is a Court of Appeal decision and must be followed by the lower courts. However, if evidence is gathered which demonstrates that a complainant has not made a free choice to reject a Restraining Order and is likely to have been in fear or under the control of the perpetrator there no reason why that evidence cannot be put before the Court to support an application for a Restraining Order notwithstanding the express views of the complainant at that time. This would be a different set of circumstances to the Brown case so could be used by the prosecution to distinguish from that case and argue that it should not be followed.

16.77. In this case there was no pre-sentence report requested for the court and no consideration of the original reason for why the Restraining Order (based on assault and breach of non-molestation order) had been made. Therefore, the Restraining Order was squashed without the relevant information having been available to alert the court of the continuing risk posed by Carson and the manipulation and coercive controlling nature of the relationship.

16.78. This case highlights the importance of courts requesting and reviewing information before making decisions on Restraining Orders and other protective measures in order to safeguard victims of domestic abuse from dangerous perpetrators and in particular where coercive control exists because the victim is mostly unable to promote their own truth and safety due to the level of manipulation and psychological conditioning. Victims often place the needs of their perpetrator first owing to the level of "grooming" they experience and as a defence against escalating abuse. In order to protect victims of coercive control the state should take decisions out of the victims' hands to protect them.

16.79. It is true to say that Matilda had never supported the prosecutions against Carson in respect of the breaches of the Non-Molestation Order or pre-bail conditions and none had the desired effect of preventing contact between them. However, these "Orders" including the Restraining Order may have offered a ring of hope, support and containment for Matilda with a sense of caution for Carson.

16.80. On the day Carson was release from prison, he was assessed as posing a medium risk of serious harm and attended his first appointment with his designated Probation Officer at the Criminal Rehabilitation Company (CRC) which was seen as an area of good practice. Carson was offered weekly appointments by his Probation Officer who overtime became of the view that Carson was disingenuous and implausible. Carson was also found to be arrogant and had blamed Matilda for keeping the Non-Molestation Order in place and Carson was appropriately challenged for these views.

16.81. The Probation Officer was contacted by Carson's Mental Health Practitioner who shared concerns of Carson's lack of empathy and the likelihood that Carson had a Personality Disorder. These are high risk factors which are often found in people who harm others. It was reported that Carson had made a comment to the mental health practitioner that without any further court orders he was confident to have a relationship with Matilda. With the lens of hindsight, it is possible that once the legal barriers of Non-Molestation Order / Restraining Order were removed that Carson felt more powerful within the relationship which placed Matilda at greater risk.

16.82. Despite increasing concerns regarding Carson, the Probation Officer did not take the opportunity to escalated to the Senior Probation Officer or refer to MARAC as was expected practice. An escalation to a senior manager could have led to reassessment of risk and if Carson had been found to be "high risk" the National Probation Service (NPS) internal service could have assessed Carson for Personality Disorder. This in turn would have increased monitoring at a higher level and if relevant within timeframe, Carson would have been returned to prison.

16.83. Since the murder of Matilda CRC and the NPS have unified their services with Probation Service being the primary service for convicted criminals. However, had the new unified Probation Service policy on domestic abuse and child safeguarding checks been completed and presented to Court at the time of sentence, this information may have potentially led to a different assessment of risk to high and different allocation to the NPS.

16.84. An assessment of "high risk" may have led to additional Police/safeguarding management via a referral to MAPPA. The Integrated Offender Management (IOM) Pathway underwent a national refresh and whilst relaunched in 2019 referrals were only targeted at neighbourhood crime. Carson's offending profile meant he was unsuitable for a referral via this multi-agency pathway. Management by the NPS would have allowed for a consultation assessment under the personality disorder pathway to inform future management alongside the assessment that was completed by mental health services whilst Carson was subject to CRC supervision.

Progress – IOM processes locally have accepted Domestic Abuse perpetrators since 2022 and the Community Safety Team pay for the specialist IDVA focused on the perpetrator management who attends the IOM Panel meetings. This promotes a further level of surveillance and monitoring needed to contain perpetrating behaviours.

16.85. Carson's thoughts on the legal system were gained by the Independent Reviewer during an informal interview. Carson told the Reviewer that he did not recognise or agree that Matilda should have been included on the Police Bail Conditions list relating to Operation XX because he claimed that Matilda was nothing to do with the case. Therefore, it

may be the case that Matilda was more protected by the Non-Molestation and Restraining Orders (which had been lifted) than she was by Police Bail Conditions which in effect had been unsuccessful in keeping Carson and Matilda apart.

16.86. In the weeks leading up to the murder of Matilda there was evidence that their relationship was becoming more strained as was seen when Carson left Matilda and another couple for several hours following a heated argument when on holiday. Carson and Matilda were seen by the couple to be arguing frequently and the holiday ended early after Matilda and the couple experienced a mystery illness (not experienced by Carson) after a meal.

16.87. There was a sense that the relationship was in trouble but with no suggestion of a separation, although we cannot be sure of Matilda's thoughts and feelings on the matter. It is relevant to point out that it is known that post-separation can actually see an escalation of abuse with women reporting continued threats and intimidation when leaving their abusive partner. This abuse ranges from harassment type behaviour to physical abuse with a heightened risk of homicide.

Key Learning Points:

- Complexity of managing risk in coercive controlling relationships
- Complexity in balancing and prioritising different victims when police investigate perpetrators with multiple crimes.
- Importance of the support of IDVA's in court to promote the welfare of victims.
- Understanding the attitude of the perpetrator in relation to considering the discharge of Restraining Orders and Non-Molestation Orders.
- Psychological assessment to understand perpetrators of suspected serious crime with suspected personality disorder is important in understanding the level of risk.

Criminal justice arrangements for Operation XX.

16.88. The Judge at the Family Court Finding of Fact Hearing in relation to Care Proceedings for a four-month-old child who had been in the care of Carson at the time of their collapse, released a twenty-four-page verdict that Carson had "on the balance of probability on both occasions caused the child's airways to be obstructed." This followed evidence from five separate medical expert witnesses who reported to court. The medical experts had consisted of a Consultant Paediatricians in the field of Respiratory Medicine, Clinical Genetics,' Cardiology, Neonatology and Neuroradiology.

16.89. The Judge rejected the claim made that one or both episodes was a medical event that could not yet be explained by science. The Judge described Carson as a *"disturbing witness," "he was able to ignore reality and truth without a second thought."* Also, Carson was *"capable of doing things most would find abhorrent," "his warped way to restore his relationship," he lied to protect himself from the consequences"* and *"I think he is a dangerous man."*

16.90. Following this court case, the Judge wrote to the Police requesting an investigation into the deaths of Carson's children who died in 2013 and had also been in his care immediately prior to their deaths. The Judge's request to the Police resulted in a Gold Command meeting which was taken over by a Senior Investigating Officer (SIO) under

Operation XX. The Independent Reviewer was able to interview the SIO for the case and requested an internal review of the case from CPS to better understand the complexities of the investigation.

16.91. Initially, Carson was arrested in September 2016 under suspicion of attempted murder of the child who had been the subject of the Family Court Hearing. This led to the expanded police investigation (Operation XX) to include the deaths of Carson's children who died in 2013 as suggested by the Judge.

16.92. A complication for Operation XX was that under Section 98(2) Children Act 1989 which states that a statement or admission made for family proceedings is not admissible in criminal proceedings against the person making it or his spouse, except for an offence of perjury. The standard of proof in family proceedings is the balance of probabilities. The standard of proof in criminal proceedings is beyond reasonable doubt. The fact that the Family Court evidence was not admissible in criminal proceedings presented a highly complex challenge for the Police Investigation in that new evidence needed to gained from scratch.

16.93. Between April 2018 and October 2019, the Police SIO worked closely with the CPS complex case team (which was good practice) and submitted three comprehensive complex evidential files on behalf of Operation XX for CPS charging advice as was expected police investigative practice with relevant case discussion meetings taking place in response to this.

16.94. Covid 19 delayed some of the evidence reports and interviews in preparation of the additional evidence. The police prepared a further timeline of investigation to CPS in July 2019 which was updated in August 2019. The CPS described the evidence submitted as "massive." For example, there was over 1000 pages of evidence including complex medical evidence, witness statements and suspect interviews.

16.95. The charging decision for Operation XX was delayed by eight weeks which was found to be due to the scale and complexity of the evidence provided which required detailed analysis to ensure that family court material was removed and that the nuances of the expert evidence was clarified and fully understood.

16.96. The charging decision made by CPS had been in accordance with the Code for Crown Prosecutors as set by statute and is the test by which all prosecution decisions must be made. The evidential test requires that the evidence must be sufficient for there to be a realistic prospect of conviction. This means that a Jury must be more likely than not to convict based upon the evidence put before it. The jury has to be satisfied beyond reasonable doubt before it can convict.

16.97. Meeting the threshold of the evidential test was a challenge in this case owing to the case relying on consequential evidence which had been based on the fact that Carson was present at the time of the incidents. Also, of complexity was the medical scientific evidence that the children involved had been (without doubt) deliberately harmed by him.

16.98. The CPS decision not to charge Carson on the basis that there was, at that point, insufficient evidence was made the day before Matilda was found dead (October 2019) and although this was distressing and frustrating for the police officers on the investigation team, it is CPS responsibility to uphold decision making paraments to prevent cases without sufficient evidence going before the court and leading to miscarriages of justice.

16.99. Following Matilda's death, the subsequent Police investigation was held under Operation YY and Carson was arrested for the suspected murder of Matilda in June 2020 with further Police Bail Conditions applied. The Police and CPS agreed in January 2021 to pull the two police investigations together to provide a "cumulative approach" to establish a case which met the evidential test i.e. where a jury was more likely than not to convict.

16.100. Carson who had been on Police bail for two years and two months was arrested and placed on remand in January 2021 pending criminal trial which took place in December 2021. He was found guilty of the historical murders of his children and of Matilda. He was also convicted of the attempted murder of a third child.

16.101. The Independent Reviewer is aware that Ministry of Justice data for 2017 – 2021 show that 130 people were killed by suspects on bail. Critics of the criminal justice system say that the "benefit of the doubt" is given to too many suspects who go on to commit more offences. Whilst no failing has been found in this case it remains frustrating that Carson was allowed to remain at large for some considerable time.

16.102. On review of Operation XX CPS have found learning in respect of making *"clearer instruction to the expert witnesses as to the evidential requirements needed to be considered as part of the investigation policy and strategies."*

Key Learning Points:

- Complex medical criminal investigations are challenging and can take a number of months/years to conclude.
- Clearer instruction to medical expert witnesses as to the evidential requirements is needed to promote clarity of the medical information provided.

Effectiveness of specialist domestic abuse services and women's refuge

16.103. The local specialist domestic abuse service (WISH) in this case is a registered commissioned charity providing practical and emotional support to people impacted by domestic abuse. They offer crisis support, operate a domestic abuse helpline, provide safe refuge accommodation, counselling service and a range of therapeutic programmes for victims, perpetrators and young people.

16.104. Matilda was originally referred to the WISH AIMs programme in January 2018 by Children Social Care. At this point they had little information available about Matilda's childhood history involving ACEs because she had been subject to child protection proceedings in a neighbouring Local Authority. Information was being awaited by Children Social Care as part of child care proceedings for Matilda's child.

16.105. WISH was already aware of Carson and were supporting his ex-partner. A history of Matilda's relationships was recorded but the initial risk assessment lacked detail of Matilda's past childhood experience to identify her level of vulnerability for themselves which demonstrated a lack of professional curiosity.

16.106. The IDVA reported as part of this DHR that there had been a push back from the Clare's Law team around sharing relevant domestic abuse information with Matilda because Children Social Care were involved and it was seen as being the role of the social worker to inform Matilda of the risk posed by Carson. This appears to be a suppression of information relevant for the IDVA in working effectively with Matilda.

16.107. The IDVA acted appropriately when Matilda disclosed that Carson was making serious threats to harm her and her child if she left him. The IDVA appropriately referred Matilda to the Police and MARAC and supported Matilda to gain a place of safety at Women's Refuge and to obtain the Non-Molestation Order against Carson which was good practice.

16.108. Once Children Social Care receive Matilda's past childhood history of trauma the information does not appear to have been routinely shared with WISH either directly or via MARAC to enable them to review their interventions with Matilda despite their direct involvement with her. This highlights the role of agencies to share Information which is a key theme in most DHRs.

16.109. Practitioners are often left to take the word of the victim at face value at the commencement of their intervention and the information gathered is not regularly revisited to expand understanding. Professional curiosity is essential in enquiring about past life trauma and then making checks with other practitioners in other services to cross reference information gathered should be an expectation and a key role of MARAC.

16.110. The knowledge of historical ACEs is essential information to understand a victim's level of vulnerability and to ensure that trauma informed practice is used when relevant to gain trust and establish a meaningful professional relationship to strengthen support and improve outcomes.

Progress - Since this case there has been a review of the WISH service in relation to its risk assessment processes. It found that when a referral was made to the service background information was very limited and inadequate in terms of making safe decisions on behalf of victims. WISH have established a new system in line with SafeLives guidance to improve information gathering around family history, support networks and barriers to making safe choices. This will promote understanding of a victim's personal skills and emotional ability to break free from abuse. WISH have since recognised that counselling would have been helpful for Matilda in terms of understanding her own thoughts and feelings.

16.111. The IDVA temporarily closed the case when Matilda was placed at a women's refuge out of area and re-opened once she returned locally. It was felt not possible to keep cases open with out-of-area victims in order to keep caseloads at a manageable level. This was unfortunate since Matilda needed continuity of care by having at least one consistent person who she could trust and provide a level of containment.

16.112. Trauma informed practice relies on having a practitioner who can build a trusting and non-judgemental relationship with a victim and provide a longer-term bond which can reduce the feeling of isolation and provide a narrative which is different to the perpetrator to promote empowerment and confidence.

16.113. The overwhelming narrative for Matilda was from Carson that *"if you leave me, I will harm your child and the child's father" and "I will not put up with you leaving me".* Matilda absolutely believed Carson's threats would be carried out and had vocalised to professionals that she *"did not want to be in a relationship with Carson."* However, Matilda had no consistent professional voice to encourage and support a way out of the abusive situation and the IDVA did not have the background information to help Matilda as they should have done. This being acknowledged, Matilda's parents did provide a consistent voice to support her and continued to plead with her to end the relationship in her best interest.

16.114. It has been found that the role of the IDVA in reducing victim risk was not well recognised or utilised by partners at the time. WISH found that agencies referring to them often referred directly to their harm reduction programmes rather than to their IDVA team for support. Whilst the IDVAs are not employed within a statutory agency they are experts in their own right and require the same level of information as any other agency would require in order to carry out a comprehensive risk assessment to inform appropriate levels of intervention.

16.115. The work of specialist domestic abuse services is an essential part of keeping victims of domestic abuse safe. They work in partnership with a network of women's refuge who accommodate victims at danger points in their lives. Matilda was found a place at two separate refuges, both of which were out of area to where she was living. The key issue for Matilda was that she was keen to maintain her involvement with her child and keep up her weekly contact sessions with the child.

16.116. Matilda only remained at the first refuge (Chorley) for a few days before she was evicted following meeting up with Carson and revealing where she was staying. This disclosure put not only Matilda at risk but other residents who were residing at the refuge and for that reason Matilda had breached a paramount rule of the refuge and was evicted, which was expected practice.

16.117. The second refuge (South Lakeland) Matilda remained there for ten weeks. She disclosed details of her perpetrator (Carson) and stated that she was at risk from her birth parents, but no further information was recorded. Her support plan (April 2018) included that she would like to talk to a GP about her mental health (which she did) eat more healthily, feel safe, have counselling, consider benefit support, like to do some volunteering, like to do a part-time college course, like to be involved in activities at the refuge. This reflected Matilda's wishes and feelings at the time and revealed some ability for free thinking about life without Carson.

16.118. Unfortunately, this period of positive reflection did not last for long and on week two of her stay Carson's family member repeatedly contacted Matilda to phone Carson because he was going to throw himself off a multi-storey car park. This resulted in Matilda contacting Carson and talking to him until the police arrived. Matilda was worried about the situation and the impact this may have on her being able to see her child. Practitioners at

the refuge appropriately engaged with Matilda to reassure her and to inform her to speak with staff before contacting Carson in future which she agreed to do. Refuge informed the relevant police officer involved which demonstrated good information sharing.

16.119.Although Matilda appeared to settle at the refuge and was said to be seeing friends and family it soon became apparent that she was in contact with Carson via WhatsApp on a regular basis and she was receiving money from him. Matilda was given a written warning for this issue. She admitted that she found it difficult to break from Carson as she had strong feelings for him.

16.120. At this point Matilda was feeling isolated and had low mood for which she was being treated by her GP with anti-depressants. Counselling sessions were commenced which she initially felt would be beneficial. However, Matilda disclosed to her key worker that she found talking about her past childhood very depressing which is not unsurprising given the nature of her past abuse. Counselling someone with high level past trauma should only be done by a professional with the qualification and understanding to be able to support a client without retraumatising them.

16.121. As Matilda's stay progressed, she started to make bids for properties in Darwen but was evicted from the refuge for continuing to see Carson and providing him with the address of the refuge. She was collected and returned to Blackburn by a Police Officer and eventually was found a place with the Salvation Army because of her homeless status.

16.122. Since this case the refuge in South Lakeland have reviewed their service and in 2022, they appointed a new board and CEO as part of a complete overall of the provision. Key lessons from the refuge services provided have been around, case recording systems, trauma informed practice, training needs of staff, case management and supervision, information sharing and multiagency working, police review, and being in line with SafeLives guidance.

Key Learning Points:

- Professional curiosity, information sharing and multiagency working are key to keeping victims safe.

Effectiveness of supported housing scheme

16.123. Matilda moved from the Salvation Army into a flat at one of THA Supported Housing Schemes, in August 2018. The scheme provides short stay accommodation (typically up to 12 months), together with support to vulnerable people experiencing homelessness. The purpose of the service is to enable residents to have time to recover and to develop skills to move onto independent living.

16.124. When Matilda entered the service, she was known to be a victim of domestic abuse and there was a Non-Molestation Order in place against Carson. THA staff elicited information from Matilda as part of their risk assessment meeting with her which was good practice. Matilda reported her previous accommodation history and that she had her young child removed from her care who was now living with the child's birth father. They were also told that she herself had been removed from the care of her own parents as a child by

the Local Authority due to concerns of neglect and had experienced domestic abuse throughout her life.

16.125. Whilst THA were aware of Matilda's background and issues around mental health and continued coercive control, when issues arose such as rent arrears, regular absences from the scheme, finding out about Matilda registering a business using her tenancy address, staff regarded these concerns purely as a breach of tenancy issue and took an enforcement approach rather than considering through the lens of safeguarding/financial abuse.

16.126. Throughout Matilda's time with THA, she remained in an abusive relationship with Carson. She did not consistently engage with staff at THA and there were signs of her struggling to cope with her tenancy, including non-payment of rent, evading contact with staff and being absent from the scheme. Their assessment on admission to the scheme showed that Matilda was at high risk with medium support needs due to harassment and domestic abuse. Carson was said to be emotionally and financially abusive but it is not clear in what form the financial abuse took. Under the "*anything" else* section of the assessment Matilda reflected that she *"did not have the skills to maintain a tenancy at this present time."* This demonstrates that Matilda did have some insight into her own abilities and needing support.

16.127. The THA support plan involved Carson not being allowed to enter the THA building and a photo was available to staff although they were aware that Matilda was in contact with Carson on a regular basis away from the scheme. There was an opportunity for THA staff to request a copy of the Court Order and to take a multi-agency approach through WISH and MARAC referral but this did not take place. There was a lack of professional curiosity by staff to understand the nature of the relationship, nor was any support provided around the domestic abuse or advice given about how Matilda could keep herself safe.

16.128. Early in the tenancy there was a lack of professional curiosity around why Matilda was finding it difficult to pay her rent which were in arrears. Matilda's wishes and feelings about her future were not well understood by THA to enable them to promote positive progress in her life. Support sessions appeared to be superficial for example, her relationship with her child was never explored and she did not receive any help to apply for a make-up course at the local college she was considering. THA did not take the opportunity to learn more about Matilda by requesting or sharing Information with other agencies

16.129. There were a number of enquiries from the child's social worker to check that Matilda had settled into the scheme presumably as part of the Children Social Care parenting assessment although this was never confirmed by THA staff. This was an opportunity for joined up working and information sharing in terms of helping strategies for Matilda. The Social Worker confirmed to THA that they had advised Matilda to contact WISH for support and THA agreed to chase this up.

16.130. In November 2018 the key worker at THA recognised that Matilda was only offering information when questioned and was not giving detail of any other issues taking place. This was further evidence for the need for agencies to work closely together and would have been expected practice for THA to seek updates from Children Social Care around progress with Matilda's child.

16.131. Later in November 2018 it came to light to THA staff from another Housing Provider that Matilda was spending a lot of time with Carson and another couple who were travelling to Blackpool together and staying in hotels and using money from Carson in Arcades. Carson was changing his car on a regular basis and there were concerns around him being involved in fraud because he was asking people if he could place money into other people's bank accounts. It was requested that this information should be shared with the police.

16.132. Matilda reported to THA she was being blackmailed for 100k by a snapchat group in December 2018 this occurred a few days following her second termination of pregnancy with Carson's baby. The incident of fraud was reported to the police and Matilda made a police statement. On discussion between THA staff and police it was found that the story Matilda gave were slightly different. The police reported to THA staff that Matilda had been proven to be a "compulsive liar" on a number of occasions. This additional information did not prompt THA or the Police to refer to MARAC as should be expected practice.

16.133. Whilst it is true that Matilda did not always tell the truth to professionals, the police officer's comment of referring to Matilda as being a compulsive liar was not helpful language in terms of supporting victims of coercive control. There is caution for all, in that it is common for victims to lie for many reasons such as shame, misplaced loyalty, panic, fear, distress. The fact that someone lied about some matters does not mean they lie about everything or have a compulsion to do so.

16.134. In early January 2019 during Carson's prison sentence THA staff discovered that a Construction Business had been set up from the scheme address in Matilda's name. There was a lack of understanding, awareness and compassion in terms of the impact of coercive control and domestic abuse on Matilda at this point. It was most likely that Matilda had been coerced into setting up the company by Carson, since she reported to THA staff that it had been Carson's idea. It was evident that Matilda was involved in something beyond her understanding and control and needed help, which was not offered.

16.135. There was a lack of probing to gather information about why the business was set up and what the implications or risks maybe to Matilda when instructed to close it down. Albeit this was a breach of tenancy conditions and needed to be addressed, staff could have approached this through a safeguarding lens, given their awareness of the abusive relationship. This information should also have prompted a multi-agency approach via the MARAC given what was known at the time.

16.136. From March 2019 onwards it appeared that Matilda was spending less time at the THA scheme and was not engaging or attending key worker sessions as expected. By late April 2019 Matilda was reported as a missing person by THA because she had not been seen for over a week and there were concerns, she was with Carson who was seen as a significant risk towards her. Matilda was later found and returned to the scheme residence but left again after a few minutes.

16.137. Early in May 2019 the DWP Fraud Squad were wanting to speak to Matilda in connection to her benefits whilst apparently owning a company. THA reported they had not seen her and gave a phone number which Matilda had previously reported as being lost.

16.138. When Matilda returned to THA, she reported that Carson had been taken to hospital following an overdose which he had taken when the Police broke in to try to arrest him. She complained that she was very tired and had not slept properly *"for ages".* This was not explored further and the focus appeared to be on rent arrears.

16.139. During the time Carson was in hospital Matilda stayed at the scheme and was involved in helping another resident cleaning out their flat and helped another resident cook a meal for other residents (chilli and rice). These acts of kindness showed a different side to Matilda which was positive and demonstrated promise for a future away from Carson.

16.140. Once Carson was in Prison Matilda was seen infrequently and her whereabouts unknown and with no checks with other agencies involved to find out where she was and what was happening. As previously stated, Matilda had been spending more time at her parents' home a matter which could easily have been checked with them resulting in a missed chance to promote a "golden opportunity" to intensify work with Matilda and to help her to understand the toxic nature of the relationship and support her in moving forward without Carson.

16.141. Following Carson's release from Prison in September 2019, Matilda was said to be busy looking for a property to rent with a view to ending her tenancy with THA. Support with a deposit was forthcoming although help in finding a flat fell short of expected practice.

16.142. The last contact THA had with Matilda was three days before her death. This was to check that she had cleared her arrears for her rent. Matilda responded that she was unwell, (probably already under the influence of the drugs being surreptitiously provided by Carson) and was having difficulty walking with a plan to see the GP at 6pm that evening.

16.143. Immediately following Matilda's death, THA files were closed down and whilst it was recognised that Matilda's death had occurred away from the scheme the Head of Service decided that an Internal Review of services involvement should be undertaken to consider the death of a vulnerable tenant.

Key Learning Points:

- Professional curiosity is important to seek pertinent information for the purpose of assessment and understanding someone's issues in order to help them.
- Information sharing is a two-way process.
- Importance of trauma informed practice when working with victims and people with other vulnerabilities, including those who have suffered ACEs
- Importance of working with other agencies, ongoing assessment of risks and safety planning, including linking into MARAC
- Improving understanding of domestic abuse, including coercion and control

Progress: Together Housing conducted an early (pre-DHR) comprehensive Internal Review of its services in respect of Matilda's tenancy which was conducted using the principles of an IMR. This has enabled prompt implementation of key changes including: restructure of the team to strengthen the management of the service, a move away from key working to address silo-working, internal case management support from managers and inhouse safeguarding team, refresher training on safeguarding and domestic abuse, improvements

to the quality of the support through embedding a trauma-informed approach, improved record-keeping and working as part of the multi-agency framework.

17. Conclusion

17.1. The circumstances of Matilda's homicide were tragic and unique in that it was a premeditated, cruel, prolonged act by a vengeful partner who tried to cover their tracks by making the death by lethal poisoning look like a suicide.

17.2. Key findings from the analysis of domestic homicide reviews (Gov.UK, March 2022.) draws on the findings after reviewing 124 DHRs from October 2019 for 12 months, which found that 73% of victims had perpetrators which were a partner or an ex-partner. 80% of those victims were female and 61% of had a vulnerability. It also found that approximately 60% of perpetrators were indicated to have a previous offending history. Of these three quarters had abused previous partners and one third family members. These figures match the overall professionals view that Matilda was in a high-risk relationship which required high level resource and support.

17.3. The turbulent and coercive controlling nature of Matilda's relationship with Carson appears to be the trigger for her death by deliberate lethal poisoning which had been administrated over a number of days. At the time of her death Carson had been under suspicion of murdering two of his children and for attempting to murder a third child by deliberate suffocation. It was alleged that these serious criminal acts had been motivated by the breakdown of a relationship and his determination to prevent any partner from leaving him.

17.4. It is of significance that prior to the end of Carson's short prison term (August 2018), that the Restraining Order in place to protect Matilda and the teenage sibling was removed at the appeal hearing following Matilda's (and sibling) insistence that this was not required. At this stage Matilda had disengaged from helping services and had rejected offers for continued support.

17.5. Despite some concerns which should have been escalated by the Probation Officer, Carson went on to successfully completed the licence element of his probation supervision and was being managed on the post sentence supervision. The only existing thread of protection for Matilda at this point appeared to be the pre-bail conditions for Operation XX which Carson did not respect in terms of their application to Matilda. Matilda was murdered ten weeks later during a time when their turbulent relationship became strained.

17.6. The findings of this DHR acknowledges that initially Matilda had several agencies and practitioners working with her to break free from the grip of coercive control. The highly complex nature of the relationship and the different strands of criminality which stemmed from Carson along with his attempts to continually frustrate and manipulate every situation must have been exhausting for all involved.

17.7. The review highlights the danger of coercive control and the need to improve the management of repeat offenders. In particular the need to strengthen multiagency systems such as MARAC (which has now taken place) to identify and monitor serial perpetrators of

domestic abuse and to strengthen the role of the IDVA who are often the practitioner working in partnership with the victim and are in the best position to advocate for them.

17.8. A further complexity of coercive control illuminated by this DHR is that there is no quick fix to resolving these abusive relationships. Perpetrators of coercive control do not play to the same rules as everyone else as Carson displayed throughout this DHR. Carson had Pre-Bail Conditions, Non-Molestation Order and Restraining Order to legally obligate him not to have any contact with Matilda none of which appeared to work. He remained under the illusion that he was above the law.

17.9. It would therefore, not be surprising if professionals had felt disenfranchised from the situation and instead of seeing Matilda's fear and hostage situation from extreme coercive control, they had started to label Matilda as being a liar and blamed her for wanting a relationship with Carson. The reality from Matilda's perspective is not fully known but the Independent Reviewer has reflected that it is likely that Matilda may have become jaded with a feeling of helplessness within the situation after months of agency involvement and with no clear positive end result in sight.

Predictable / preventable?

17.10. This is a highly complex question which had a split response from Panel Members. Panel agreed that Carson's predicted risk towards children was extremely high and agencies working with Matilda understood this. The evidence of this was straight forward in that Carson was on Police Bail throughout the review timeline for the suspected murder of two of his own young children and for the attempted murder of a third child. Furthermore, Matilda's own child was removed from her care in respect of Carson's contact with the child. The end result of agency working has been that Carson was not able to harm any other child which is a credit to all involved.

17.11. Carson had been viewed as being a "high risk" perpetrator against the mother of the murdered children with a predicted possible risk of mother's own suicide. High-level police involvement, IDVA and mental health support were placed around her as she struggled to break-free from his coercive controlling behaviours and as she tried to come to terms with the enormity of what had happened to her children which again was commendable.

Was Matilda's homicide predictable? –It has been accepted that there were a number of alerts relating to Carson that was known to professionals during the timeline:

- Police bail for suspected murder of his own two young children
- Suspected of attempting murder of a third child
- Known high risk threats by Carson made to ex-partner
- Harassment and stalking of ex-partner – despite police bail conditions
- Long history of coercive control, manipulation, financial and emotional abuse.
- Finding of fact Judge stated that Carson was a dangerous man and convincing liar
- Historical disclosure by Carson to GP about non-fatal strangulation of ex-partner
- Killed animals when he was young
- Breach of Police Bail conditions, Non-Molestation Order and Restraining Order by meeting up with Matilda
- Threatened to seriously harm Matilda's child and the child's birth father

- Social Workers recognised Carson's high risk of uncontrolled aggression at a meeting and issued care proceedings for Matilda's child rather than holding a Child Protection Conference.
- Information at police interview that Matilda was afraid of Carson and he made threats of serious harm if she tried to leave him.
- Used physical force to hold her up to a wall on a regular basis.
- Coercive control of Matilda resulting in three MARACs in one year.
- Threat to cut his own throat with a knife during arrest
- Deliberately took a serious medicine overdose as police broke his door down during a further arrest. Act felt to be manipulation to resist sentencing.
- Charged with possession of a knife on two occasions
- Claimed he had Mental Health issues to resist arrest
- Threats to jump off a multi-story car park to manipulate justice system
- Involved in financial fraud
- Mental Health Practitioner reported likely Personality Disorder and lack of empathy
- Lack of empathy reported by ex-partner following deaths of their children and by Matilda following report of miscarriage (actual termination).
- Matilda terminated two pregnancies by Carson because she did not want a child linked to him and the likelihood the child would be removed.
- Lack of honesty about his employment and other aspects of his life.
- Recognised as been disingenuous and arrogant by probation officer.
- Poor attitude towards effectiveness of justice system and his belief that the police had nothing on him in relation to the deaths of his children.
- Assault of teenage sibling by non-fatal strangulation.
- Belief that once the Non-Molestation Order had been removed, he was free to have a relationship with Matilda without fear of police interruption as he (in his own words) did not recognise the terms of the pre bail conditions in respect of Matilda
- Carson felt he was above the law.

17.12. It is fair to say that no one alert on its own suggests that Carson would murder Matilda however, when seen together the Independent Reviewer has acknowledged that it shows a cumulative level of profound concern that Carson was capable of doing anything.

17.13. Different agencies had viewed Matilda at different levels of predictable risk, one side of the Panel felt that Matilda was a young woman wanting a relationship with Carson and with no recent disclosure of abuse being made by her to escalate concern. Also, her on-going risk was being managed by the police bail conditions which remained in place. The remaining agencies on the Panel continued to view Matilda as a high-risk vulnerable victim of domestic abuse/coercive control who had been groomed by Carson and was at serious risk of harm.

17.14. This difference of opinion between agencies is unsurprising given that the events took place during a time when agencies were not effectively working together to share information and to plan together through MARAC arrangements / local joint working practices have since been improved.

Was Matilda's homicide preventable? - There are a number of issues to address in considering if and how Matilda's homicide could have been prevented:

- **The mixed agency views** of Matilda of either "wanting the relationship" or being at "high risk in the relationship" may have left the team of professionals around Matilda being confused about the situation as interventions failed and the relationship continued.
- **Three MARACs** to consider Matilda's risk were insufficient to promote multiagency planning and working to protect Matilda.
- **Voice of Matilda** appeared to be quickly forgotten or dismissed as a lie. Matilda said *"I am afraid of Carson" "He will harm my child if I don't stay with him." He is manipulating contact with me." "I don't want to be in a relationship with Carson."*
- **Two terminations of pregnancy** are highly significant as a marker of risk as Matilda reported to professionals that she did not want a child linked to Carson.
- **Two Women's Refuge** stays as Matilda tried to break free from Carson. Whilst Carson was aware of her location due to a location App on her mobile phone.
- **Legal intervention** of non-molestation order, police bail conditions and restraining orders did not result in being an effective barrier to end the relationship despite Carson being charged of breach of the non-molestation order on two occasions.
- **Operation XX** was a lengthy and highly complex police investigation which was ongoing throughout their relationship and was struggling to meet the threshold for CPS to meet statutory charging standards for Carson to be legally charged for murder which would have removed him from society.
- **The abating safeguarding arrangements** for Matilda as time passed and interventions failed to prevent the relationship, the evolving mixed professional view of Matilda's level of risk and Matilda disengaging from services for reasons' that were not fully explored or understood.
- **The nature of Carson** was not fully assessed by a psychologist and therefore the relevance of his disregard of the justice system and his level of arrogance and lack of empathy was not understood or managed.

17.15. Whilst it cannot be concluded that Matilda's death was preventable because it was not predicted by agencies involved, it can be said that on balance, there did not appear to have been sufficient safeguarding of Matilda by the collective multiagency partnership. Her level of vulnerability was seemingly not fully understood, neither was the risk she faced from Carson's controlling behaviour and possible personality disorder ever effectively assessed despite a number of available legal and support strategies being applied at the time.

18. Lessons to be Learnt from this DHR

Nature of coercive control

18.1. Coercive controlling behaviour by a perpetrator is an act or a pattern of acts of assaults, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim (Women's Aid - website). This controlling behaviour is designed to make a person dependent by isolating them from support, exploiting them, depriving them of independence and regulating their everyday behaviour. This can be seen as a form of "grooming" or "brain washing" it is often be relentless, emotionally draining and psychologically damaging resulting in an increased incidence of suicides and mental health issues.

18.2. Perpetrators of coercive control often have personality traits akin to narcissistic personality disorder (NPD) which is characterised by a pattern of grandiosity, need for admiration, exploitation of others and lack of empathy (Degges-White.S.2021). This can make any professional relationship difficult to manage as those with NPD do not respect the greater knowledge and experience of others. All professionals working with families need to consider NPD personality traits as part of any safeguarding assessment and where identified this should act as a "red alert" for further safeguarding consideration. Psychological Assessment is required in relevant cases to fully understand the nature and extent of the risk posed by the perpetrator.

18.3. Research (2017) by Criminology expert Dr Jane Monckton Smith found an eight-stage pattern in 372 killings in the UK. The University of Gloucestershire lecturer said controlling behaviour could be a key indicator of someone's potential to kill their partner.

The eight-stage pattern in Dr Monckton Smiths study showed:

1) A pre-relationship history of stalking or abuse by the perpetrator
2) The romance developing quickly into a serious relationship
3) The relationship becoming dominated by coercive control
4) A trigger to threaten the perpetrator's control - for example, the relationship ends or the perpetrator gets into financial difficulty
5) Escalation - an increase in the intensity or frequency of the partner's control tactics, such as by stalking or threatening suicide
6) The perpetrator has a change in thinking - choosing to move on, either through revenge or by homicide
7) Planning - the perpetrator might buy weapons or seek opportunities to get the victim alone
8) Homicide - the perpetrator kills his or her partner, and possibly hurts others such as the victim's children

Recognising, assessing vulnerability and intervening for victims of domestic abuse.

Recognising ACEs - There are several factors which can make an adult more vulnerable including, mental health issues, drugs and alcohol, learning difficulties and the impact of past childhood adversity. It is recognised that Adverse Childhood Experience (ACEs) can create harmful levels of stress which impact on the brain's development and can result in long-term effects on learning, behaviour and health. ACEs are relevant because they can impact on day-to-day decision making and relationship choices. ACE assessment is not routinely used in practice and therefore the opportunity to fully understand an adult's cognitive skills and perspective is missed.

Service fatigue - It is possible in protracted cases of domestic abuse that practitioners can become frustrated with a situation as the strategies used to disrupt a relationship become exhausted and fail to achieve change to the situation resulting in the practitioners downgrading and adjusting contact with victims accordingly.

Golden opportunity - There is a "golden opportunity" to intensify working, understanding and future planning with the victim rather than viewing this as an opportunity to withdraw because the victim is safe. Work with vulnerable victims at this point has the potential to

yield positive outcomes because the victim may feel safe to speak out and has space to reflect on their present and future life.

Early assessment of vulnerability - Early assessment, information gathering and information sharing has a key role to play in recognising relevant ACEs and providing opportunity to understand and gain the trust of a victim through trauma informed practice principles

Trauma informed practice

18.3. Trauma-informed practice is grounded in the understanding that trauma exposure can impact on an individual's neurological, biological, psychological and social development. It aims to develop professional relations which can promote mutual trust, feeling of safety which can reduce the sense of isolation It also, seeks to address the barriers that people affected by trauma can experience when accessing helping services. (Working definition of trauma-informed practice. Gov UK. Nov 22)

18.4. There are six principles of trauma-informed practice: safety, trust, choice, collaboration, empowerment and cultural consideration. There is an opportunity for promoting trauma-informed practice across the spectrum of professional services through raising awareness throughout the workforce and through training.

18.5. Trauma informed practice is key to working face to face with vulnerable victims of domestic abuse. Practitioners such as IDVAs have an important role to play in helping victims to feel there is someone available they can trust and who will not judge them outside of the statutory agencies (police, health and social care). Victims need someone to share their side of the story with and to advocate for them in times of need. Additionally, IDVAs have an important role in containing the victim's thoughts and feelings through regular contact and by submitting an alternative narrative to that of the perpetrator.

Disengagement and avoidance

18.6. It is recognised that victims of domestic abuse who are or have been in abusive relationship can become isolated, have their self-esteem eroded and can begin to blame themselves, or deny or cannot recognise that abuse is happening to them. Fear, anger, guilt, shame, resentment, and sense of powerlessness are all emotions commonly described by victims.

18.7. Disengagement and avoidance of professionals is not uncommon behaviour by victims who may find themselves using avoidance coping instead of facing stress. This can be learnt behaviour when growing up trying to avoid stressful situations which becomes a habit in adult life. Other reasons why people disengage or become avoidant is because they are trying to hide something to avoid unwanted consequences. Understanding this behaviour is essential because these are warning signs that a victim is under most stress when at greatest risk.

18.8. Finding out the motivation for the behaviour at the time is difficult but it is an important part of safety planning. However, what often happens is that professionals become fatigued with helping a victim and begin to view disengagement and avoidance as the victim rejecting help and wanting to be in the abusive relationship which can sometimes

lead to unhelpful rhetoric such as “she wants to be in the relationship,” “she’s a liar,” “she’s that sort”, “she deserves what she gets”.

18.9. It is important to remember that victims who lie do so for a reason but does not mean that the victim lies about everything and should not be seen as a reason to stop supporting them**.**

18.10. Careful planning for disengagement and avoidance should be part of the overall safety plan to help professionals to maintain resilience and to focus on increased action at these points rather than allowing safety plans to fizzle out.

The role of MARAC in protecting victims

18.11. As previously stated, multi-agency risk assessment conference (MARAC) is a meeting where information is shared on the “high risk” domestic abuse cases between representatives of local police, probation, health, child and adult protection, housing, IDVA’s and other specialists and relevant voluntary sector. “High risk” domestic abuse is defined by the Home Office as serious harm *“which is life threatening and/or traumatic, and from which recovery whether physical or psychological can be expected to be difficult or impossible.”*

18.12. In this case, the victim was referred to MARAC on three occasions but arrangements were not sufficiently robust to protect her. New arrangements covered by MARRAC have improved the efficiency and effectiveness of the multiagency working arrangements to protect future victims of domestic abuse.

Multiagency working in domestic abuse

18.13. The statutory arrangements to safeguard children were effective in keeping the victim’s child and other children safe. However, there was a delay in initiating the first multi-agency strategy meeting and early ICPC. The benefit of an ICPC in relation to supporting victims of domestic abuse is that it may provide an opportunity for better understanding of the risk posed by the perpetrator and may lead to the parent receiving domestic abuse-helping services and legal protection sooner.

18.14. The delay in this case has been acknowledged by Children Social Care and appropriate service improvements have already been made as discussed. There was good practice found within the review around the way that the police and children social workers worked together to coordinate their visits and share information about the child.

18.15. Domestic abuse arrangements involving individual services working with the victim and perpetrator need to avoid working in silos to maximise the effectiveness of safeguarding plans. Since this case partnership working has been expanded to include IDVAs joining the Police on domestic abuse visits which may help to bring a victim perspective to the joint assessment and promote a further level of advocacy on behalf of victims.

Professional curiosity

18.16. Professional curiosity is the capacity and communication skill to explore what is going on in the life of a person rather than taking what they say at face value. When faced with

uncertainty it is key that professionals remain sceptical (respectful uncertainty) whilst applying critical evaluation to any information they receive, keeping an open mind and considering how they can verify the information provided. Much has been written about the importance of professional curiosity during encounters with victims of domestic abuse and the need to maintain close relationships of the kind where the professional is able to see, hear and touch the truth of their lived experiences of the victim.

18.17. Practitioners working with domestic abuse and coercive control may be impacted by the victim's ability to make decision and judgements freely, unfretted by fear, coercion, manipulation and undue influence. It is unwise to assume that a victim is free to make unwise decisions requiring practitioners to explore the context, motivation and impact of the behaviour in order to consider a response to reduce risk. In other words, the reason why something is happening is equally as important as understanding what is happening.

18.18. Whilst there were some good examples of professional curiosity within the review this area of practitioner skill was not maintained to a high enough standard. It appeared that overtime professional curiosity about the relationship began to fade as all options to prevent the relationship became exhausted. There became a working assumption amongst some professional that Matilda was in a situation of her own making as interventions to safeguard her stalled and Matilda was left to her own devises.

Management and review of offenders on bail

18.19. A number of complexities have been recognised in relation to managing Carsons criminal behaviour and domestic abuse / coercive control.

Public view point - Whilst reviewing this case the Independent Reviewer has appreciated the contribution made by Matilda's parents and a personal friend. It was revealing that one of the first thing they all said was that Carson *"should not have been allowed to walk the streets as a free man following the suspected deaths of his children."* The sentiment of Matilda's family and friends possibly represents the majority of the general public who would find it difficult to comprehend how someone suspected of such heinous child crimes could be allowed to continue to harass and abuse those around them.

Complexity of criminal investigation based on medical evidence - Whilst the family response is reasonable in the circumstances the reality of the complexity of the criminal investigation and the time it takes to harvest expert medical evidence which proves a murder has been committed beyond reasonable doubt is highly complex and bound by legal processes which can take months and years to conclude.

Legal safeguards and repeat offending - During the timeline Carson was on police bail and complied with weekly visits to the police station. However, his criminal activity continued and he was arrested on six occasions for crimes including suspected child murder, breaching his conditions of Police Bail and Non-Molestation Orders and a charge of Battery following an assault on his own teenage sibling which was later appealed against and squashed. It was Matilda's death that eventually brought together the criminal evidence for CPS to meet the charging threshold on all counts (including the deaths of the children) and to move forward for a positive charging decision and conviction.

Monitoring of murder suspects – Probation Officers working with suspected murders, even when monitoring is related to a separate crime should escalate warning signs when there are concerns about lack of empathy and personality disorder to ensure further assessment takes place. The reunification of the Probations Service has addressed this issue.

Information sharing/gathering and record keeping issues

18.20. Recording is an integral and important part of any professional's role when managing domestic abuse cases. Recording is vital because:

- It supports good care and support
- It is a legal requirement and part of staff's professional duty
- It promotes continuity of care and communication with other agencies
- It is a tool to help identify themes and challenges in a person's life
- It is key to accountability – to people who use services, to managers, to inspections and audits
- It is evidence – for court, complaints and investigations

18.21. There have been areas of record keeping which fell short of expected best practice which have been recognised and addressed by the agencies and the multiagency arrangement processes involved. It is recognised that information sharing is an essential part of safeguarding practice however, the burden of information gathering should not be left to the referring agency. The receiving service has an equal responsibility in requesting the correct information and for pursuing any gaps in the information they require as part of routine inquiry prior to making an assessment.

18.22. Adults have a general right to independence, choice and self-determination including control of their personal information. In the context safeguarding these rights can be overridden in certain circumstances. The law does not prevent the sharing of sensitive, personal information held within agencies where there are safeguarding concerns and the sharing of information is justified. Neither does the law prevent the share of such information where public interest outweighs the need to remain confidential. There should be local agreement and protocol in place which sets out the processes and principles for information sharing between agencies. All front-line staff within partner agencies should understand the potential risk of not sharing information.

18.23. Whilst it is seen as good practice to seek the views and wishes of victims the lesson here for all agencies providing helping services to victims of domestic abuse is that when considering coercive control cases, the views and wishes of victims should be balanced with any previous history of threats, blackmail and manipulation before decisions are made. **Remember victims may not always be able to help themselves.**

19. Recommendations:

The historical nature of this Domestic Homicide Review has been acknowledged and recognises that a number of service improvements have already been made to promote the safety of future victims of domestic abuse.

Recommendations to improve practice

1) All organisations within Pennine Lancashire Community Safety Partnership require relevant staff to be trained in the following topics:

- Aetiology of coercive control within domestic abuse relationships
- Trauma informed practice
- Professional curiosity
- Effective record keeping
- Information gathering and sharing
- Establishing lines of multiagency communication during a live investigation
- Role of IDVAs and how to support their work
- Eight-stage pattern by criminologist Dr Jane Monkton-Smith to promote understanding of the nature and behaviours of perpetrators of coercive control

2) Pennine Lancashire Community Safety Partnership should consider how Blackburn and Darwin MARRAC new arrangements could be implemented across the geographical area of the partnership.

3) Pennine Lancashire Community Safety Partnership should ensure that the lessons learned from this Domestic Homicide Review are shared across the partnership and any outstanding area for improvement identified in the agencies IMRs are addressed.

Recommendations for Home Office consideration

4) The Home Office should consider strengthening the legal system around serial perpetrators of coercive control to better protect victims.
Progress – Domestic Abuse -statutory guidance (July 2022) has clarified Coercive Control as a crime and supports the full range of multi-agency practices (statutory and non-statutory agencies) which is required to support victims. In addition, a civil protective order was introduced in the Domestic Abuse Act 2021 and piloted in a select number of Police force areas in 2024. These orders were introduced to improve the protection available to survivors of domestic abuse and be tougher on perpetrators.

20. Recommendations from Individual Management Reviews

- **Blackburn with Darwen Borough Council Children's Services**

A recommendation to highlight the need to have a strategy discussion in a timely manner where there is reason to believe a child is at risk of significant harm.
It is noted that: This is not just a role for Children Social Care to identify any potential need for a strategy discussion and can be requested by multi-agency partners through discussion with Children Social Care. Health multi-agency challenge is to be encouraged.
Progress since review period – Children Social Care have carried out significant work to improve the timing and attendance of the three statutory agencies at strategy discussions.
Should consider – working relationship with domestic abuse specialist services to ensure early engagement and information sharing.

- **Blackburn with Darwen Borough Council Adult Service**

No recommendations

- **Lancashire & South Cumbria Integrated Care Board (ICB**)

Both Carson and Matilda were registered with the same GP.
1) Review of quality of documentation within patient records following discussion at child safeguarding/MARAC meetings.
2) Review level of professional curiosity and safeguarding/criminal considerations when there are disclosures of domestic abuse.

- **East Lancashire Hospitals NHS Trust (ELHT)**

No recommendations
Progress since review period – Routine domestic abuse enquiries are asked at all maternity contacts.

- **Lancashire & South Cumbria NHS Foundation Trust (LSCFT)**

No recommendations identified

- **WISH Centre (Blackburn & Darwen District Without Abuse Ltd)**

1) Development of a memorandum of understanding to promote the sharing of information about victims being referred to the service from other agencies.
2) Raise awareness of the role of the IDVA and how and when to refer to the IDVA service.
3) Raise awareness of the manipulative nature of the coercive controlling perpetrators and the brain washing impact negative on victims.
4) Promote the use of practical and legislative interventions to support/protect victims and to modify/disrupt perpetrators abusive behaviours.

- **Springfield Domestic Abuse Support Services in South Lakeland**

1) Improve case management via a new case management system
2) Develop robust training packages on trauma, safeguarding and risk assessment
3) Establish monthly case work supervision
4) Record of user's voices throughout their journey with the service.
5) Review recruitment process
6) Use of this DHR in training
7) Review current policies and procedures and circulate to team members

- **Together Housing Association**

1) Centralisation of record keeping and move to new case management system
2) Review of victim assessment and support pathway
3) Improve the quality of record keeping
4) Introduce guidance and training on professional curiosity for all staff members
5) Promote the importance of information sharing and information gathering to improve multiagency working and risk reduction
6) Review of performance management and quality assurance systems and processes.
7) A change of culture and practices to ensure the service is fulfilling its fundamental purpose of being supported housing. Including supportive approach, outcome focused person-centred practice (and as above)

- **Lancashire Constabulary**

1) Information obtained during covert operations regarding vulnerable persons should be shared with a relevant SPOC within Local Authority. This could include discussions at a Strategic level with relevant domestic abuse services regarding risk levels of all persons.

2) During a major investigation where the responsibility for the safeguarding of an individual is passed to a team outside the Major Investigation Team, regular communication should take place between the SIO of the investigation and the safeguarding team regarding any developments. The meeting and discussions of the meetings should be recorded within the SIO log.
3) Lancashire Constabulary should ensure that Disengagement and Avoidance by victims and dealing with such matters is included as part of any DA training package and should form part of any safety plan.

- **Crown Prosecution Service**

Clearer instructions to the expert witness as to the evidential requirements needed to be considered as part of the investigation policy and strategies.

- **Probation Service & Community Rehabilitation Company -**Reunification - June 2021

The key areas for improvement have been identified and addressed as follows:
1) Initial decision making in respect of the initial allocation of Carson to CRC rather than NPS.
2) Case recording and management oversight
3) Difficulties in obtaining relevant safeguarding information from other agencies
4) Absence of liaison between Probation and IDVA service
5) Absence of home visit
6)Lack of information pertaining to the victim (Matilda) and their circumstances
7) Absence of delivery of structured offence related intervention
8) Concern over Court decision to discharge the existing Restraining Order which has been reported to His Majesty's Court & Tribunal Service (HMCTS) for their consideration. With a view to ensuring relevant agencies are notified in advance and have the opportunity to share relevant information to the presiding judge to assist with informed decision making

- **HMP Preston**

No recommendation required.

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PENNINE LANCASHIRE COMMUNITY SAFETY PARTNERSHIP

DOMESTIC HOMICIDE REVIEW

EXECUTIVE SUMMARY REPORT

"Matilda"

October 2019

Independent Chair and Author: Kathy Webster

Date: 14/03/2025

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1. Introduction

1.1. This Executive Summary Report is to outline the content of a Domestic Homicide Review (DHR) which has been conducted in respect "Matilda" who was murdered by her partner in October 2019. Any death of a young women/mother is a tragic loss and our deepest condolences and sympathy are extended to Matilda's family and friends.

2. The Review Process

2.1. The summary outlines the process undertaken by Pennine Lancashire Community Safety Partnership domestic homicide review panel in reviewing the homicide of "Matilda" (victim's pseudonym) who was a resident in the Blackburn and Darwen area.

Reason for the significant delay in the completion of this review.

2.2. There has been a significant delay in producing the DHR which was in part due to the joint decision made between Pennine Lancashire Community Safety Partnership and Blackburn with Darwen, Blackpool and Lancashire Children's Assurance Partnership (CSAP) in 2020, to complete a Child Safeguarding Children Review (CSPR) relating to the murder of Carson's two children and the attempted murder of a third child to be completed first.

2.3. The rational for this decision was to allow the CSPR to establish the circumstances of the children's death and to fully understand the nature of Carson's previous relationships prior to conducting the DHR. The CSPR was highly complex and was eventually published in November 2022.

2.4. A further delay was due to a request being made at the latter stage of the reviewing process for the Crown Prosecution Service (CPS) to further review their role in "Operation XX" (investigation into the suspected murder of Carson's children) with that of the Police in relation to any delay in bring criminal charges to Carson who murdered Matilda whilst on police bail.

Subjects of the review

2.5. Pseudonyms were used in the DHR to maintain the confidentiality of those involved.

- **The victim** – "Matilda", was White British aged 23 when she died
- **The perpetrator –** "Carson", described himself as White British and was aged 28 when he the domestic homicide took place.
- **Matilda's child**
- **Matilda's ex-partner**
- **Carson's ex-partner**

***Domestic Homicide Review (DHR) -** is a multi-agency review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by a person to whom he or she was related, or with whom he or she was or had been in an intimate personal relationship; or a member of the same household as himself or herself

***Community Safety Partnership –** has a role to focus on community safety and to bring local agencies together to deliver multiagency solutions to local problems by pooling resources and experience

***Children Assurance Partnership –** local multiagency arrangements committed to improving safeguarding knowledge, understanding and expertise across the wider children's workforce.

***Child Safeguarding Practice Review (CSPR)** – are statutory reviews which are undertaken when a child dies or has been seriously harmed and there is cause for concern as to the way agencies worked together.

***Operation XX** – Serious crime investigation into the deaths of Carson's two children in 2013

- **Carson's two children - subjects of Operation XX.**
- **Third child – subject of Operation XX – identity not revealed for legal reasons.**

Criminal proceedings

2.6. Carson was convicted of murdering Matilda by lethal poisoning in October 2021. At the same trial he was also convicted of the murders of two of his young children by smothering them and the attempted murder of another child. He was initially imprisoned for 40 years but this was later overturned by the Lord Chief Justice and his jail term extended to 48 years.

Decision and agencies involvement.

2.7. The circumstances of Matilda's death were reported to the Chair of Pennine Lancashire Community Safety Partnership in February 2021. It was agreed that the criteria under the Domestic Violence Crime and Victims Act 2004 for a domestic homicide review were met. The methodology of the review complies with national guidance described in *Multi-agency statutory guidance for the conduct of domestic homicide reviews (December 2016).*

2.8. Sixteen agencies were identified as having contact with Matilda from August 2017 when the relationship started up until her death in October 2019. The twelve agencies who had significant contact with Matilda, her family and with Carson were requested to provide Individual Management Review (IMR) reports to address the terms of reference. Four agencies with minimal contact were asked to share a summary review.

3. Contributors of the Review

3.1. The panel confirmed that authors of the IMR's had no prior knowledge or engagement with the subjects of the review to ensure their independence.

Agencies providing an IMR include:

- Blackburn with Darwen Borough Council Children's Services
- Blackburn with Darwen Borough Council Adult
- Lancashire & South Cumbria Integrated Care Board (ICB)
- East Lancashire Hospitals NHS Trust (ELHT)
- Lancashire & South Cumbria NHS Foundation Trust (LSCFT)
- WISH Centre (Blackburn & Darwen District Without Abuse Ltd)
- Domestic Abuse Support Services in South Lakeland
- Together Housing Association (THA)
- Lancashire Constabulary
- Crown Prosecution Service
- Probation Service.
- Lancashire and Cumbria – Community Rehabilitation Company (CRC)

***Independent Management Review (IMR)** - is a report detailing, analysing and reflecting on the actions, decisions, missed opportunities and areas of good practice within the individual organisation.

Agencies providing additional information

- HMP Preston
- Salvation Army
- Domestic Abuse Service in Chorley
- Victim Support

Parallel Reviews

3.2. There were four statutory reviews contributing to the DHR and include;

- Independent Office for Police Conduct (IOPC)
- Police Professionals Standards
- A Serious Further Offence Review
- Child Safeguarding Practice Review (CSPR) CSPR Child C, D & E - Children's Safeguarding Assurance Partnership (safeguardingpartnership.org.uk).

Contribution of family and friends

3.3. The panel was grateful for the assistance of a Victim Support Practitioner who provided relevant advice and information leaflets from Advocacy After Fatal Domestic Abuse (AAFDA) for the family and were a reliable source of support throughout the reviewing period.

3.4. Special thanks go to Matilda's parents (guardians) who gave their time to share their many fond memories of Matilda and provided their insights into the circumstances which led to their daughter's homicide. They were facilitated in considering the initial terms of reference of the review and contributed to the final report and recommendations.

3.5. The Panel was grateful for the assistance of HMP Wakefield who facilitated a virtual interview between the Independent Reviewer, Community Safety Manager for Blackburn and Darwen Borough Council and Carson. The Panel would also like to thank Carson for his attendance at the meeting and for sharing his recollections and reflections.

3.6. Significant others were approached by letter including Matilda's ex-partner, who is the birth father of Matilda's child and Carson's close family members were also invited to participate in the review process. There has been no response from these parties and their right not to participate in the DHR process has been respected.

4. The Review Panel Members

4.1. The Panel Chair confirmed that Panel Members had no prior involvement with the subjects of the review to ensure their independence. Panel member names have not been given. This is because there has been significant television coverage about this case prompting caution in naming individuals practicing locally

Membership of the review panel

JOB TITLE	ORGANISATION
Independent Chair and Report Author – Kathy Webster	Safeguarding Consultant

Community Protection Manager	Pennine Lancashire Community Safety Partnership
Head of Social Work & Specialist Services	Blackburn with Darwen Borough Council Children's Services
Service Lead – Specialist Services	Blackburn with Darwen Borough Council Adult Services
Deputy Designated Nurse for safeguarding and children in care.	Lancashire & South Cumbria Integrated Care Board
Adult Safeguarding Team Nurse	East Lancashire Hospitals NHS Trust
Named Nurse for Safeguarding	Lancashire & South Cumbria NHS Foundation Trust
Chief Executive Officer	Blackburn & Darwen District Without Abuse Ltd (WISH)
Chief Executive Officer	Springfield Domestic Abuse Support Services
Assistant Director of Supported Housing and Neighbourhood Safety	Together Housing Association
Safeguarding Manager	Together Housing Association
Lead Review Officer	Lancashire Constabulary
Deputy Chief Crown Prosecutor	Crown Prosecution Service
Senior Probation Officer	Probation Service

4.2. The first panel meeting took place in September 2022 and there were three further panel meetings to receive and consider the IMRs prior to writing of the report. There were a further nine panel meetings to agree the final DHR and discuss Home Office evaluation. The number of meetings were influenced by the vast amount of information available causing several meetings overrun necessitating additional meetings.

5. Author of the Overview Report (Kathy Webster)

5.1. Kathy Webster has not had any involvement with Pennine Lancashire Community Safety Partnership and has not had any prior dealings with the subjects of this review, or any of the family members, or professionals involved, or provided any professional advice on this case at any time.

5.2. Kathy has past career history of over forty years working in midwifery and children nursing working with families in a variety of settings in the NHS. The final eighteen years in

the NHS was working in specialist safeguarding roles including Designated Nurse for Safeguarding. Kathy has a number of nursing and midwifery qualifications and holds BMedSci in Clinical Nursing (child) and MSc in Healthcare Education (safeguarding) and has participated in the AAFDA course on Domestic Homicide Reviews.

5.3. Kathy has completed a number of published Serious Case Reviews/Child Safeguarding Practice Reviews, Serious Adult Reviews and has been involved in a number of DHRs. Kathy completed three Serious Case Reviews within Lancashire between 2019 and 2020 and was the author of the Child Safeguarding Practice Review published in 2022 which relates to the children murdered by Carson who is the perpetrator in this DHR.

6. Terms of Reference for the Review

1. To establish the circumstances surrounding the homicide
2. To establish whether there are any lessons to be learned from the case about the way in which professionals and organisations work together and carried out their duties and responsibilities and to identify areas of good practice.
3. To identify clearly what those lessons are, how they will be acted upon and what is expected to change as a result.
4. To establish whether the concerns and responses by professionals and their organisations were appropriate both historically and, at the time, leading up to the homicide.
5. To establish whether organisations have appropriate policy and procedures to respond to the circumstances identified in this case and to recommend any changes as a result of the review process, with the aim of better safeguarding victims and their families.
6. All enquiries was restricted to a period of no more than 2 years prior to the date of the domestic homicide and until the review has concluded. Historical information or convictions of domestic abuse, outside of this timeframe was included to provide context.
7. To provide details of additional records concerning domestic violence and medical Issues including mental health or physical injury or disability that may have a relevant impact on the review.
8. To consider any cultural or environmental issues which may have contributed to barriers faced by the victim in accessing protection and examine why any targeted interventions were not effective.

7. Summary Chronology

7.1. The catalyst for the DHR was that Matilda was deliberately given a lethal amount of controlled medication over a number of days by her partner Carson, following which he tried to cover up the murder by making the death look like a suicide.

Historical background information.

7.2. **Matilda -** was known to have previously been a Looked After Child from the age of seven following serious child abuse within her birth family where she remained until

adulthood and later changed her surname to theirs as a token of her love for the family.

7.3. The level of trauma resulting from Adverse Childhood Experiences (ACEs) seemingly impacted on Matilda's ability to make good decisions and relationships in her adult life and increased her vulnerability when trying to cope with difficult situations and stressors.

7.4. **Carson -** lived with his birth family and at the age of 12 years he was known to be smoking, drinking alcohol and had his first police warning for criminal damage.

7.5. There had been an Education and Health Care Plan (EHCP) to support Carson's behaviour in school and during his older adolescence (aged eighteen) he visited his GP with anger management issues involving a non-fatal strangulation incident with his girlfriend. He was arrested later that year (2009) for a domestic abuse incident with the same girlfriend who remained in the relationship for several more years and is the ex-partner of Carson considered as part of the review.

7.6. It was of note that during police investigation it was found that Carson's ex-partner gave an historical account that Carson was extremely controlling (Coercive Control) throughout their relationship and he had debt problems due to gambling.

7.7. During Carson's adult life he was said to be employed on construction sites and at some point, he was said to have set up his own construction company with several building sites involved although his lifestyle did not support this view.

Background to the relationship

7.8. When Matilda met Carson in the Public House where she worked, he had recently split from his ex-partner and Matilda was making plans to move out with her baby away from her partner who was the birth father of the child.

7.9. The encounter took place shortly before a Family Court Hearing in May 2017 which found that Carson had been responsible for the deliberate harm (non-fatal smoothing) of a child known to him. The Judge at the time described Carson as a "dangerous man" and requested a Police investigation into the deaths of Carson's children who had died in 2013 with a similar pattern circumstance. A serious crime investigation ensued under "Operation XX" with Carson being assessed by the Senior Investigative Officer as being a serious risk to children.

7.10. When Matilda began to live independently with her five-month-old child, it became known to Police and Children Social Care that Carson was seeing Matilda and visiting the home. This raised serious concern for the safety of the child and following Children's Social Care assessment, the child was eventually placed under an Interim Care Order to live with the birth father due to Matilda continuing a relationship with Carson.

***Looked After Children (LAC)** – is a child in the care of the Local Authority by reason of a care order.

***Adverse Childhood Experiences (ACE)** – are negative events occurring in childhood likely to cause trauma

***Education and Health Care Plan (EHCP)** – is a multiagency plan for children and young people who need more support than is routinely available through special educational needs support.

***Coercive Control –** is a pattern of behaviour that enables someone to exert power over another person through fear and control.

***Operation XX** – Police code name for the Serious Crime Investigation into the deaths of Carson's two children in 2013

Summary of Domestic Abuse in the relationship

7.11. Throughout the relationship Carson was under Police investigation by the Major Investigation Team under Operation XX. Carson remained on police bail conditions not to have contact with any witnesses for the case and not to have contact with children under 16 years. He was also ordered to report to Blackburn Police Station twice weekly and it appears that he did so. Police considered Carson to be a risk to children and vulnerable adults and was placed at "medium risk".

7.12. The risk to Matilda was initially viewed as being "low" because she was seen as a young woman wanting to maintain a relationship with Carson. However, as time progressed the level of risk increased to "medium".

7.13. Eight months into the relationship and following a termination of pregnancy, Matilda disclosed (April 2018) to the Independent Domestic Abuse Advisor (IDVA) that she was afraid of Carson who had been threatening to harm her if she tried to leave him and would set fire to the home of her child and ex-partner. This was reported to the Police who took a statement and the case was referred to Multiagency Risk Assessment Conference (MARAC). During this time the IDVA supported Matilda in moving to a Women's Refuge and assisted in successfully applying for a Non-Molestation Order at the family court.

7.14. Coincidentally, on the same day that Matilda made her Police Statement, Carson was arrested for the suspected murder of two of his children which dated back to 2013.

7.15. It was known that Carson continued to harass his ex-partner and manipulated a number of meetings with her which she had regretted and reported to her key worker.

7.16. Matilda was evicted from the first Refuge following disclosing her address to Carson resulting in Matilda being moved back home before a place at a second Refuge was found. Matilda was assessed as at serious risk (high risk) from Carson and a safety plan was agreed. Matilda disclosed that she was in fear of Carson, who had been manipulative and controlling and he understood when she was at her most vulnerable and would prey upon that.

7.17. Police and the Social Worker involved with Matilda and her child remained in touch with Matilda to check on her safety. A feature of this professional relationship was that Matilda denied contact with Carson which was known to be untrue and eventually led to the view that Matilda was untrustworthy.

7.18. A second MARAC meeting took place in early August 2018 following a referral from the police around a number of threats made against Matilda's child, the child's birth father and Carson's ex-partner who had been subjected to stalking by Carson. It was confirmed that Carson was a high-risk perpetrator of domestic abuse and there was a non-molestation order in place to protect Matilda until May 2019.

***Interim Care Order** - is a short-term court order which means that a child becomes looked after in the care system.
***Independent Domestic Abuse Advisor (IDVA)** – has a specialist role to support victims of all forms of domestic abuse
***Non-Molestation Order**- is a type of injunction which can be sought by a victim of domestic abuse against their abuser.
***Multiagency Risk Assessment Conference (MARAC**) – is a meeting where agencies share information and develop safety plans for high-risk victims of domestic abuse

7.19. The MARAC clarified that Matilda was still seeing Carson but had admitted that she was fearful of him and he was using controlling and manipulative behaviours towards her.

7.20. During the timeline Carson was arrested on six occasions for offences which included the suspected murders of his children in 2013, breach of the Non-Molestation Order for Matilda, assault on his teenager sibling and failing to attend court for sentencing. In addition, he was charged with possessing a knife on two occasions. On all occasions he took the opportunity to frustrate his arrests by actively manipulating the situation. For example, he claimed to have mental health issues, took an overdose as police broke in to arrest him, threatened to jump off a multi-storey car park and threatened to cut his own throat.

7.21. It was additionally alleged that Carson was involved in criminal behaviour around financial fraud involving a number of business people which the police had started to investigate separately. He claimed to have his own Construction Company which was highly implausible given his personal circumstances.

7.22. Matilda had a further pregnancy in 2019 which also resulted in termination. Matilda admitted to professionals that she *"did not want a child connected with Carson"* and had told Carson that she had a miscarriage because she had been afraid of his reaction.

7.23. Following eviction from the second refuge, Matilda eventually moved into a flat at Together Housing Association (THA) supported housing scheme where staff tried to support her. After the initial period Matilda spent a great deal of time away from her THA residence and staff struggled to engage with Matilda and felt she was probably spending time with Carson. Protection for Matilda continued to be managed by the Police in the child protection team/public protection team and specialist domestic abuse services.

7.24. A third MARAC, was initiated by the Police, in response to a domestic abuse assault on Carson's teenage sibling over money at the family home. A Restraining Order was issued in respect of both Matilda and Carson's teenage sibling in respect of the assault, breach of the Non-Molestation Order and breach of a Suspended Sentence Order (SSO). However, when Carson successfully won his appeal over his twelve-week prison sentence, the Restraining Order was lifted with the support of Matilda who had been in court at the time and promoted her view that she did not need protection from Carson. By this point the Non-Molestation Order had expired.

7.25. On the day Carson was released from prison, he was assessed as posing a "medium risk" of serious harm and attended his first appointment with a designated Probation Officer at the Criminal Rehabilitation Company (CRC) (now reunified with the Probation Service).

7.26. Overtime, the Probation Officer recorded that they were of the view that Carson was disingenuous and implausible. Carson was also found to be arrogant and had blamed Matilda for keeping the Non-Molestation Order in place with Carson being appropriately challenged for these views.

***Restraining Order -** is an order used by a court to protect a person in a situation involving alleged domestic violence, child abuse, assault, harassment, stalking, or sexual assault

***Suspended Sentencing Order (SSO**) - is a sentence on conviction for a criminal offence, the serving of which the court orders to be deferred in order to allow the defendant to perform a period of probation.

7.27. The Probation Officer was contacted by Carson's Mental Health Practitioner who reported concerns about Carson's lack of empathy and the likelihood that Carson had a Personality Disorder. None of the concerns identified were seemingly escalated to the Senior Probation Officer or referred to MARAC.

7.28. Ten weeks after the lifting of the Restraining Order Matilda was lethally poisoned by Carson using illegally obtained prescription drugs. On the days leading up to her death, Matilda had made reports to friends and family that she was feeling unwell. Carson was on Police Bail Conditions at the time not to have contact with Matilda when she died.

8. Key Issues Arising from the Review

8.1. There were a number of overarching issues highlighted in this review for future learning. Owing to the historical nature of the review many of the themes identified have already been addressed in line with good practice.

Nature of coercive control

8.2. Coercive controlling behaviour became a crime with the Serious Crime Act 2015. More recently in April 2023 section 68 of the Domestic Abuse Act 2021 widened the offence to include partners, ex-partners and family members. Coercive controlling behaviour is used by the perpetrator to make a person dependent by isolating them from support, exploiting them, depriving them of independence and regulating their everyday behaviour. This can be seen as a form of "grooming" or "brain washing" it is often be relentless, emotionally draining and psychologically damaging resulting in an increased incidence of suicides and mental health issues.

8.3. Perpetrators of coercive control often have personality traits akin with narcissistic personality disorder (NPD) which is characterised by a pattern of grandiosity, need for admiration, exploitation of others and lack of empathy (Degges-White.S.2021). This can make any professional relationship difficult to manage as those with NPD do not respect the greater knowledge and experience of others. Psychological Assessment may be required in relevant cases to fully understand the nature and extent of the risk posed by a perpetrator.

8.4. Research (2017) by Criminology expert Dr Jane Monckton Smith found an eight-stage pattern in 372 killings in the UK. The University of Gloucestershire lecturer said controlling behaviour could be a key indicator of someone's potential to kill their partner.

The eight-stage pattern in Dr Monckton Smiths study showed:

1) A pre-relationship history of stalking or abuse by the perpetrator
2) The romance developing quickly into a serious relationship
3) The relationship becoming dominated by coercive control
4) A trigger to threaten the perpetrator's control - for example, the relationship ends or the perpetrator gets into financial difficulty
5) Escalation - an increase in the intensity or frequency of the partner's control tactics, such as by stalking or threatening suicide
6) The perpetrator has a change in thinking - choosing to move on, either through revenge or by homicide

7) Planning - the perpetrator might buy weapons or seek opportunities to get the victim alone
8) Homicide - the perpetrator kills his or her partner, and possibly hurts others such as the victim's children

Recognising and assessing vulnerability in victims of domestic abuse.

8.5. **Early assessment of vulnerability -** Early assessment, information gathering and information sharing has a key role to play in recognising relevant ACEs and providing opportunity to understand and gain the trust of a victim through trauma informed practice principles
8.6. **Understanding ACEs -**There are several factors which can make an adult vulnerable including, mental health issues, drugs and alcohol, learning difficulties and the impact of past childhood adversity. It is recognised that Adverse Childhood Experience (ACEs) can create harmful levels of stress which impact on the brain's development and can result in long-term effects on learning, behaviour and health. ACEs are relevant because they can impact on day to day decision making and relationship choices. ACE assessment is not routinely used in practice and therefore the opportunity to fully understand an adult's cognitive skills and perspective is missed.
8.7. **Service fatigue -** It is possible in protracted cases of domestic abuse that practitioners can become frustrated with a situation as the strategies used to disrupt a relationship become exhausted and fail to change the situation resulting in the practitioners downgrading and adjusting contact with victims accordingly.
8.8. **Golden opportunity** - There is a "golden opportunity" to intensify working, understanding and future planning with the victim rather than viewing this as an opportunity to withdraw because the victim is safe. Work with vulnerable victims at this point has the potential to yield positive outcomes because the victim may feel safe to speak out and has space to reflect on their present and future life.

Trauma informed practice

8.9. Trauma-informed practice is grounded in the understanding that trauma exposure can impact on an individual's neurological, biological, psychological and social development. It aims to develop professional relations which can promote mutual trust, feeling of safety which can reduce the sense of isolation It also, seeks to address the barriers that people affected by trauma can experience when accessing helping services. (Working definition of trauma-informed practice. Gov UK. Nov 22)

8.10. Trauma informed practice is key to working face to face with vulnerable victims of domestic abuse. Practitioners such as IDVAs have an important role to play in helping victims to feel there is someone available they can trust and who will not judge them outside of the statutory agencies (police, health and social care). Victims need someone to narrate their side of the story with and to advocate for them in times of need. Additionally, IDVAs have an important role in containing the victim's thoughts and feelings through regular contact and by submitting an alternative narrative to that of the perpetrator.

Disengagement and avoidance

8.11. It is recognised that victims of domestic abuse who are or have been in abusive relationship can become isolated, have their self-esteem eroded and can begin to blame themselves, or deny or cannot recognise that abuse is happening to them. Fear, anger, guilt, shame, resentment, and sense of powerlessness are all emotions commonly described by victims.

8.12. Disengagement and avoidance of professionals is not uncommon behaviour by victims who may find themselves using avoidance coping instead of facing stress. This can be learnt behaviour when growing up trying to avoid stressful situations which becomes a habit in adult life. Other reasons why people disengage or become avoidant is because they are trying to hide something to avoid unwanted consequences. Understanding this behaviour is essential because these are warning signs that a victim is under most stress when at greatest risk.

8.13. Finding out the motivation for the behaviour at the time is difficult but it is an important part of safety planning. However, what often happens is that professionals become fatigued with helping a victim and begin to view disengagement and avoidance as the victim rejecting help and wanting to be in the abusive relationship which can sometimes lead to unhelpful rhetoric such as "she wants to be in the relationship", "she's a liar", "she's that sort", "she deserves what she gets".

8.14. It is important to remember that victims who lie do so for a reason but this does not mean that the victim lies about everything and should not be seen as a reason to stop trying to support them**.**

8.15. Careful planning for disengagement and avoidance should be part of the overall safety plan to help professionals to maintain resilience and to focus on increased action at these points rather than allowing safety plans to fizzle out.

The role of MARAC in protecting victims

8.16. Multi-Agency Risk Assessment Conference (MARAC) is a meeting where information is shared on the "high risk" domestic abuse cases between representatives of local police, probation, health, child and adult protection, housing, IDVA's and other specialists and relevant voluntary sector. "High risk" domestic abuse is defined by the Home Office as serious harm *"which is life threatening and/or traumatic, and from which recovery whether physical or psychological can be expected to be difficult or impossible".*

8.17. In this case, the victim was referred to MARAC on three occasions but arrangements were not sufficiently robust to protect her. New arrangements have replaced MARAC in Blackburn and Darwen which are now covered by the new Multi-Agency Risk Reduction, Assessment and Co-ordination (MARRAC) process. The focus of MARRAC has been expanded to ensure harm to victims is reduced, reduce risk by perpetrators and safeguard children and other members of the public who may be impacted. MARRAC is underpinned by Value and Enabling steps which a) gather and analyse information; b) analyse and understand risk; c) identify solutions for victim, perpetrator, children and others; d) review cases for outcome.

Working together

8.18. Domestic abuse arrangements need to ensure that individual services working with the victim and perpetrator avoid working in silos to maximise the effectiveness of safeguarding plans. Since this case partnership working has been expanded to include IDVAs joining the Police on domestic abuse visits which may help to bring a victim perspective to the joint assessment and promote a further level of advocacy on behalf of victims.

Professional curiosity

8.19. Professional curiosity is the capacity and communication skill to explore what is going on in the life of a person rather than taking what they say at face value. When faced with uncertainty it is key that professionals remain sceptical (respectful uncertainty) whilst applying critical evaluation to any information they receive, keeping an open mind and considering how they can verify the information provided. Much has been written about the importance of professional curiosity during encounters with victims of domestic abuse and the need to maintain close relationships of the kind where the professional is able to see, hear and touch the truth of their lived experiences of the victim.

8.20. Practitioners working with domestic abuse and coercive control may be impacted by the victim's ability to make decision and judgements freely, unfretted by fear, coercion, manipulation and undue influence. It is unwise to assume that a victim is free to make their own unwise decisions, requiring practitioners to explore the context, motivation and impact of the behaviour in order to consider a response to reduce risk. In other words, the reason **why** something is happening is equally as important as understanding **what** is happening.

Management and review of offenders on bail

8.21. **Public view point -** Whilst reviewing this case the Independent Reviewer has appreciated the contribution made by Matilda's parents and a personal friend. It was revealing that one of the first thing they all said was that Carson *"should not have been allowed to walk the streets as a free man following the suspected deaths of his children".* The sentiment of Matilda's family and friends possibly represents the majority of the general public who would find it difficult to comprehend how someone suspected of such heinous child crimes could be allowed to continue to harass and abuse those around them.

8.22. **Complexity of criminal investigation based on medical evidence** - Whilst the family response is reasonable in the circumstances the reality of the complexity of the criminal investigation and the time it takes to harvest expert medical evidence which proves a murder has been committed beyond reasonable doubt is highly complex and bound by legal processes which can take months and years to conclude.

8.23. **Legal safeguards and repeat offending** - During the timeline Carson was on police bail and complied with weekly visits to the police station. However, his criminal activity continued and he was arrested on six occasions for crimes including suspected child murder, breaching his conditions of Police Bail and Non-Molestation Orders and a charge of Battery following an assault on his own teenage sibling which was later appealed against and squashed. It was Matilda's death that eventually brought together the criminal evidence for

CPS to meet the charging threshold on all counts (including the deaths of the children) and to move forward for a positive charging decision and conviction.

8.24**. Monitoring of murder suspects** – Probation Officers working with suspected murders, even when monitoring is related to a separate crime should escalate warning signs when there are concerns about lack of empathy and personality disorder to ensure further assessment takes place. The reunification of the Probations Service have addressed this issue.

Information sharing/gathering and record keeping issues

8.25. Recording is an integral and important part of any professional's role when managing domestic abuse cases. There were areas of when record keeping fell short of expected best practice which have been recognised and addressed by the agencies and the multiagency arrangement processes involved. It is recognised that information sharing is an essential part of safeguarding practice however, the burden of information gathering should not be left to the referring agency alone. The receiving service has an equal responsibility in requesting the correct information and for pursuing any gaps in the information they require as part of routine inquiry prior to making an assessment.

8.26. It is the case that adults have a general right to independence, choice and self-determination including control of their personal information. In the context safeguarding these rights can be overridden in certain circumstances. The law does not prevent the sharing of sensitive, personal information held within agencies where there are safeguarding concerns and the sharing of information is justified. Neither does the law prevent the share of such information where public interest outweighs the need to remain confidential.

9. Conclusion

9.1. The circumstances of Matilda's homicide were tragic and unique in that it was a premeditated, cruel, prolonged act by a vengeful partner who tried to cover their tracks by making the death look like a suicide.

9.2. The turbulent and coercive controlling nature of Matilda's relationship with Carson appears to be the trigger for her death by deliberate lethal poisoning which had been administrated over a number of days. At the time of her death Carson had been under suspicion of murdering two of his children and for attempting to murder a third child by deliberate suffocation. It was alleged that these serious criminal acts had been motivated by the breakdown of a relationship and his determination to prevent any partner from leaving him.

9.3. The findings of the DHR acknowledges that initially Matilda had several agencies and practitioners working with her to break free from the grip of coercive control. The highly complex nature of the relationship and the different strands of criminality which stemmed from Carson along with his attempts of manipulation in every situation must have been exhausting for all involved.

9.4. It also highlights the danger of coercive control and the need to improve the management of repeat offenders. In particular the need to strengthen multiagency systems such as MARAC (which has now taken place) to identify and monitor serial perpetrators of domestic abuse and to strengthen the role of the IDVA who are often the practitioner working in partnership with the victim and are in the best position to advocate for them.

9.5. A further complexity of coercive control illuminated by the DHR is that there is no quick fix to resolving these abusive relationships. Perpetrators of coercive control do not play to the same rules as everyone else as Carson displayed throughout the DHR. Carson had Pre-Bail Conditions, Non-Molestation Order and Restraining Order to legally obligate him not to have any contact with Matilda none of which appeared to work.

9.6. It would therefore, not be surprising if professionals had felt disenfranchised from the situation and instead of seeing Matilda's fear and hostage situation from extreme coercive control had started to label Matilda as being a liar and blamed her for wanting a relationship with Carson. The reality from Matilda's perspective is not known but it is likely that Matilda may have become jaded and helpless within the situation after months of agency involvement and with no clear positive end result in sight.

10. Lessons to be Learned

10.1. Summary of recommendations and progress made by the individual agencies involved.

- **Blackburn with Darwen Borough Council Children's Services**

A recommendation to highlight the need to have a strategy discussion in a timely manner where there is reason to believe a child is at risk of significant harm.
It is noted that it is not just a role for Children Social Care to identify any potential need for a strategy discussion and can be requested by multi-agency partners through discussion with Children Social Care. Health multi-agency challenge is to be encouraged.
***Progress -** Since 2017, it has been recognised that the key learning areas have been addressed within Children Social Care and multiagency child protection arrangements have improved. There is a new "front door" service known as Children Advice and Duty Service (CADS) for safeguarding services which promotes greater access to qualified social workers and increased management oversight. Further work has been carried out to ensure that Police, Health and Children Social Care attend all strategy discussions with a new escalation process to manage difference of opinion.
***Should consider –** working relationship with domestic abuse specialist services to ensure early engagement and information sharing.

- **Blackburn with Darwen Borough Council Adult Service**

No recommendations

- **Lancashire & South Cumbria Integrated Care Board (ICB**)

Both Carson and Matilda were registered with the same GP.
1) Review of quality of documentation within patient records following discussion at child safeguarding/MARAC meetings.
2) Review level of professional curiosity and safeguarding/criminal considerations when there are disclosures of domestic abuse.

- **East Lancashire Hospitals NHS Trust (ELHT)**

No recommendations
***Progress since review period –** Routine domestic abuse enquiries are asked at all maternity contacts.

- **Lancashire & South Cumbria NHS Foundation Trust (LSCFT)**

No recommendations identified

- **WISH Centre (Blackburn & Darwen District Without Abuse Ltd)**

1) Development of a memorandum of understanding to promote the sharing of information about victims being referred to the service from other agencies.
2) Raise awareness of the role of the IDVA and how and when to refer to the IDVA service.
3) Raise awareness of the manipulative nature of the coercive controlling perpetrators and the brain washing impact negative on victims.
4) Promote the use of practical and legislative interventions to support/protect victims and to modify/disrupt perpetrators abusive behaviours.
***Progress -** Since this case there has been a review of the WISH service in relation to its risk assessment processes. It found that when a referral was made to the service background information was very limited and inadequate in terms of making safe decisions on behalf of victims. WISH have established a new system in line with SafeLives guidance to improve information gathering around family history, support networks and barriers to making safe choices. This will promote understanding of a victim's personal skills and emotional ability to break free from abuse. WISH have since recognised that counselling would have been helpful for Matilda in terms of understanding her own thoughts and feelings.

- **Springfield Domestic Abuse Support Services in South Lakeland**

1) Improve case management via a new case management system
2) Develop robust training packages on trauma, safeguarding and risk assessment
3) Establish monthly case work supervision
4) Record of user's voices throughout their journey with the service.
5) Review recruitment process
6) Use of this DHR in training
7) Review current policies and procedures and circulate to team members

- **Together Housing Association**

1) Centralisation of record keeping and move to new case management system
2) Review of victim assessment and support pathway
3) Improve the quality of record keeping
4) Introduce guidance and training on professional curiosity for all staff members
5) Promote the importance of information sharing and information gathering to improve multiagency working and risk reduction
6) Review of performance management and quality assurance systems and processes.
7) A change of culture and practices to ensure the service is fulfilling its fundamental purpose of being supported housing. Including supportive approach, outcome focused person-centred practice.
***Progress:** Together Housing conducted an early (pre-DHR) comprehensive internal review of its services in respect of Matilda's tenancy which was conducted using the principles of an IMR. This has enabled prompt implementation of key changes including: restructure of the

team to strengthen the management of the service, a move away from key working to address silo-working, internal case management support from managers and inhouse safeguarding team, refresher training on safeguarding and domestic abuse, improvements to the quality of the support through embedding a trauma-informed approach, improved record-keeping and working as part of the multi-agency framework.

- **Lancashire Constabulary**

1) Information obtained during covert operations regarding vulnerable persons should be shared with a relevant SPOC within Local Authority. This could include discussions at a Strategic level with relevant domestic abuse services regarding risk levels of all persons.
2) During a major investigation where the responsibility for the safeguarding of an individual is passed to a team outside the Major Investigation Team, regular communication should take place between the SIO of the investigation and the safeguarding team regarding any developments. The meeting and discussions of the meetings should be recorded within the SIO log.
3) Lancashire Constabulary should ensure that Disengagement and Avoidance by victims and dealing with such matters is included as part of any DA training package and should form part of any safety plan.

- **Crown Prosecution Service**

Clearer instructions to the expert witness as to the evidential requirements needed to be considered as part of the investigation policy and strategies.

- **Probation Service & Community Rehabilitation Company -**Reunification - June 2021

The key areas for improvement have been identified and addressed as follows:
1) Initial decision making in respect of the initial allocation of Carson to CRC rather than NPS.
2) Case recording and management oversight
3) Difficulties in obtaining relevant safeguarding information from other agencies
4) Absence of liaison between Probation and IDVA service
5) Absence of home visit
6)Lack of information pertaining to the victim (Matilda) and their circumstances
7) Absence of delivery of structured offence related intervention
8) Concern over Court decision to discharge the existing Restraining Order which has been reported to His Majesty's Court & Tribunal Service (HMCTS) for their consideration. With a view to ensuring relevant agencies are notified in advance and have the opportunity to share relevant information to the presiding judge to assist with informed decision making

- **Pennine Lancashire Community Safety Partnership**

***Progress –** Blackburn with Darwen MARAC (does not cover other surrounding areas in Lancashire) have undertaken a Police led review of the effectiveness of its arrangements and processes. Since January 2022 Blackburn and Darwen initiated new MARRAC arrangements as already highlighted (page18).

11. Recommendations from the Reviewer.

The historical nature of this Domestic Homicide Review has been acknowledged and recognises that a number of service improvements have already been made to promote the safety of future victims of domestic abuse.

Recommendations to improve practice

1) All organisations within Pennine Lancashire Community Safety Partnership providing services concerned with safeguarding victims of domestic abuse should promote training and development for relevant staff covering the following topics:

- Aetiology of coercive control within domestic abuse relationships
- Trauma informed practice
- Professionals curiosity
- Effective record keeping
- Information gathering and sharing
- Establishing lines of multiagency communication during a live investigation
- Role of IDVAs and how to support their work
- Eight-stage pattern by criminologist Dr Jane Monkton-Smith to promote understanding of the nature and behaviours of perpetrators of coercive control

2) Pennine Lancashire Community Safety Partnership should consider how Blackburn and Darwin MARRAC new arrangements could be implemented across the geographical area of the partnership.

3) Pennine Lancashire Community Safety Partnership should ensure that the lessons learned from this Domestic Homicide Review are shared across the partnership and any outstanding area for improvement identified in the agencies IMRs are addressed.

Recommendations for Home Office consideration

4) The Home Office should consider strengthening the legal system around serial perpetrators of coercive control to better protect victims.
Progress – Domestic Abuse - statutory guidance (July 2022) has clarified Coercive Control as a crime and supports the full range of multi-agency practices (statutory and non-statutory agencies) which is required to support victims. In addition, a civil protective order was introduced in the Domestic Abuse Act 2021 and piloted in a select number of Police force areas in 2024. These orders were introduced to improve the protection available to survivors of domestic abuse and be tougher on perpetrators.

Appendix B: Multi-agency action plan

Title of DHR	BwDDHR8	To be actioned	
Plan	Multi-agency Action Plan	Ongoing	
Independent author	Kathy Webster	Complete	
Governance arrangements	The Pennine Community Safety Partnership provides the governance arrangements for Domestic Homicide Reviews across the Pennine area. The board will oversee and ensure effective implementation of the recommendations within an appropriate timeframe.		

Recommendations	Lead Agency	Key Actions / Intended Outcomes	Evidence	Key Outcomes Achieved	RAG	Target Date/ Completion Date	Progress/ Completed
A recommendation to highlight the need to have a strategy discussion in a timely manner where there is reason to believe a child is at risk of significant harm. It is noted that: This is not just a role for Children Social Care to identify any potential need for a strategy discussion and can be requested by multi-agency partners	BwD Children's Services	- Improve attendance of statutory agencies at strategy discussions - Working relationship with domestic abuse specialist services to ensure early engagement and information sharing.	Strategy Meeting: Timeliness, critical analysis of threshold application and quorate attendance at strategy meeting has been an area of focus for practice improvement over the last 24 months. Recent data and QA shows improvement and a spot light report- completed by partners is coming to the Safeguarding effectiveness Group on 16th May 2024- this will be the evidence that this has improved and detail on further work to take place Working with WISH: Childrens services have led the multi-agency guidance on	All children will receive a timely and multi-agency response to understanding their lives experience and application of the significant harm threshold.		*June 2024*	Completed - Progress has been made in this area with better representation within strategy discussions and evidence of DA tools being used in practice.

through discussion with Children Social Care. Health multi-agency challenge is to be encouraged.			DA, incorporating WISH support- awaiting sign off and follow through re impact by the DA board. Bimonthly meetings between service leads and WISH take place to review referrals and impact. WISH are part of the DA triage at the front door (CADS) WISH are working with children re reviewing quality and consistency of DA practice (practice learning day and IDVA role)	Consistent approach to identifying and responding to DA CSC and WISH have worked together for the last 6 months to strengthen practice and have implemented a workplan that has been reviewed on a monthly basis. This led to bespoke training being delivered to CSC based on audit findings.			
Recommendations for GP practices. - Review of quality of documentation within patient records following discussion at child safeguarding/MARAC meetings.	Lancashire & South Cumbria Integrated Care Board (ICB)	Details of discussions at the practice safeguarding meeting and agreed actions to be documented within patient records. Process for sharing information and documenting actions from MARRAC meetings to be explored. Learning identified from historic consultation in 2009, it has been recognised in the DHR report that there have been significant developments in practice since then. Primary care Domestic abuse policy in use at	Assurance received that this action has been completed and that details of discussions and actions from the practice internal safeguarding meeting are documented within patient records. Process explored at GP practice visit Jan 23. Process is robust, no concerns identified.	Discussions that have taken place and any actions are clear within the patient record. Robust process in place for		Reviewed 12th June 2024	Complete

- Review level of professional curiosity and safeguarding/criminal considerations when there are disclosures of domestic abuse.		the specific GP surgery and available to all primary care across Lancashire and South Cumbria ICS, identifies actions to be taken upon disclosures of domestic abuse. Prompt resource shared with Gp practices to aid enquiry of domestic abuse Electronic record Domestic abuse template available to all primary care across Lancashire and South Cumbria ICS to assist the identification of domestic abuse. Non-fatal strangulation training provided via the children's safeguarding partnerships across multi agency partners including primary care/health. (still ongoing). Non-fatal strangulation 7mb developed and distributed across agencies	Pan Lancs GP DA Sample Policy.pdf Health Professionals ASK flyer (002).png Routine%20Enquiry%20Template%20on% Final%20NFS%20CSAP%20May%2024.pp 7MB_NFS_2023.pdf	sharing and receiving information re: MARRAC. Primary care staff are able to identify and respond appropriately to Domestic abuse. Primary care staff have resources available to aid the identification and response to domestic abuse. Raise awareness regarding non-fatal strangulation			
1) Development of a memorandum of understanding to promote the sharing of information about victims being referred to the service from other agencies.	**The Wish Centre**	The MOU for MASH covers the information sharing agreement for all agencies regarding safeguarding.	BwD MASH ISA Draft v0.1 Jan 2025.docx	The MASH receives the referral and will share information with relevant agencies.		January 2025	Complete

2) Raise awareness of the role of the IDVA and how and when to refer to the IDVA service.		*Training is being delivered to frontline practitioners in BWD and the role of the IDVA is covered in the training.* *Training is also being delivered to practitioners Pan Lancashire again the role of the IDVA is covered in the training.* *Agencies attending training include the statutory sector, VCFSE sector and the private / business sector.* *IDVA's are present at Marac / Mappa meetings to give information and offer advice on cases. IDVAs are also attending family hubs on a rota basis to ensure they are accessible to service users and staff.* *The Wish Centre is part of the CADS working group and regular updates are provided on current cases to the CADS team to ensure risk is managed and on going risk factors are highlighted.*	*Data is gathered on the agencies attending training for monitoring purposes this is provided to the safeguarding lead in BWD* *Information on the support provided by and IDVA and referral process is available on the website* [*https://www.thewishcentre.org/services/idva/*](https://www.thewishcentre.org/services/idva/)	*The role of the IDVA and the referral pathway is explained.*		October 2024	Completed – the training is being delivered
3) Raise awareness of the manipulative nature of the coercive controlling perpetrators and the brain washing impact negatively on victims.		*Training is being delivered to frontline practitioners in BWD and coercive control is covered in the training.* *Training is also being delivered to practitioners Pan Lancashire again coercive control is covered in the training.* *Agencies attending training include the statutory sector, VCFSE sector and the private / business sector.*	*Data is gathered on the agencies attending training for monitoring purposes*	Practitioners have a better understanding of Coercive control and the impact on victims.		October 2024	Completed – the training is being delivered

4) Promote the use of practical and legislative interventions to support/protect victims and to modify/disrupt perpetrators abusive behaviours.		The Wish Centre has a significant reach via its social media platforms and regular posts on practical measures that can be used to support victims are shared to ensure people in the community as well as services are aware of them. The promotion of practical and legislative interventions is also covered in training. Training is also being delivered on how to communicate with perpetrators, information on the behaviour change programmes currently being delivered and the referrals process.	*Data is gathered on the agencies attending training for monitoring purposes.* *https://www.thewishcentre.org/services/behaviour-change-programmes/* https://www.thewishcentre.org/resources/resources-adults/ https://www.thewishcentre.org/resources/articles-research/	People in the community and practitioners have an increased understanding of practical and legislative interventions to support/protect victims. Awareness is also raised on behaviour change interventions both with the community and with agencies.		October 2024	Completed
1) Improve case management via a new case management system	**Springfield Domestic Abuse Support Services in South Lakeland**	OASIS case management system implemented	Case management evidenced on OASIS cases	Quality recording on case files		June 2023	Completed
2) Develop robust training packages on trauma, safeguarding and risk assessment		Training plans implemented for every staff member.	Document2.docx	Staff appropriately trained		April 2024	Completed – training being delivered

3) Establish monthly case work supervision		Monthly case work supervision sessions with a manager to ensure each case has management oversight.	Evidenced on individual case notes	Clients achieving the best quality support		June 2023	Completed
4) Record of user's voices throughout their journey with the service.		Clients having autonomy over their support and goals	Evidenced on individual case notes and through client feedback	Client autonomy		June 2023	Completed and this practice will continue
5) Review recruitment process		Robust recruitment processes in place	Policies and staff recruitment files	Staff employed with relevant qualifications, experience and all pre-employment checks satisfactory		October 2022	Completed
6) Use of this DHR in training		Learning to be incorporated into training for all staff	Document above	Staff appropriately trained		April 2024	Completed – training being delivered
7) Review current policies and procedures and circulate to team members		Policies and Procedures on a table to review regularly	Policies and procedures reviewed and updated regularly and discussed in team meetings	Team are aware of policies and procedures and put them into practice		October 2022	Completed
1) Centralisation of record keeping and move to new case management system (including escalation)	Together Housing	Safeguarding procedures updated to include case supervision and escalation procedures	Safeguarding procedure/Escalation procedure.	Case sample audits, including evidence of supervision practice.		April 2023	Completed

		Training on QL with regard to case management	Training records. Case audits				
2) Review of victim assessment and support pathway		Case Review roll out, identifies importance of MA working. Included in Safeguarding Training programme. Supervision of case management to improve confidence. Built effective relationships with partner agencies and keep up to date with existing and new pathways and processes (ie, complex case panel/MARAC).	Case audits Case Review pack. Safeguarding training packs/records of training.	Improved working relationships with partner agencies. Improved staff confidence in proactive information sharing and health professional challenge.		June 2023	Completed
3) Improve the quality of record keeping		Training of what good record-keeping looks like as part of case rollout Guidance in place as part of safeguarding procedures re record-keeping Change from manual to electronic record keeping system Improve management oversight of cases	Training pack of case roll out following THA internal review Refresher training on safeguarding procedures All records now recorded on electronic system *Managers now required to do 20% sample auditing of safeguarding* cases	More effective record-keeping and case auditing Full team access to cases		December 2020 and rolled out learning in 2021. Arrangements revised from April 2023 (for audit checks)	Completed

a) Improve understanding of professional curiosity and domestic abuse		Include within case review roll out Included in mandatory ongoing training programme, including domestic abuse training Management support and guidance to build confidence as part of day to day coaching and supervision Sample case management quality checks	Case Review training pack Training records Improvement in practice monitored management oversight *THA's appointed auditors verified assurance of safeguarding practice (2021 & 2023)* *Quality assurance reports to THA safeguarding learning group*	Staff look below the surface and explore sensitively and with compassion links to more recent work also around building culture of trauma-informed practice		Case Review refresher rolled out in June 23 to SH Team. Further follow on session planned when DHR published	Completed
b) Improve multiagency working, information-sharing and key pathways/processes		Case Review roll out, identifies importance of MA working. Included in Safeguarding Training programme. Supervision of case management to improve confidence.	Case audits Case Review pack. Safeguarding training packs/records of training.	Improved working relationships with partner agencies. Improved staff confidence in proactive information sharing and health		June 2023	Completed

		Built effective relationships with partner agencies and keep up to date with existing and new pathways and processes (ie, complex case panel/MARAC).		professional challenge.			
c) Full-service review to improve performance (covering all aspects of service delivery – purpose culture, support, safeguarding, housing management etc)		Change culture and performance through training, updated policies/procedures and guidance. Disband key working as part of service delivery to support customers holistically and effectively as a team. Improve information sharing and a joined-up approach internally. Implement case management supervision/peer support.	Mandatory training, including – safeguarding, Support Planning, trauma informed approach, risk assessments. Training matrix specific to role. New Starter induction programme Case audits Team meeting minutes.	Team delivering high performance and use of performance monitoring to record progress.		June 2023	Completed

Appendix C: Multi-agency Recommendations Plan

Title of DHR	BwDDHR8						
Plan	Multi-agency Recommendations						
Independent author	Kathy Webster						
Governance arrangements	The Pennine Community Safety Partnership provides the governance arrangements for Domestic Homicide Reviews across the Pennine area. The board will oversee and ensure effective implementation of the recommendations within an appropriate timeframe.						
Recommendations	Lead Agency	Key Actions / Intended Outcomes	Evidence	Key Outcomes Achieved	Overall RAG	Target Date/ Completion Date	Progress/ Completed
All organisations within Pennine Lancashire Community Safety Partnership providing services concerned with safeguarding victims of domestic abuse should	Lancashire Constabulary	*Developed a domestic abuse training programme with The Wish Centre to address the topics listed.*	*This training is incorporated within the DA Matters Training which is being delivered across Lancashire Constabulary having commenced on 19th February 2024.*	*To ensure that Domestic Abuse training delivered across the Pennine area draws learning developed through the Domestic Homicide Reviews.*		*Completed 2023*	*Completed*

promote training and development for relevant staff covering the following topics: • *Aetiology of coercive control within domestic abuse relationships* • *Trauma informed practice* • *Professionals curiosity* • *Effective record keeping* • *Information gathering and sharing* • *Establishing lines of multiagency communication during a live investigation* • *Role of IDVAs and how to support their work* • *Eight-stage pattern by criminologist Dr Jane Monkton-Smith to promote understanding of the nature and behaviours of perpetrators of coercive control*	The Wish Centre & Local authorities	Developed a domestic abuse training programme with The Wish Centre to address the topics listed. All partners to ensure it is included within their training packages if they use other training providers.	 Training packages 2024 Wish Centre 05.	To ensure that Domestic Abuse training delivered across the Pennine area draws learning developed through the Domestic Homicide Reviews.		*December 2024*	*Completed – training updated as and when there is new learning*
	Integrated Care Board	Non-fatal strangulation training developed by the ICB and provided via the children's safeguarding partnerships across multi agency partners including primary care/health. (still ongoing). Lancashire and South Cumbria ICB have a programme of Trauma Informed Care training that is being rolled out across the integrated care system. The IRIS domestic abuse programme has been delivered within selected GP practices within Blackburn with Darwen. IRIS is a specialist domestic violence and abuse (DVA) training, support and referral programme for General Practices. Blackburn with Darwen domestic abuse training developed with the	 Final%20NFS%20CS AP%20May%2024.pp	To ensure that Domestic Abuse training delivered across the Pennine area draws learning developed through the Domestic Homicide Reviews.		*December 2024*	*Completed – training being delivered and reviewed regularly*

		Wish centre disseminated across health economy. Dedicated protected learning sessions completed on Domestic abuse for primary care. Primary care training brochure updated to include specific domestic abuse training and resources. Health provider organisations deliver in house domestic abuse training as part of their training offer.					
Pennine Lancashire Community Safety Partnership should consider how Blackburn and Darwin MARRAC new arrangements could be implemented across the geographical area of the partnership	Lancashire County Council BwD Council	Lancashire County Council has reviewed its MARAC arrangements and the changes have been implemented.		To ensure a consistent MARAC/MARRAC approach across Lancashire.		November 2024	Completed

Pennine Lancashire Community Safety Partnership should ensure that the lessons learned from this Domestic Homicide Review are shared across the partnership and any outstanding area for improvement identified in the agencies IMRs are addressed.	Pennine Lancashire Community Partnership Agencies listed on the action plan	The Pennine Partnership are aware of the lessons learned from this Domestic Homicide Review.	- Delivery to the Pennine CSP on 26th January 2024 - Incorporated learning into DA training with The Wish Centre Review the action plan and organisational improvements -Delivery to Pennine CSP on 12th Dec 2024 -Pennine DHR learning and recommendations report	Sharing the learning across the partnership at all levels – practitioner to strategic		Learning shared 26/01/2024 12/12/2024 Pennine DHR learning and recommends report completed and to be shared with the partnership and safeguarding boards	Completed April – August 2025

Appendix D: Home Office Quality Assurance Feedback Letter

Home Office

Interpersonal Abuse Unit
2 Marsham Street
London
SW1P 4DF

Tel: 020 7035 4848
www.homeoffice.gov.uk

Partnerships Manager, Community Safety Team
Blackburn with Darwen Borough Council
Localities & Prevention
L Floor, Old Town Hall
King William Street
Blackburn
BB1 7DY

23rd April 2025

Thank you for resubmitting the report (Matilda) for Pennine Lancashire Community Safety Partnership to the Home Office Quality Assurance (QA) Panel. The report was reassessed in March 2025.

The QA Panel is grateful for your full and comprehensive report into what is clearly a complex and challenging case. They commended the significant efforts that were made to engage with the lived experiences of the victim and her family and friends. They also noted the impactful tribute made to Matilda from her guardians, which provided an insight to her as a person, how much she was loved by her family and the adversities she experienced throughout her life.

The QA Panel noted that most of the issues raised in the previous feedback letter following the first submission have now been addressed.

The view of the Home Office is that the DHR may now be published. The QA Panel would like you to consider whether publishing the DHR in full is appropriate given there is a child involved. This is up to the CSP to decide, and the QA Panel will support your decision.

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

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

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

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

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

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

Yours sincerely,

Home Office DHR Quality Assurance Panel