PENNINE LANCASHIRE
COMMUNITY SAFETY
PARTNERSHIP

Domestic Homicide Review

In respect of Helen, who took her own life
On the 30th August 2022

Independent Chair and Author: Paul Withers, QPM & Neil Ashton
Report completed: December 2024
Home Office Quality Assurance Panel: June 2025
Home Office Feedback: July 2025
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Preface

The Pennine Lancashire Community Safety Partnership wishes to express their condolences to the family and friends of Helen. This review has been undertaken to learn lessons and improve the overall response to domestic abuse. It is hoped that this will enable partner agencies to work effectively and collaboratively to make the public safer in the future. The review panel has also sought to conduct this review in a spirit of learning and non-blame. Thanks are expressed to the agencies and professionals participating in the review.

Abbreviations

AP: Approved Premise
CAB: Citizens Advice Bureau
CBT: Cognitive Behavioural Therapy
CFWS: Child and Family Wellbeing Service
CPR: Cardiopulmonary Resuscitation
CLCRC: Cumbria and Lancashire Community Rehabilitation Company
CPP: Community Probation Practitioner
CSC: Children's Social Care
DA: Domestic Abuse
DHR: Domestic Homicide Review
DWP: Department of Work and Pensions
EDT: Emergency Duty Team
EH: Environmental Health
ELHT: East Lancashire Hospital Trust
GP: General Practitioner
HARV: Hyndburn and Ribble Valley – Domestic Abuse Charity
HCRG: HCRG Care Group
IDVA: Independent Domestic Violence Adviser
IMRs: Individual Management Review Reports
LCC: Lancashire County Council
LSCFT: Lancashire and South Cumbria NHS Foundation Trust (mental health)
MARAC: Multi-Agency Risk Assessment Conference
MASH: Multi-Agency Safeguarding Hub
MH: Mental Health
NFS: Non Fatal Strangulation
NWAS: North West Ambulance Service
PLCSP: Pennine Lancashire Community Safety Partnership
PLDASG: Pan-Lancashire Domestic Abuse Steering Group
PSRF: Police Safeguarding Referral Form
RAR: Rehabilitation Activity Requirement days
TAF: Team Around the Family
ToR: Terms of Reference

Contents

1.0 Introduction

1.1 This Domestic Homicide Review (DHR) examines agency responses and support given to Helen prior to her death at her home address in August 2022. A coronial inquest later determined that the cause of death was suicide by hanging.

1.2 In addition the review will also consider Helen's relationship with Dave, with whom she had been in an intimate relationship for approximately 5 years. It seeks to identify any relevant background or history of abuse prior to Helen's death, if support was accessed within the community and whether there were any barriers to accessing support.

1.3 Helen resided at an address in Accrington with her 3 children prior to her death. Dave is not the father of any of the children and did not reside at the home address of Helen.

1.4 During the evening of 29th August 2022, Helen (35 years) had spent time socialising in Accrington town centre with her mum Jean. During the evening, they had met with Helen's partner Dave and another male, and later all four returned to Helen's home address. The other male subsequently left, leaving Helen, Dave and Jean at the address. Helen's 2 younger children, Lisa (14-years) and Megan (10-years), were also present at the address at this time. Helen's eldest child, Tom (17-years), was not at home and was in the company of his father. Helen and Dave therefore slept in his bedroom whilst Jean slept downstairs in the property. At approximately 5am, Helen was struggling to open the bedroom door as it would stick and be difficult to open from the inside. As a result, her daughter Lisa was awoken by the banging and helped her to open the door. At 5.30am Helen is known to have sent a text to a relative asking to borrow some money. It is known that Helen was facing eviction due to significant rent arrears, owing more than £4000, and was due to attend a court hearing on the 5th September 2022. At 11am, Jean discovered Helen hanging from the light fitting in the living room. Jean shouted for help and with Dave's assistance, they managed to release the ligature and they commenced CPR. Paramedics were called and quickly arrived at the scene, and at 11.20am Helen was pronounced dead.

1.5 The subsequent police investigation into Helen's death concluded that there was no third-party involvement in the hanging. A coronial inquest was held where the cause of death was concluded to be death by hanging.

1.6 An examination of Lancashire Constabulary databases outlined numerous incidents of domestic abuse involving Helen and Dave in the years leading up to Helen's suicide.

1.7 On 15th July 2018 Helen reported to police that she had been assaulted by her partner Dave after they had been out drinking in Accrington town centre. Helen stated that she had been thrown around the bedroom by her hair and that Dave had tried to strangle her. This had caused reddening and bruising to her neck and bruising to her arms. Helen stated that she was okay with Dave if he had not been drinking but indicated that he regularly assaulted her when he had consumed alcohol. Dave was arrested and charged with an offence of a

section 39 assault (common assault by battery). He was convicted and received a sentence of 3 months imprisonment that was suspended for 12 months.

1.8 On 31st August 2019 the police attended an incident at the home address of Helen. Helen and Dave had been involved in a verbal argument, following which Dave threw Helen to the floor causing her to bang her head and lose consciousness. Dave had initially left the address but returned and damaged a window. Dave then picked up a broken piece of glass and held it to his neck and threatened to cut his own throat. As Helen tried to ring the police Dave had stamped on her mobile telephone causing damage. Dave was arrested and the circumstances presented to the Crown Prosecution Service. No further action was taken due to Helen retracting her statement and declining to support a criminal prosecution.

1.9 On 31st December 2020 the police attended a report of a disturbance on Lodge Street in Accrington. Helen was present at the scene and indicated that she had been involved in a verbal argument with her partner Dave. Dave had left the area but was located nearby. Dave was taken to an alternative address to avoid any escalation of the disturbance.

1.10 On 1st May 2021 the police attended the home address of Helen. Dave had been verbally aggressive towards her and had then thrown an ashtray at Helen, striking her on the head and causing a lump and bruising. Helen's son Tom (aged 15 years at the time of this incident) had intervened forcing Dave to leave the address. At this time Dave was in possession of Helen's bank card. Dave was arrested and subsequently released on police bail conditions, with the aim of safeguarding Helen and her children. Dave was later released with no charge after Helen and Tom retracted the statements they had made to the police and declined to support a prosecution.

1.11 On 13th April 2022 the police attended the home address of Helen. Helen reported that Dave had assaulted her following an argument and had punched her in the face. Dave was arrested and later placed on police bail conditions to safeguard Helen and her children. Dave was subsequently released with no charge due to evidential difficulties after Helen retracted her statement and declined to support a prosecution.

1.12 The circumstances of the incidents were referred to the Pennine Lancashire Community Safety Partnership (PLCSP) by the Lancashire Constabulary on 24th January 2023. The DHR was commissioned on 3rd February 2023, having deemed to have met the criteria in accordance with section 9 (3) of the Domestic Violence, Crime and Victim's Act 2004.

1.13 Members of the review panel decided to consider agency contact with Helen and her partner Dave between July 2018 and Helen's death in August 2022 as the period for the review. This timeframe includes all reported incidents of domestic abuse between Helen and Dave. Additional events that are relevant to the review that occurred outside this timeframe were also considered.

1.14 The key purpose for undertaking a DHR is to enable lessons to be learned from homicides where a person is killed because of domestic violence, or alternatively where a person takes their own life as a result of domestic violence and abuse. For these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand fully what

happened in each homicide or suicide, and most importantly, what needs to change to reduce the risk of such tragedies happening in the future.

Timescales

1.15 The first review panel meeting took place on 3rd March 2023. The final review panel meeting was concluded on 30th January 2024. Reviews, including the overview report, should be completed, where possible, within six months of the commencement of the review.

Confidentiality

1.16 The findings of each DHR are confidential. Information is available only to participating officers/professionals and their line managers. Pseudonyms were agreed with Helen's family and used in the report to protect the identity of individuals involved. All members of the review team have signed a confidentiality agreement in relation to this review.

1.17 At the time of her death, Helen was 35 years old and her partner Dave was 28 years old. The ethnicity of Helen and Dave is White British.

2.0 Terms of Reference

2.1 The terms of reference for the DHR are as follows:

1. To establish the circumstances surrounding the suicide and how experiences of domestic abuse contributed to this.

2. To establish whether there are any lessons to be learned from the case about the way in which professionals and organisations worked together and carried out their duties and responsibilities.

3. To identify clearly what those lessons are, how they will be acted upon and what is expected to change as a result. Agencies will also identify good practice and how that enabled partners to work together in this case.

4. To establish whether the concerns and responses by professionals and their organisations were appropriate both historically and, in the time, leading up to the suicide.

5. To establish whether organisations have appropriate policy and procedures to respond to the circumstances identified in this case and to recommend any changes because of the review process, with the aim of better safeguarding families.

6. All enquiries are to be restricted to a period of no more than 4 years prior to the date of the suicide, and until the review has concluded. However, any historical information or convictions of domestic abuse outside of this timeframe should be considered.

7. To provide details of additional records concerning domestic abuse 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, environmental, or mental capacity issues which may have contributed to any barriers the victim faced in accessing protection, and learning why any interventions did not work for them.

9. To consider the impact that the COVID-19 pandemic had on the victim accessing support to domestic abuse services, and how the pandemic may have led to increasing episodes of domestic abuse, and the deterioration of the victim's mental health.

10. To consider the impact of long-term domestic abuse on the wider family, particularly the children of the victim in this case.

11. To consider the impact of financial debt and potential financial abuse on the victim and the wider family.

12. To consider the impact the victim's substance misuse had on their deterioration of mental health, and the impact the substance misuse had on the increasing episodes of domestic abuse.

3.0 Methodology

3.1 The DHR was conducted in accordance with the Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (December 2016). Individual Management Review (IMR) reports were requested from all agencies who had had relevant contact with Helen and her partner Dave during the DHR period. Agencies who had minimal contact were permitted to submit reports.

3.2 The IMR's were scrutinised by the DHR panel and further information was requested where necessary.

Contributors to the DHR

3.3 The following agencies provided Individual Management Reviews to inform the review:

- Children Social Care – Lancashire County Council
- Citizens Advice
- Department for Work and Pensions
- East Lancashire Health Trust
- Environmental Health – Hyndburn Borough Council
- Housing – Hyndburn Borough Council
- Integrated Care Board
- Lancashire 0-19 Service HCRG Care Group
- Lancashire and South Cumbria NHS Foundation Trust
- Lancashire Constabulary
- Lancashire Victim Support
- National Probation Services
- North West Ambulance Service
- St Christopher's Church of England High School

3.4 The following agencies provided short reports to inform the review:

- Sharps Letting Agency

3.5 The authors of each IMR and report were independent in that they had no prior involvement in this case.

The DHR Panel Members

3.6 The DHR panel consisted of:

Independent Chair and Author
Joint Author
Senior Manager Safeguarding, Inspection & Audit – Lancashire County Council
Review Officer – Lancashire Constabulary
Named Nurse Safeguarding – HCRG Care Group
Head of Environmental Health – Hyndburn Borough Council
Housing Manager – Hyndburn Borough Council
Head of Policy – Hyndburn Borough Council
Community Safety Manager – Hyndburn Borough Council
Pennine Partnerships Manager – Blackburn with Darwen Borough Council
Business Support – Blackburn with Darwen Borough Council
Chief Executive - Citizens Advice East Lancashire
Head of Probation Delivery Unit – National Probation Service
Senior Probation Officer – National Probation Service
Named Nurse Safeguarding – East Lancashire Hospitals NHS Trust
Named Nurse Safeguarding – Lancashire and South Cumbria NHS Foundation Trust
Deputy Safeguarding Lead – Integrated Care Board
Domestic Abuse Commissioner – Lancashire County Council
Assistant Head Teacher – St Christopher's High School

3.7 DHR panel members were independent of the line management of any staff involved in the case. The panel met on six occasions on 3rd March 2023, 12th May 2023, 20th June 2023, 18th September 2023, 24th November 2023 and 30th January 2024.

Authors of the overview report

3.8 Neil Ashton and Paul Withers were appointed as the joint authors of the overview report. Paul was also appointed as the independent chair of the DHR panel established to oversee the review. Both are retired senior policers and completed the AAFDA DHR chair accreditation in February 2023.

Statement of independence

3.9 In 2020 Neil Ashton retired as a Detective Chief Superintendent from the Lancashire Constabulary. In his role as Head of Crime, he was portfolio lead for local investigation (including domestic abuse), safeguarding (both adult and child) and criminal justice. He holds no other position that may impair his independence whilst conducting this review.

3.10 In 2019 Paul Withers retired as a Detective Superintendent from the Lancashire Constabulary. As a senior investigating officer, he dealt with numerous domestic homicides

throughout the last 10 years of his service. Paul was awarded the Queen's Police Medal in 2020 for outstanding services to British policing. Since April 2020 he has performed the role of independent chair of Lancashire's Reducing Reoffending boards. He holds no other position that may impair his independence whilst conducting this review.

3.11 Neil Ashton and Paul Withers have no current connection to services in Pennine Lancashire.

Parallel reviews

3.12 No parallel reviews were running at the same time as this DHR.

Equality and diversity

3.13 The panel considered the nine characteristics set out in the Equality and Diversity Act 2010[1]

- The panel noted Helen's female sex as a protected characteristic.

  The panel noted that females are statistically more likely to experience domestic abuse than males. The ONS (Office for National Statistics, November 2023) reports an estimated 1.4 million women (and 751,000 men) aged 16 years and over experienced domestic abuse in the last year, a prevalence rate of approximately 5.7% of women and 3.2% of men.

  Further, the panel noted that the ONS reports that crimes recorded by the police highlight that the victim was female in 73.5% of domestic abuse related crimes in the year ending March 2023. Between the year ending March 2020 and the year ending March 2022, 67.3% of victims of domestic homicide were female compared with 12.1% of victims on non-domestic homicide.

- The panel noted Helen's ethnicity as white.

  The ONS report for the year ending March 2023, the Crime Survey for England and Wales (CSEW) showed that a significantly higher proportion of people aged 16 years and over in the mixed and white ethnic groups experienced domestic abuse in the last year compared with those in the Asian or Asian British groups. Almost twice as many women in the white ethnic group experienced domestic abuse in the last year (6%) compared with Black or Black British women (3.1%) and Asian or Asian British women (3%).

[1] https://www.gov.uk/government/organisations/department-of-health-and-social-care/about/equality-and-diversity#our-duties-under-the-equality-act-2010

- The panel noted Helen's declining mental health as a disability and a protected characteristic.

  Helen received sporadic treatment for her mental health during the period of this review. Her experience of domestic abuse may have impacted her mental health and her ability to access mental health support at times when it was available.

  During the course of the review, it became clear that Helen's daughter Megan (aged 10 years) had additional support needs.

Dissemination

3.14 In addition to the DHR panel members, the overview report will also be sent to:

Role	**Organisation**
Community Protection Manager	Blackburn with Darwen Borough Council
Head of Adult Social Care	Blackburn with Darwen Borough Council
Councillor	Blackburn with Darwen Borough Council
Deputy Director Adult Social Care	Blackburn with Darwen Borough Council
Public Health Specialist	Blackburn with Darwen Borough Council
Pennine Community Safety Coordinator	Blackburn with Darwen Borough Council
Community Safety Head of Service	Blackburn with Darwen Borough Council
Strategic Director Adult and Health	Blackburn with Darwen Borough Council
Housing Needs & Support Manager	Blackburn with Darwen Borough Council
Service Manager Youth Justice	Blackburn with Darwen Borough Council
Head of Street Scene	Burnley Borough Council
Housing Strategy & Policy Manager	Hyndburn Borough Council
Community Safety Lead	Hyndburn Borough Council
Chief Inspector for Neighbourhood & Partnerships (Burnley & Pendle)	Lancashire Constabulary
Chief Inspector for Neighbourhood & Partnerships (BwD & Hyndburn)	Lancashire Constabulary
Police & Crime Commissioner	Lancashire Police & Crime Commissioner
Domestic Abuse Commissioner	Lancashire County Council
Deputy Community Safety	Lancashire County Council
Early Help Lead	Lancashire County Council
Community Safety	Lancashire County Council
Children and family wellbeing	Lancashire County Council
Public Health Specialist	Lancashire County Council
Public Health	Lancashire County Council
Service Delivery Manager	Lancashire Fire & Rescue Service
Service Delivery Manager	Lancashire Fire & Rescue Service
Service Delivery Manager	Lancashire Fire & Rescue Service
ICB Head of Safeguarding	NHS Lancs & South Cumbria ICB

Policy & Partnerships Manager	Office for the Police and Crime Commissioner
Chair of Pennine CSP	Probation Service
Head of Probation Delivery Unit	Probation Service
Neighbourhood Safety	Together Housing
Neighbourhood Safety Manager	Together Housing

4.0 Involvement of the family and friends of Helen and perpetrator Dave

4.1 The chair was keen to personalise this review and ensure that Helen was remembered as a much-loved mum, daughter, sister, and friend to many within the local community. As a result, the eulogy from Helen's funeral was shared with panel members at the beginning of the first meeting. At the second panel meeting and with the permission of Helen's family, a photograph of Helen was also displayed prominently for the duration of the meeting.

4.2 On the 30th March 2023 the chair spoke with family members of Helen by telephone. These family members included Jean (mother), Paul (brother) and Tina (sister). The chair also spoke with the perpetrator Dave. The purpose of these calls was to introduce himself and explain that a DHR had been established. The chair also arranged to meet the named persons in the following week, accompanied by the joint author.

4.3 On the 3rd April 2023 the chair and joint author met with Tina and her partner at her home address. At this location they also met with Lisa and Megan, who are the children of Helen. The chair offered his condolences and then explained the purpose of the DHR and what was involved. Helen's family members were also given the Home Office DHR leaflet and an accompanying letter with the contact details of the Pennine Community Safety Partnership. The chair explained in detail that DHRs are also relevant to a suicide where domestic abuse was prevalent in the household. The chair advised Tina and Lisa that they could contribute to the DHR in a manner of their choosing. Tina indicated that they would think about it and may provide a written response in due course. Megan was not involved in these discussions at this time.

4.4 On the 3rd April 2023 the chair and joint author also met with Jean, and Geoff, Helen's brother, at Geoff's home address. Also present at this meeting was Debbie, who was described as the best friend of Helen. Again, the chair offered his condolences and explained the purpose of the DHR and what was involved. All persons present were given the Home Office DHR leaflet and Jean and Geoff were provided with the accompanying letter. Jean indicated that they were keen to contribute to the DHR as a family and that they would write a letter and send it to the relevant e-mail address displayed on the accompanying letter. Jean also disclosed that she had been struggling since the death of Helen and discussions took place regarding accessing further bereavement counselling.

4.5 On the 2nd July 2023, Geoff sent an e-mail to the chair which included a typed account from his mother Jean, relating to the death of his sister Helen. Jean described how difficult she had found writing the account about her daughter. Jean referred to the day of the suicide and described it as a haze and that she kept getting flashbacks. Jean indicated she recalled

performing CPR with Dave even though she realised it was too late. Jean went on to describe the action of agencies who arrived at the house. The ambulance staff who did not even try to resuscitate her daughter. The police and crime scene investigators, including the officer in charge who indicated he would text her with crime reference numbers but never did. Jean outlined that no statements were taken and that she had to kick up a fuss before one was eventually taken. Jean expressed concern that Helen's body was kept for about a week and a half at the hospital and during this time only completed a basic body autopsy. This was despite her advising the police that she had found what looked like an 'empty coke bag' in Helen's purse. Jean indicated that 'they were just not interested'. The police retained her daughter's mobile phone for four months and when she made enquiries she felt as if she was just being given excuse after excuse. Jean highlighted that the police could not access the phone as it was PIN locked, and they never asked for the PIN. Jean indicated that she wanted the phone back as it had all of her daughter's photos and memories on it.

4.6 Jean outlined that her daughter was being evicted by her landlord and had a court hearing scheduled for the 5th September 2022. Jean indicated that she believed this was because Helen had got environmental health involved and then went on to describe the significant state of disrepair at the house. Jean believed that the repairs to the property that Helen had asked for were not done to a satisfactory standard and that they only really covered up the damp. A short time later Helen received a letter from the landlord raising her rent by £50 per month and then another letter asking her to increase her payments towards her rent arrears. Additional correspondence followed and included numerous eviction notices. Jean indicated that this had a profound impact on her daughter's mental health and that she was clearly struggling after years of financial stress and domestic abuse from Dave.

4.7 Jean described her daughter changing over time, from a happy social butterfly who loved her children, loved going out with friends and was always laughing and smiling. Jean described her daughter as someone who would light up a room as soon as she entered. She advised that Helen subsequently went downhill as her debts accumulated, she had no interest in life and would not get out of bed some days. Mental health services got involved but did little to help her and never followed anything up if she missed an appointment. Jean indicated that they admitted not doing enough for her daughter at the inquest and that they had missed opportunities and made mistakes.

4.8 Jean concluded her account by stating:

> *'my daughter was a loving mother, sister and a daughter. She was in a bad place and could not see any other way out. Helen is missed by all her family, and I hope by writing this letter it will save others from doing what my daughter did and save a family from having to live without them.'*

4.9 In the first week of September 2023, Jean died in hospital following a significant medical procedure. The Pennine Lancashire Community Safety Partnership wishes to express their condolences to the friends and family of Jean.

4.10 Dave was visited at the home address of his mother on the 3rd April 2023. Dave was clearly very agitated and indicated that he was struggling to cope. He was tearful and his

behaviour at times was quite erratic. He spoke about not being allowed to attend the funeral of Helen and suggested he had been receiving threats from the friends and family of Helen. Again, the process relating to the DHR was explained and relevant documentation shared. Dave was advised he could contribute to the DHR and he suggested he would think about it. The chair enquired about any new relationships and Dave advised that he was not with anyone at that time. Again, discussion took place around additional support and Dave indicated that he would readily accept any support that was offered to him to help him manage his emotions.

4.11 On the 2nd June 2023 the chair recontacted Dave to advise him that he was going to be referred to the Changing Futures programme. Dave again indicated that he was happy for this to take place and subsequently advised the chair that he was now in a new relationship. Dave was subsequently referred to Changing Futures[2] and on the 7th June 2023 Dave was accepted on the programme.

4.12 As a beneficiary of the Changing Futures programme Dave was allocated 2 'navigators' to primarily support him with his mental health issues, his substance misuse and his offending behaviour. The following is a summary of their initial dealings with Dave.

4.13 Dave initially expressed concern regarding his mental health. He indicated he was having nightmares and felt anxious when entering the community as he was fearful of Helen's family. As a result the 'navigators' referred Dave to initial mental health services, but he subsequently failed to engage with them and was discharged from their services. A further referral was made but Dave failed to engage again. The 'navigators' initially found it difficult to engage with Dave and he repeatedly cancelled appointments, whilst expressing concerns about his mental health. Eventually a number of meetings took place and the 'navigators' began to develop a level of trust with Dave. However, Dave then suffered a family bereavement and his engagement was impacted, resulting in minimal contact with the 'navigators'.

4.14 The 'navigators' established that Dave was living with his new girlfriend and he disclosed that he was still using cannabis and drinking alcohol. They suggested a referral to Inspire Services[3] and Dave indicated he would self-refer. Again, Dave did not engage with services offered and simply advised the 'navigators' that he had given up drinking and smoking cannabis. On the 10th July 2023, Dave advised that he was no longer living with his girlfriend following an argument. Dave was offered support and the 'navigators' endeavoured to take him to housing support at the local authority so he could declare himself as homeless. Dave declined and began to live with different relatives in the local area.

4.15 The 'navigators' indicate that the primary focus for Dave had been the local Job Centre. He had repeatedly asked for support in keeping his 'work coach' off his back and had asked the 'navigators' to confirm his mental health problems. It is clear that the 'navigators' were not fully comfortable with these requests and they advised Dave that their role is to help him

[2] www.gov.uk - Changing Futures is a 4-year, £77 million programme aiming to improve outcomes for adults experiencing multiple disadvantage – including combinations of homelessness, substance misuse, mental health issues, domestic abuse and contact with the criminal justice system.

[3] Inspire Lancashire deliver alcohol and substance misuse services and support across Lancashire. inspirelancs.org – *'Inspire services are designed to encourage individuals to find the strength and resources within themselves to achieve and sustain the life and behavioural changes they seek'.*

engage with services. They stated that Dave initially indicated that he would engage but then this diminished when services tried to establish some form of contact. The 'navigators' continued to conduct welfare calls on a weekly basis but Dave declined to meet on a face-to-face basis and reported that he was too ill or anxious to meet.

4.16 The chair made arrangements to visit Dave on the 13th November 2023. The purpose of this meeting was to discuss Dave contributing to the DHR and taking part in a domestic abuse perpetrators programme. This meeting was cancelled and did not take place and was hoped to be rescheduled. Dave has since declined further opportunities to meet and has now also disengaged from his 'navigators' from Changing Futures.

4.17 On the 15th December 2023 a Clare's Law[4] disclosure was made to a female who was believed to be the current partner of Dave. This was well received, and the individual indicated that she was no longer in a relationship with Dave. All relevant safeguarding matters were addressed at this time.

4.18 On the 11th May 2023 the chair met with Paul (brother of Helen) and her son Tom. The chair expressed his condolences and explained the DHR process. The relevant Home Office document and letter was shared with Paul and Tom and they were advised they could contribute to the DHR in a manner of their choosing. The chair also made Tom aware that he had seen the written observations he had provided to his school. Tom indicated that he was happy that these observations were used as his contribution to the DHR process. He also indicated that he was happy that people now believed what he had been saying after many years of family members suggesting he was telling lies. The panel have considered if Tom's written observations should be summarised for the overview report. The opinion of all was that they should be shared in their entirety.

4.19 Tom's account is shown below:

Foreword

This document is the accumulation of 8 hours worth of writing. This is a comprehensive record of almost every major event I can remember from 2017-2022. This has been written to the best extent of my memory, no detail about any event has been left out, whether this be a good or bad thing.

Before you begin reading this document there are a few things I must clear up:

Despite the events listed I loved my mum dearly and I will forever miss her and my biggest regret is that I could not help her enough, so that she felt strong and brave enough to tell these events herself.

Although the police were called many times and legal action could have been taken, the reason Dave was never locked up is because my mum decided to always drop

[4] www.gov.uk – The Domestic Violence Disclosure Scheme (DVDS), also known as 'Clare's Law' enables the police to disclose information to a victim or a potential victim of domestic abuse about their partner's or ex-partner's previous abusive or violent offending

charges, even when I begged her not to, she would do it behind my back. Since I was too young to press charges on my own this meant Dave always got away with his actions.

This is the end of everything for me, my mum's death was the last straw. I am done with the lies, the manipulation and the mistrust. If you wish to continue to argue that this is not the truth after reading this, you will fall upon deaf ears, as I couldn't care less, this is to my best efforts, the complete and total truth.

I tried my best to order everything chronologically but since some things happened years ago it is simply not possible, everything happened just possibly not in the exact order listed.

Goodbye mum, I love you.

<u>2017-2019</u>

During these years of my mum's life, I can only describe her as being in a downward spiral. After starting to date Dave, my mum slowly slid into depression and alcoholism. These years are highlighted with witnesses of mental and physical abuse my mum had to endure from Dave constantly, neglect me and my sisters faced and nothing but an endless crushing despair of a house.

This applies to all 5 years. The reason my mum could never fully leave Dave is because of textbook domestic abuse reasons. Once I found my mum's phone laying open on her bed and I saw messages from Dave, in these messages he was threatening to kill himself if she left him. This is classic manipulation; he manipulated my mum into letting him back in as she feared he would hurt himself if not, although Dave knew that he wouldn't. Dave also lowered my mum's confidence to the point where she felt he was all she deserved and he treated her how she deserved, this made her in a sick way dependent on him as her self-esteem was shattered by him. If you research abusive relationships online you will find my mum fell under many of the reasons why women can't escape abusive relationships. Lack of support, Isolation, Fear of losing her children if she spoke out, embarrassment and fear of Dave. Many times when my mum tried to kick Dave out between 2017-2019, but he threatened to call social services and get us all taken away from our mum, leaving her no choice but to let him stay.

Once Dave moved into the house that's when everything began to go wrong. From this point onward our family and mum would begin to fall apart, almost everyday would display extreme psychological abuse with regular intervals of physical abuse throughout from Dave. My mum and Dave would drink at least 3-5 times a week, in the house in or out at the pub. As I will further elaborate, the nights they went to the pub were far worse than those they drank in the house. They would often spend £20 on alcohol and £10 on food, this left me and my sisters with just barely enough food so they could drink heavily. Many people liked to mention during this time that my mum was doing nothing wrong because we never went without food, but this entire time she was the creator of her own problems, manipulated by Dave. As she always had

*enough money for food, gas and electricity she just chose to spend it on alcohol, during this time we could have lived comfortably but we lived day by day with just enough food due to how my mum and Dave spent their money on drugs and alcohol. When Dave went to the shop it was "let me spend £10 on Stella and £4 on food". This is only scraping the surface though. From the constant drinking and drug usage my mum began to slip into a shadow of herself which Dave further pushed her into. My mum would barely get out of bed unless it meant going out to drink, leaving Dave to do mostly everything (when he wasn't lying in bed hungover with her) and leaving me and my sisters to care for ourselves. Dave was no good Samaritan though as whenever my mum was awake, he would abuse her at every possible chance with degrading comments calling her a "worthless b*tch" and hundreds more insults for not getting up to help him and constantly screaming and arguing with her about the slightest thing, like who was going to the shop. His abuse came in a far more venomous format than this still, apart from the outright comments he would slowly chip away at her and, make her and my sisters nothing but an object, my sisters would be playing with their toys and he would go "girls shouldn't play like that" or a women would do something on TV he doesn't agree with and he'd say to my mum; "if you did that I'd twat the f*ck out of you", constant little comments like this slowly took away my mum's confidence, never did he say anything nice about her unless he'd just beat her up, upon which he'd beg that he was sorry and shower her with compliments. I wholeheartedly believe he made my mum feel worthless and at some point, she started to believe his words. When you feel worthless, would you want to wake up?*

<u>FROM THIS POINT ON ARE EVENTS THAT HAPPENED BETWEEN 2017-2019</u>

This was the night after Dave had first met Auntie Debbie. Auntie Debbie had said something to Dave that had really set him off and I woke up to them arguing about it. My mum was begging that she meant no harm but Dave somehow blamed my mum for what had happened. Dave is screaming at my mum and my mum is just whimpering and crying begging him to stop. I remember standing at the top of the landing listening to my mum beg, I was only 13-14 and I'd never felt so helpless in my life. I wanted to run down there and help her but my legs wouldn't work, I was terrified and my whole body was shaking. But then I hear him hit my mum and my mum screams for him to get off her, I run downstairs and scream at him to get off my mum. He gets up and both my mum and him act like nothing is happening, I tell Dave to get out of the house but my mum just tells me to go upstairs and that everything is fine, there was not much I could do so I head upstairs. I then hear Dave begging my mum he was sorry and he won't do it again and it was just an accident. My mum tells him to get out but he begs for so long she eventually gives in and heads to bed. He did hit her again and again and again during these years.

The only time I went out alone with my mum and Dave was to Monte Cristo. It was Dave's payday. Dave had offered to take me and my mum there while my sisters were away with Neil. I cannot think of a worse dinner experience, the entire time Dave was snarky to my mum with little degrading comments, he made it out as if she owed him the world when it was HIS idea to go out for dinner and he constantly kept using it against throughout the whole dinner to manipulate her into doing what he wanted. I

felt sick to my stomach the whole time and all I could do was look down and eat my food. We got home and I went straight to my room, that night Dave also ordered 4 takeaways. We had no money to buy food the next day, and Dave would stress at my mum about money.

The first time I decided to speak out against Dave I wasn't sure who to tell and what to do so I decided to tell my mum that I didn't want Dave to live with us anymore (since I'd witness him hit her multiple times at this point) she shouted at me and told me to go upstairs. I didn't know what to do so I decided to just lie on the floor of my sister's room and scream and cry until she got rid of him. However, she called Neil and Jean and made it out like I was just some bratty teen acting out. Neil came to pick me up and take me down to Jean's, my mum came upstairs to tell me to get in granddad's car but I did not move and decided to remain silent and still. So, Neil and Dave picked me up and carried me down the stairs, while doing this they accidentally slammed my head against the banister at full force. It hurt so bad but I remained silent. They then put me in the back of Neil's car, and Neil and my mum got in. On the car ride down, Neil berated me and degraded me, calling me the worst child he had ever seen and many more insults. Jean and Uncle Paul waited for my arrival. Uncle Paul carried me out of the car and Jean promised she'd make my life a living hell. They put me in Uncle Geoff's room. While in that room I felt completely alone and helpless. I did not think anyone in the world cared about what was happening. Later that night, I ran away from Jean's house with no shoes, just socks, because I was so terrified of what she might do to me if I stayed. I sprinted as fast as I could from the house towards Accrington and decided if no one was going to help me I might as well head home, at least I had my belongings there. I told my mum I was sorry and she forgave me. However, after this event I refused to ever stop the night at Neil's again and put as much distance as I could between myself and him.

<u>2020</u>

For this year, I cannot say much of what happened with Dave as I spent most of it living with Uncle Paul and Uncle Geoff. However, of what few events I did witness this year, still make my arms feel weak with anxiety as I write them down, I underwent mental torment throughout this year and was manipulated into believing Dave had done nothing wrong and that I was worse than him. A stigma was created against me for telling the truth, just because I was young.

My mum had said she was going to her mates and was out for the night. In the middle of the night, I hear loud banging on the front door, I go into Lisa's room and look out of her window at the front door, I see Dave there banging on our door. Lisa is awake and asking me who it is, I tell her to keep an eye on him while I call my mum. I call her and tell her he is at the house. She says she is on her way. While waiting Dave eventually leaves. 10 minutes later, an SUV pulls up and 3 guys get out and head towards my house and enter, they shout my name and ask if I'm okay, I shout back yeah, a couple of minutes later my mum arrives and I ask why Dave was there and she shouts at me saying she doesn't know. I head to my room and some guy I'd never seen before checks on my sister's and then comes to me and tells me to be easier on my

mum and that he personally guarantees Dave will not be back. He didn't live up to his guarantee. Then, they all leave the house again including my mum. I went to bed.

*During the main part of lockdown, I ended up living with Uncle Paul and Uncle Geoff as once again we found Dave at the house and Uncle Paul took me away from this situation. During this time Jean made it her goal to make my life a living hell, spreading lies about Dave not being there and me just being a moody brat. She would constantly come over and tell Uncle Paul to take my PlayStation off me, to which Uncle Paul would reply to her I did nothing wrong and I was barely on it anyway since I spent all day doing schoolwork. Once I also put the washing machine on to wash my clothes at about 10pm, I did not know that it would keep Uncle Geoff up and he comes down and turns it off and tells me not to put it on late at night because he has work in the morning. However, the next day I wake up to Jean twisting it into me being a brat and making trouble all the time. I was only 14 and this was one of my first times ever washing my own clothes after only just being taught how to use it. During this time, I felt isolated in my own head, it felt that nothing I did was ever right and that I was in the wrong for trying to keep Dave out of the house, my spirit was broken and I began to believe Jean's words, that I was making it all up and Dave wasn't that bad. The worst thing that happened to me during my stay was when Jean came into the house and started telling me I was lying and making it all up and that it was all my dad's words not mine, even though I barely spoke to my dad during my stay, I said back to her that it wasn't and she began screaming, while Uncle Paul and Uncle Geoff watched, I stood up to tell her to get out of the house because she was screaming nothing but lies and Uncle Paul slams me into the wall and tells me to get away from his mum (he thought I was squaring up to her). I sit on the floor and look down at it while Jean continues to scream insults at me and about my dad, calling him things like a "f*ggot" while Uncle Paul and Uncle Geoff watched. Eventually it became too much for me and I sat on the floor with my whole body shaking and then I started to cry but Jean did not let up for another 10 minutes until Uncle Geoff told her to stop. At which point Uncle Paul and Jean left and Uncle Geoff headed upstairs leaving me crying and shaking on the floor. Shortly after this, I was so mentally broken and scared I decided to return home to my mum. My mum was appalled with what happened that day.*

Just a few weeks after returning home in December, Dave shows up again. I wake up at about 7am to the sound of screaming and smashing. Dave is in the kitchen throwing and breaking plates and bowls. I come downstairs to check what is going on but my mum says it's too dangerous and to head back upstairs so I do. I hear screaming and arguing as Dave tries to throw stuff at my mum, however my mum eventually convinces him to leave. I called Uncle Len to come pick me up. When Uncle Len arrives, my mum asks us to go to the shop to get some cereal and toilet roll quickly so we do before Uncle Len drives me to his house to stay there. While at Uncle Len's house I get a call from my mum, she sounds scared, and she tells me that Dave has come back and asks me to call the police. I can hear Megan crying in the background and Dave shouting, she tells me that Dave smashed Megan's breakfast bowl in front of her. While I'm on the phone to her, Uncle Len calls the police for her. Later that day, we got a call from the police asking me to come back to the house to provide a statement, I

obliged. I stopped at Uncle Len's for 2 weeks but eventually I had to return home as Uncle Len could not keep me for any longer.

<u>2021</u>

Although my mum got slightly better this year, my mum could still not keep Dave away as his grip on her was just too tight. This was the final full year of my mum's life, and it was hard and she almost escaped and got better, but it was by the actions and venom of those that claimed to care for her that she did not.

*Although Dave was meant to have been gone for many months, I woke up at about 6am to screaming. I open my bedroom door and realise it is Dave and my mum arguing, my mum is begging Dave to leave and Dave is throwing barrages of unspeakable insults at my mum and refusing to leave. I go downstairs and walk into my mum's room and tell him to leave or I will call the police. This seems to change his tune and he agrees to leave but he has to "grab his belongings" first. I head back upstairs to sit on my bed and understand what is happening while he "gets his stuff together". In reality he is screaming about not having some bank card and accusing my mum of stealing it and being a money grabber. My mum tells me there is no card and he is making it up. Eventually we convinced him to leave. However, 5 minutes later we hear loud thudding at the door, Dave was basically trying to knock the door down. My mum tries to ignore it at first but then Dave starts shouting through the letterbox "Helen I know you've got my card! Helen give me my f*cking card!". My mum shouts back that she doesn't and tells him to go away, he continues beating the door leaving the door damaged in parts. After no response, he walks away and we think he has left, but then we hear banging on the living room window and back door, he was trying to get through the back door. My mum calls the police at this point and also calls Stuart to help for some reason. I go to the back door to watch what Dave is doing and attempt to calm him down. I ask him to stop for the sake of my sisters who are scared and crying, he tells me to "f*ck off" and carries on. Eventually the police arrive and he runs for it, later they catch him but my mum dropped the charges on him. I go to care for my sisters, Stuart arrives and the police take statements from all of us. Once the police leave, I realise my mum had a massive bruise on her forehead and it's because Dave had thrown a laughing gas container at her head leaving her with a massive bruise and bump on her forehead. These containers were all over my mum's room but my mum swore she had not taken any, I decided to believe her as she seemed normal but I cannot be sure if she was telling the truth. Things settle down and my mum cleans up the mess and the day carries on like nothing happened. She asks me not to tell anyone so I don't.*

The girls are out for the weekend, I am chilling playing PlayStation when I hear arguing at about 11pm. I open my door and listen and realise it is Dave. I go downstairs and go to my mum's room and open the door. My mum instantly jumps up and tries to block the door and keeps pushing me back. I stand at the door and I tell her I know Dave's

there and she tells me it is not him and I'm embarrassing her in front of her friend. Comically, as she sees this, I see Dave's eyes peeking from behind her bed. At this point I say to my mum I can see him right there but she continues to shout at me and say it's not him. After a couple of minutes of this I decide I'm fed up and I move my mum out of the way holding her shoulders with both hands ensuring I have full control of where she moved so she didn't fall or hit against anything, and move past her towards Dave shouting "Dave you dirty rat get up" he stands up and starts swearing at me. I say "You little rat come on, get out of my house now" he begins to square up to me but my mum steps in between us and tells Dave to go, and tells me to call Uncle Paul to pick me up because she doesn't want me anymore. I go upstairs and call Uncle Paul and he comes to pick me up. Before his arrival Dave shouts upstairs that my dad is a dog and I'm nothing but a dirty mutt. I tell him "Come on then, come up here and do something you wimp, hit me like you hit women", he does nothing but leave because my mum warned him that Uncle Paul was coming. After packing, I head with Uncle Paul down to an address. Once there my mum and Jean try to spin the story that I hit my mum when I purposely acted as to not hurt her, this was all to draw attention away from Dave being there. After living with Uncle Paul and Uncle Geoff for a few weeks I had no
choice but to return home, due to my ability to get to school and just not wanting to burden Uncle Paul and Uncle Geoff with having to provide for me anymore.

*It is a Friday and Lisa has gone to her friend's as she did almost every Friday and Megan was at Neil's. It is around 10pm and I hear whispering coming from my mum's room that sounds like Dave's voice. At first, I'm not sure but I text Uncle Paul to tell him, he tells me to be completely sure and to double check. I wait at the top of the stairs for 10 minutes listening for his voice, they are whispering and arguing and I know it is Dave now as I recognise his voice. I also text Auntie Debbie for help as she told me to tell her if he ever came back. Both Uncle Paul and Auntie Debbie say they are on their way. Auntie Debbie knocks on the door and since I asked her not to mention me, she says to my mum, "I've just been in town and someone told me Dave was up here". My mum acts confused but Uncle Paul and Auntie Debbie begin rushing into the house and searching. They search my mum's room but find nothing and I search upstairs and we cannot find Dave. My mum is crying at the bottom of the stairs saying "He hasn't been here in months; this isn't fair I haven't done anything wrong! I don't deserve this, he's not here". I begin to feel guilty, my mum's performance is extremely convincing and I think I have got it wrong. Auntie Debbie and Uncle Paul stop searching and my mum sits with Auntie Debbie in the living room and Auntie Debbie tells her she can't be having that guy back anytime and my mum pretends to be understanding. However, as Auntie Debbie is talking to my mum, Uncle Paul decides to take one last look in my mum's room. He pulls away my mum's duvet and there Dave is. The house goes silent and Auntie Debbie shouts to Uncle Paul from the living room "He's there isn't he?" to which he replies "Yep". Auntie Debbie slaps my mum and calls her a "lying b*tch" and then gets up and removes Dave from the house and shouts up to me to pack a bag because we are leaving. After this I lost all trust for my mum, I finally saw the full extent of her lying and manipulation. I had been completely sure he was there and for a second she had manipulated me into thinking he wasn't. I could never trust her again*

because she seemed completely genuine but was lying the whole time and I couldn't tell the difference. Finally I saw there was nothing that she wouldn't not lie about.

*I ended up in hospital due to Bell's Palsy. While in there, Nana comes to visit me, my mum and Neil leave the room and Nana whispers to me "not to trust Auntie Debbie or my dad" because all they do is put poison in my head and that my mum had done nothing wrong, that school stress had put me in hospital. I would like to set the record straight. Firstly, my mum openly thanked Auntie Debbie for what happened that night with Dave and I saw the first positive change in my mum in years when Auntie Debbie helped and for once my mum seemed actually determined on improving her life and escaping Dave. Secondly, all of my ideas are my own, my dad never spoke ill of my mum, unlike my mum and Jean who constantly tried to convince me my dad was evil, on several occasions Jean would call him a "retarded f*ggot" and not to listen to him, my dad only ever offered help and support and without my dad, me and my sisters and my mum would not have many of the belongings and comforts we are privileged to have . Finally, it is delusional to think my school work is the reason I was under intense stress, school was my only escape from everything, for 6 hours a day I got to pretend I've got a normal life and no one knows about what goes on at home, I'm just a kid who's really good at science. The things that stressed me out where the lies Jean and my mum were constantly telling about me and not being sure where I was going to live and not really having any home or anywhere I felt I belonged, and worrying that if I went home, about the next time Dave would show up since I could not trust my mum. Most Bell Palsy cases are caused by extreme stress and all of my stress came directly from my mum and Jean's actions, so I'm sure everyone reading can connect the dots. If you wish to still insist that this isn't what caused it, to this day my face slumping still comes back when I am stressed out, its intensity varying depending on how stressed out I am, and most likely this is something I will have to live with my whole life.*

<u>2022</u>

This is it. This is the year that what could have just been another event in this document ended up being the time my mum died. I was not shocked when I was told the news and what had happened, this could have happened anytime in the last 5 years, any of those times could have been the time she died, and on some days I came home fearful that, that day, she might have killed herself. I was only saddened by the news, saddened by the fact that she could have been saved and by the fact she died with Dave. Dave should not have been there when my mum died, he should have been behind bars 4 years before.

The night before my mum had told me she was going to hang out with her friend Susan. I wake up for school in the morning at about 8:00 and get ready. I then proceed to check on the girls and see that neither of them is ready for school. I ask them "why are you not ready" to which Lisa replies "Mummy said we don't have to go". It is obvious to me why, as I already hear talking downstairs. I walk downstairs and stand at the last step outside my mum's room listening. Some lady I'd never met before is drunkenly rambling about how she doesn't want to leave her boyfriend because she loves him even though he beats her almost to death. I walk into the room to see the lady

chugging a bottle of vodka and my mum next to her just as drunk. My mum slurs hello to me and tells the lady that "I'm very smart" and "her star". I reply coldly "I'm going to school" and head to Sixth Form. Once I return home, my mum apologises and says she will never hang out with Susan again. Susan was coming back over within the next 2 weeks.

My mum and Jean have an argument, I hear them screaming on the phone from the second I wake up in the morning. I come downstairs to my mum in tears, I give her a hug and ask her what's up, she says it's all too much and no one is helping, she mentions that Auntie Debbie doesn't text anymore even though she needs her and that Jean is just causing trouble. I tell her I'm here to help and she has lots of support. Mornings like this were common in the house, at least 4-5 times a month my mum would be in tears in the morning due to something Jean had said to her.

I wake up in the morning and hear my mum puking. Me and Lisa come downstairs to help her. At first, I'm concerned but then I noticed three empty bottles of vodka on the floor next to her bed. She had just drank too much. Lisa does not notice and we get her some water. I then head upstairs back to my room. My mum would go out 2-3 days every week. Her life worked in a pattern of she would go out then be "sick" (hungover) the next day, unable to do anything but be in bed all day. The day after she would recover from her "sickness" and be back to normal, and then she would go drinking that night. This cycle would repeat over and over again.

In the middle of the night, me and Lisa wake up to my mum screaming for help. We run down to her room and she tells me to ring an ambulance. I notice she is being sick into a pan and grab my phone to call the emergency services. I tell them my mum is sick and they ask to speak to her. My mum is feeling a little better at this point and says she just panicked and explained to the emergency services that she took too many of her sleeping tablets but that she should be okay. The emergency services hang up. I pass my mum a glass of water and head back to bed as she says she is okay and just panicked.

*My mum and Jean went out the previous night. That day I come back from sixth form early, Jean and my mum are screaming the house down. I come in and calm them both down. Jean goes into the bedroom and calls Julie; my mum goes out to call Neil. I stand in the room to calm Jean and ask her to leave, on the phone she is saying horrible things about my mum to Julie. Julie agrees and shouts down "f*ck that silly b*tch and those disgusting runts of hers". Jean agrees in front of me. I call Uncle Paul to help and he helps for about 15 minutes but has to get back to work and thinks I'm capable enough to sort it out. I sort it out and Jean agrees to leave. Jean tries to apologise to my mother but my mother refuses, after an hour they forgive each other and talk again. I headed upstairs to do the physics homework I had planned to use the extra hour to complete.*

April 16th

I was not here for this incident as I was away in Spain. However, there is an 8-minute video of Lisa explaining everything to me, and a 2-minute video of the actual incident. To summarise this video. Lisa states that in the middle of the night she was woken up to the sound of arguing, it was my mum and Dave. At some point my mum texted her to call the police. The police came and sorted the situation. Uncle Norman came to pick up the girls and looked after them for a bit. A few days later, Lisa heard Dave talking at night again.

August 26th

Lisa told me Dave was at the house. I told Uncle Paul; however, we were unable to do anything without video proof due to the stigma against us. Unfortunately, Lisa was unable to take video proof and we could not do anything. Lisa informed me each following day that he was there, and I informed Uncle Paul, but without a video we couldn't do anything. Unfortunately, on August 30th my mum passed away with both Jean and Dave present.

Summary

That's it, this is most of the important things that happened between 2017-2022. Of course I have dozens more stories to tell that are just as horrific as the ones above. To write those would take 20 more hours and 15 more pages though, and it is not time for that. Everything above is adequate enough for everyone to understand what led to my mum's death and the torment my mum faced. With this, I say goodbye to these events and I say: ***Goodbye mum, I love you.***

This is not an insult to anyone, just to put the truth out there and stop gossip.

4.20 On the 12th June 2023 Tom provided a further written account to the review team. The account of Tom is summarised below.

4.21 Tom indicated that whilst witnessing the domestic abuse his mum suffered over a five-year period, he had forgotten that agencies should have been trying to safeguard her from these situations. He stated that there had been limited government interventions to help rescue his family or to try and support them. Tom suggested that more work has been done by every agency after his mum's death than before she died. He further commented that he is disappointed with his country and each and every one of these agencies. Tom suggested it takes someone dying for agencies to act or to even pay attention. He stated that agencies need to listen and learn to save people in the future.

4.22 Tom commented that he'd like to start with the where the police and the legal system went wrong. He finds it difficult to comprehend how the police could attend his home eight times for the same type of crime, and each time fail to do anything to uphold fairness or justice. Tom stated the police saw his mum with bruises, little girls crying and smashed doors and windows, but never took any action. He stated that it should have been taken to a higher

level of authority. Tom believes that if Dave had just been in jail for a couple of months his mum would have been able to break away from his manipulative shackles. Tom indicated that Dave still walks free and he believes another woman will suffer the same fate as his mum. He questions how the police can let this happen and asked if they will do anything to save the next woman. Tom then outlined changes that he'd like to see happen.

4.23 Tom believes that when the police visit a household several times, there should be a system implemented for a higher level of scrutiny to understand why these things keep happening. The police should then consider if there is anything they can do independently to stop it from happening again. Tom also indicated that the police could also invite the victim and some trusted family members for a meeting to make them aware of what is happening and what legal action they can and should take. Tom acknowledged that this may require the consent of the victim but feels the meeting would help. It would prevent the victim feeling isolated and would provide a pedestal of authority for the family to rely on. Tom applies this to his mum's circumstances and believes it would have helped by making other family members aware of the abuse. He indicated that it was difficult for him as a child as they did not believe him. Tom is of the opinion that family members would have believed a police officer and may have responded differently. He believes his mum would not have felt so isolated and would have benefitted from having a parent with her or a responsible adult. This could have enabled discussions with the police regarding her legal options. He believes his mum may have felt braver and committed to a conviction or restraining order. Tom believes having the family support and guidance from a respected authority might be enough to help a victim escape the spiral of domestic abuse.

4.24 Tom also commented on where he believes that social services got things wrong. He indicated that it is the statutory obligation of them to safeguard and promote the welfare of vulnerable adults and children. Tom suggests they should identify problems, organise support and monitor improvements. He indicated that this never happened with his mum's situation and there was limited involvement with social services. Tom believes that no action was taken to support his mum or her children despite serious incidents taking place at the house. He believes that they should have been visiting at least once a month, organising food and financial support for his mum, and referring her to support groups and educational programs for women experiencing domestic abuse. Tom also indicated that social services should have been organising support for him and his sisters, speaking to school to see what support could be offered, and organising therapy for the children. Tom highlighted his concerns for his youngest sister Megan who must overcome what she has experienced throughout her whole childhood and the resulting trauma and fear. Tom believes that it was a catastrophic failure that no action was taken by social services. Tom recommends that social services should simply uphold their statutory obligation and commented that there is still a lack of significant social services support. He outlined that his auntie Tina still lives in a two-bedroom house with four children and her partner with no indication when they will get a new home. He believes that more should be done to find a house for that many people. This would allow them their own individual space to grieve and overcome everything.

4.25 Tom reflected on his mum's interaction with mental health services. He outlined how his mum was anxious and struggled talking to professionals. Tom believes that people should also have the option to communicate via text. He suggested it would be helpful for a busy mother

to be sent a text with a list of questions that could be dealt with at an appropriate time. Another option would be identifying a trusted individual that the specialist could call if the patient does not engage. Tom believes this would support someone who was nervous or apprehensive and may encourage them to fully engage with relevant health professionals.

4.26 Tom concluded his account by asking agencies to commit to long term support and cohesion. To ensure each service works together to prevent isolation. He indicated that an abuser works to isolate a person and strip down their humanity. Tom believes consistent support from agencies and bringing in trusted individuals from a victim's life would help loosen the grip of the abuser. Tom indicated that it is too late for his mum, but he hopes that agencies will listen to his recommendations and act upon them so that someone else's mum can be saved.

4.27 On the 20th July 2023 the chair contacted Frank by telephone and introduced himself. Frank is the father of Helen, and he lives in Accrington. The chair explained the DHR process, offered Frank words of reassurance and arranged to visit him at his home address. On the 2nd August 2023 the chair spoke with Frank at his home address. Frank was provided with the relevant Home Office DHR leaflet. The chair explained in detail that DHRs are also relevant to a suicide where domestic abuse was prevalent in the household. The chair advised Frank that he could contribute to the DHR in a manner of his choosing. At this time Frank was in the company of his wife. Frank indicated that they did not wish to contribute to the DHR as they had both suffered recent health issues. The chair again offered reassurance and indicated that Frank could change his mind at any point during the review. At this point Frank again indicated that he did not wish to contribute to the DHR but would like to be updated when the review had concluded.

4.28 Further to the chair meeting with Debbie (Helen's best friend) on the 3rd April 2023, he met with her again at her home address on the evening of the 28th June 2023. At this time she was provided with the relevant Home Office DHR leaflet and the chair explained that this was also relevant to suicide cases where domestic abuse had been prevalent in the household. The chair managed to ascertain that Debbie had been a close friend of Helen for most of her life and it was clear that she had a good awareness of the domestic abuse that Helen had been subjected to. As a result, Debbie was invited to contribute to the review and she indicated that she was happy to do so. Debbie indicated that she was happy for the chair to make notes as they talked and that she was happy for the chair to write them up on her behalf later. This process took place and Debbie subsequently confirmed she was happy with her account in an email to the chair on the 17th July 2023. The account of Debbie is summarised below.

4.29 Debbie indicated that she had known Helen all her life and had acted as her babysitter when she was young due to her friendship with Helen's mother Jean. Debbie was honoured to be godmother to Helen's children. Over the years, Helen became a vibrant young lady and they became strong friends, supporting and endeavouring to look after each other. Helen did not drink alcohol excessively albeit Debbie was aware that she smoked cannabis at times. Helen had 3 children and brought them up largely as a single mum.

4.30 Debbie believes that Helen eventually met Dave in 2017 in the town centre. Debbie outlined her first meeting with Dave at Helen's home address and that she took an instant

dislike to him. They argued and he stormed out of the house. Debbie indicated that she subsequently discovered that he had returned after she left and had assaulted Helen. Debbie advised Helen that it would happen again, but Helen was dismissive and played it down. Debbie suggested that she never really thought that Dave would beat Helen on such a regular basis throughout their relationship.

4.31 Debbie indicated that she began to see less of Helen after she met Dave, and that they drifted apart. Debbie stated that she believes this was due to Dave isolating her from her friends and family. Debbie became aware that Helen had started using cocaine and believes that Dave had introduced her to this drug. Debbie initially thought that it was just infrequent social use, but it became clear that both Helen and Dave were using cocaine on a daily basis. Debbie described a time when she had broken up with her partner and that Helen had come to see her to offer some support. Debbie was horrified when she saw Helen and described her as being skinny and looking like a 'smackhead'. Debbie attempted to offer her support and advice and spoke about the abusive relationship that Helen had with Dave. At this point it became evident that Helen was in significant debt and Debbie believed that any money Helen and Dave had was spent on either alcohol or drugs. Helen was dismissive about this and began to tell lies to cover up the lifestyle she was living. Debbie described her as being unrecognisable from the vibrant and fun young lady she used to know.

4.32 As time progressed Debbie became more aware of the beatings that Helen was regularly exposed to at the hands of Dave. Debbie became increasingly concerned about the children and would give Tom a £1 coin so he could ring her from a payphone if Dave was beating his mum. Debbie indicated that family and friends stopped buying the children presents as they knew that Dave would simply sell them to get more money for alcohol and cocaine. Debbie was aware of occasions when Helen would report the assaults to the police, but she would always withdraw her complaint and refuse to support any prosecution. It was evident that Dave had complete control over her. Debbie indicated that Dave would regularly assault Helen in front of the children and threaten to expose her lifestyle to children's services. He would follow this with a threat that the children would be removed from her care. Dave also threatened the children and on one occasion Tom began to suffer with a condition called bell's palsy. Debbie genuinely believes that this was caused by the stress that Tom was experiencing whilst living at home with his mum and her abusive partner Dave.

4.33 Debbie suggested that Dave was not officially living with Helen and the children but would be present more often than he was at his own home. As a result of this Debbie began to communicate secretly with Tom and would encourage him to contact her if Dave was present and causing problems. On one such occasion Debbie attended the address with Helen's brother Paul. On arrival Helen denied Dave was at the address but after a thorough search Paul found him hiding beneath the bed. Debbie offered Dave some forthright advice and threw him out of the house. Debbie also took a similar approach with Helen and spoke with her firmly about her lifestyle. Debbie indicated that Helen wasn't really listening and was in a distressed state. Debbie believes that Helen's mum Jean was also aware of the life that her daughter was living but that Helen would always minimise the levels of violence, alcohol, and drugs. Debbie believes it was easier for Jean to dismiss what Tom had been disclosing to her as she would not then have to deal with the sad reality. Debbie suggested that her relationship with Helen and Jean was not as strong as it used to be and that she began to see

them less frequently. Again, Debbie also believes that this was down to Dave isolating Helen and keeping her away from anyone who may seek to guide her away from him and the lifestyle they were living.

4.34 Debbie indicated that Helen was suffering from mental health problems and was seeking support from her GP. It was clear to Debbie that Helen was in a downward spiral where she was abusing alcohol and cocaine, she was suffering from depression and was failing to manage an ever-increasing debt with her landlord. Helen was also being physically and verbally abused by Dave and was a single mum to 3 relatively young children. Debbie stated that she thought Dave would eventually go on to kill Helen.

4.35 Debbie outlined the wide range of emotions that she felt when she became aware that Helen had died by suicide. She was consumed with sadness but also felt anger towards Dave for the lifestyle he'd exposed Helen to. Debbie asked herself if she could have done more to help her friend but indicated that this was difficult as Helen would not disclose and would tell lies to try and protect Dave. Debbie believes that this is due to Helen fearing that Dave would make disclosures to children's services and/or other agencies and she feared the consequences.

4.36 Debbie indicated that she has been asked to consider what could have been done differently and if agencies could have done more to help Helen. Debbie suggested that it was difficult due to Helen not making disclosures and if she did, she would quickly retract her complaints. Debbie indicated that she believes the police had all the information but looked at each incident in isolation and did not consider the history between Helen and Dave. Debbie stated that she wished the police could have prosecuted Dave even when Helen refused to support a prosecution. Debbie was also aware that Helen was seeking help for her mental health problems but would not see things through and did not persevere. Debbie wishes that mental health services had tried harder and did not simply write off Helen when she was struggling to engage. Debbie accepts that this is difficult as Helen was telling lies to many of the agencies that were involved. Debbie just wishes that people could have seen through the lies and been more persistent.

4.37 Debbie concluded by indicating that Helen was much loved and a good friend over many years. Debbie is saddened that Helen had to experience such physical and mental abuse and that this ultimately contributed to her losing her life to suicide.

5.0 Chronology/Overview

Background information

5.1 Helen lived at an address in East Lancashire with her three children. The perpetrator Dave is not the father of any of the children. Helen's family described her as a loving and caring mother and someone who enjoyed social events prior to meeting Dave. Police records indicate Helen had been a victim of domestic abuse with a former partner, prior to the timeframe of

this review. There is also a record indicating that her son Tom attended hospital seeking to talk with the police suggesting Helen may have been involved with local drug dealers. The police attended and officers described smelling cannabis, Helen explained that she did not use drugs, but a friend had visited who openly smokes cannabis which explained the smell.

5.2 There are records held by Lancashire Constabulary indicating that Dave was considered a vulnerable child within a family subjected to domestic violence (2010). He received a penalty notice for the possession of cannabis on the 6th August 2014. There are primary mental health records relating to Dave experiencing anxiety and depression.

2018

5.3 On the 15th July 2018 Lancashire Police received a 999 call from Helen and a neighbour regarding an ongoing violent incident. Helen and Dave had been out drinking and as Helen went upstairs to her bedroom Dave attacked her by throwing her around the bedroom by her hair and placing his hands around her neck to strangle her. Helen suffered bruising to her arms and neck. The children present witnessed the assault. Dave had left the address prior to police arrival. Helen told officers that she did not want Dave arrested as he was just being a problem because he was drunk. Helen disclosed that she is usually assaulted by Dave when he has been drinking. Officers saw that the two children were visibly distressed by witnessing the assault on their mother.

5.4 In response to the call, the police took the following action: officers attended as a grade 1 emergency response, which was appropriate in this case; a High-Risk Domestic Abuse Protecting Vulnerable People (PVP) report was submitted to the Multi-Agency Safeguarding Hub (MASH); the incident was shared with the Independent Domestic Violence Advocate (IDVA); and a Multi-Agency Risk Assessment Conference (MARAC) referral was made; officers attempted to locate Dave and he was immediately circulated as a wanted person. This was positive action by the officers to safeguard Helen and the children. Officers also obtained a witness statement from Helen and created a crime report.

5.5 On the 17th July 2018 the PVP was received by Children's Social Care (CSC). Upon review, there were no concerns regarding Helen's ability to safeguard her children effectively. Helen was recorded as stating the relationship had ended and was engaging with IDVA and Police. Records indicate that CSC assessed DA as being unlikely to reoccur if Helen remained separated from Dave.

5.6 On the 17th July 2018 Dave was arrested and subsequently charged with section 39 Assault by Beating (Common Assault). He was bailed to Blackburn Magistrates Court on the 18th July 2018 with bail conditions imposed to safeguard Helen and the children. On the 8th August 2018 Dave appeared at Blackburn Magistrates Court and pleaded guilty to an offence of Battery (Common Assault). He was sentenced to three months imprisonment suspended for 12 months, ordered to pay £85 costs and £200 compensation, and to undertake 20 Rehabilitation Activity Requirement days (RAR days).

5.7 Between the 13th August 2018 and the 7th August 2019 there are extensive records of interactions between Dave and Cumbria & Lancashire Community Rehabilitation Company

(CLCRC). Dave had been allocated to a Community Probation Practitioner (CPP), who had assessed him as posing a medium risk of harm, and flagged his offence as a domestic abuse case. Key interactions between Dave and CLCRC during this time period are as follows.

5.8 The primary focus of initial meetings between Dave and CLCRC were on Dave's unemployment situation and exploring activities to improve his prospects of gaining employment. The records indicate that Dave had secured employment by the 30th October 2018 but no further details are listed. There appears to have been little discussion around relationships or Dave's alcohol consumption. By the 29th November 2018 it is evident from the records that Helen and Dave were back in a relationship and living together. By the 7th December 2018 Dave had lost his job, but no further details were recorded. On the 20th December 2018 a discussion took place regarding managing the relationship over the imminent Christmas period. The following is an extract:

> *"states she is supportive and not putting him under pressure as they have purchased all presents and Christmas food prior to him losing job. Discussed risk factors over Christmas including managing any increase in stress, anxiety, or anger. Dave spoke positively of his plans for Christmas with family coming round. Understood the potential risks and confident that Christmas will go well."*

2019

5.9 On the 26th February 2019 reference is made to Dave residing with Helen. This appeared to be a surprise to the CPP even though it had been evident as per entry at para 5.8. Extract as follows:

> *"Discussion around his relationship – it would appear that he is supposed to be living with his grandmother and having no contact with children, but it would appear he may be spending the majority of his time with Helen, so her address requested together with details of everyone living there. Dave provided address details and details of stepchildren. Described a positive relationship with stepchildren and their birth fathers."*

A safeguarding check was submitted to the local authority but no response was received.

5.10 During March 2019 Dave secured steady employment and described his relationship with Helen as 'strong'. Helen was reported as also being in employment at this time. Discussions took place regarding triggers, risk factors and avoiding future DA situations.

5.11 By early May 2019, Dave had lost his job due to a sickness episode, whilst Helen remained employed. Discussions with Dave took place regarding managing his alcohol consumption in terms of this being a trigger for DA incidents, as well as managing the stress and anxiety he was experiencing as a result of being unemployed.

5.12 Within the seven day period between the 28th May 2019 and the 3rd June 2019 Dave presented twice at his GP complaining of anxiety and depression. It would appear a suggestion by the GP of a referral to mental health services was declined by Dave. No further details of

the discussions were recorded and it is not known if alcohol consumption or substance misuse were explored.

5.13 On the 10th June 2019 Helen attended her GP accompanied by her mother Jean, complaining of anxiety, depression, and irregular sleep. Helen also indicated she was struggling to cope with the children and requested Diazepam[5]. This request was declined but she was prescribed Mirtazapine[6]. There is no record of any discussion regarding relationship issues, Helen's domestic circumstances or alcohol and substance misuse.

5.14 On the 18th June 2019 Dave attended a further GP appointment. A discussion took place regarding ongoing treatment and the effects of a hand injury he had experienced, and subsequent surgery. Dave stated he felt low most of the time and indicated he had separated from girlfriend and was living at home with his mum. He also stated he had lost interest in most things but was not suicidal. Dave agreed to complete a "Minds Matter"[7] self-referral and to engage with counselling. Dave was also prescribed Citalopram[8]. Again, there is no indication if alcohol or substance misuse was discussed.

5.15 On the 24th June 2019 Helen attended her GP once again regarding her mental health. Helen explained that Mirtazapine had helped for a few days, but she had then become so overwhelmed and frustrated she cut her left wrist and overdosed on tablets. Helen indicated she did not attend A&E and that Dave had looked after her. This incident was reported to have been triggered by an argument with Dave. The GP's consultation notes detail Helen was experiencing physical and mental abuse from Dave. Helen indicated she couldn't be bothered to live anymore and was having thoughts of suicide all the time. Liaison took place with the START team (MH Team) and an appointment was made for Helen and crisis team numbers provided.

5.16 On the 11th July 2019 Dave attended his CLCRC appointment. He described obtaining a full-time job. A discussion took place regarding his risk of reoffending, his abstinence from alcohol and why he would not re-offend. Dave's support needs were reviewed, and Dave was provided with a list of community resources he could use as part of an exit strategy from the support he had received from CLCRC. Dave indicated all was well and his Community Probation Practitioner (CPP) noted, "No concerns."

5.17 Dave failed to attend his final CLCRC session due to his employment and his required engagement was terminated as his order came to an end on the 7th August 2019.

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[5] Diazepam is a prescription only drug used to treat anxiety, muscle spasms and seizures or fits. https://www.nhs.uk/medicines/diazepam/about-diazepam/

[6] Mirtazapine is an antidepressant medicine that is used to treat depression in adults. It is also used to treat obsessive-compulsive disorder (OCD) and anxiety. https://www.nhs.uk/medicines/mirtazapine/about-mirtazapine/.

[7] Minds Matter - NHS psychological therapies services (IAPT), including cognitive behavioural therapy (CBT) treatment and services at this clinic.

[8] Citalopram is a type of antidepressant known as a selective serotonin reuptake inhibitor (SSRI). https://www.nhs.uk/medicines/citalopram/about-citalopram/

5.18 On the 16th July 2019 Helen was sent a "START"[9] letter offering her an appointment. A subsequent letter was sent to Helen and copied to her GP stating that Helen had failed to attend the planned appointment. The letter requested that Helen make contact to book a further appointment, otherwise she would be discharged from the service.

5.19 On the 13th August 2019 Helen attended A&E complaining of abdominal pain. She was recorded as attending with her partner, although his name was not recorded. Helen was admitted to hospital and treated for renal colic. She was discharged on the 16th August 2019.

5.20 On the 31st August 2019 Police received a report of a domestic assault at Helen's home address. In the early hours a verbal argument between Helen and Dave escalated resulting in Helen being 'thrown' to the floor. Helen was knocked unconscious for a short time before coming round on the living room floor. The incident was witnessed by Helen's son Tom (aged 14 years). Her son contacted his uncle asking for him to be collected from the address stating that he did not want to stay there anymore.

5.21 During the same evening, Dave returned to the address on several occasions to collect items of property. On the last occasion, he threw his training shoe through an internal glass window, before picking up a shard of glass and drawing it lightly across his throat before leaving for the final time. Officers attended as an emergency, but Dave had left the premises before they arrived. He was arrested later that morning but released on conditional police bail for further enquiries to be conducted. The bail conditions were imposed to safeguard Helen and the children. However, on the 30th October 2019 Helen retracted her complaint stating that she did not wish to attend court and that the incident was a result of a drunken argument between her and Dave. Helen went on to say that she and Dave had separated. During the investigation, Helen disclosed to officers that she may be pregnant, although had not confirmed this with a test or appointment with a GP. Despite the retraction statement the case was referred to CPS for consideration of charge. The case failed the CPS triage as Helen had provided a retraction statement. No further action was taken.

5.22 In addition to the criminal investigation, officers also took steps to safeguard Helen and the children. The investigation was flagged as a High-Risk DA to MASH and the need to obtain consent from Helen to share information with agencies was over-ridden due to the identified safeguarding risks. However, the case was reduced to a medium risk DA by MASH and the High-Risk Vulnerable Child notification was shared with the Emergency Duty Team (EDT). This incident was not referred to MARAC. The MASH referral was shared with CSC, Health and Education.

5.23 In response to the referral from MASH, CSC initiated an Early Help episode, however Helen did not consent to work with Early Help. Helen was spoken to as part of the referral but minimised the nature of the abuse and described it as a drunken argument.

[9] START - Specialist Triage Assessment Referral and Treatment Team. Provides timely triage, assessment, onward referral/signposting and treatment for service users referred without the need for multiple assessments. The team screens and assesses the needs of all referrals and signposts on to other services, creating a seamless and timely care pathway. The team provide functions which include ongoing assessment, brief interventions and a case management function for some service users.

5.24 On the 5th September 2019 Helen and Dave attended a GP appointment stating they were trying for a baby. Helen provided confusing information and dates around her periods. Advice was given.

5.25 In October 2019 there was a deterioration in the relationship between Helen and one of her ex-partners, and father to her daughter. There were allegations and counter allegations of assault between Helen and the ex-partner's current girlfriend. The ex-partner also contacted CSC expressing concerns about domestic abuse within Helen's household. The reviewing social worker recommended that the case met the threshold for Level 2 on the Lancashire Continuum of Need. Helen gave consent for a referral to be made to Children and Family Wellbeing Service (CFWS)[10] and Early Help[11] to support the family. Helen also reported that she was no longer in a relationship with Dave and that there was a restraining order in place. Bail conditions (no restraining order) remained in place against Dave until the 20th October 2019.

5.26 On the 30th October 2019 Helen retracted her statement of complaint against Dave in relation to the DA assault on the 31st August 2019. The associated bail conditions were also removed as a result of this retraction.

5.27 On the 4th December 2019 Helen attended hospital for a termination of pregnancy. Helen disclosed previous domestic abuse over the past two years. She advised she did not want to continue with the pregnancy as she had three children already and did not want an ongoing connection with Dave. Helen also disclosed she was experiencing depression. Helen was advised that if she did not attend a subsequent appointment the clinic safeguarding team would be informed. Helen did not attend the planned follow up appointment for long-term contraception.

2020

5.28 On the 27th January 2020 Helen attended her GP due to low mood and depression. Helen stated she had just come out of an abusive relationship, was experiencing low mood, was struggling to get out of bed, and that her mother was helping with the children. Notes refer to Helen having low self-esteem and self-worth, sleeping all the time and expressing suicidal ideation at times. Anti-depressants were prescribed, and crisis contacts were discussed with Helen. During the consultation, the following issues and resources were also discussed: domestic abuse; Think Family support; further liaison with CSC; and further urgent MH support.

[10] CFWS – Children and Family Wellbeing Service. Offers a wide range of support across the 0-19 years+ age range with a 'whole family' approach.

[11] Early Help – An intervention with a family to gather, explore and analyse with them information about all aspects of the child or young person (and their family's) life and then to identify areas where change will address support needs and positively impact on their lived experiences.

5.29 On this date Helen also withdrew consent for the Team Around the Family (TAF)[12] process and the next TAF meeting was cancelled. Between October 2019 and January 2020, Helen's children's schools had been raising concerns about the attendance of the children. Early Help is consent driven and this period focused on current issues. As the relationship with Dave had ended at that point (according to information provided by Helen) domestic abuse was not addressed. During the time the TAF was in place, direct work was undertaken with Helen and the children and appropriate advice and support offered.

5.30 On the 3rd February 2020 Helen visited her GP and reported that she had taken an overdose four to seven days previously, but she had refused to attend A&E. Helen reported her mother had looked after her and the children. Helen indicated she subsequently regretted not attending A&E and that she was now willing to accept help. An urgent referral was made to MH services. The quantity of medication Helen was taking was reduced to safeguard her from future overdose attempts. Helen's mother was also reported to be helping safeguard her and the children, and crisis numbers were reinforced.

5.31 It appears that an urgent appointment was set up for Helen to engage with mental health services, however she did not take this opportunity. Therefore, an opt-in letter was sent to Helen advising that she would be discharged from the service if she did not respond. This was the second occasion that Helen had been referred to MH services and had not attended scheduled appointments. There is no further information suggesting Helen accessed MH services after this point.

5.32 There are no recorded incidents between Helen and Dave between March and June 2020. It is possible that they were estranged during this period or that as Tom was not living in the house, there was no one reaching out to family or services for support. There are some reports to police of disputes between Helen and her mother, and between Helen and the father of her youngest daughter Megan regarding parental responsibilities.

5.33 In June 2020 Dave presented at his GP complaining of increased anxiety. Propranolol[13] was prescribed. A further telephone consultation took place in late August 2020 and the Propranolol dosage was increased and Mirtazapine[14] was again prescribed. The appointment took place via telephone due to COVID-19 protocols. There was no evidence within the notes of any exploration regarding Dave's familial or environmental circumstances or of alcohol or substance misuse. Dave again declined referral to other agencies in relation to anxiety and depressive disorder.

5.34 On the 31st August 2020 Helen contacted 111 and reported that she had taken an overdose one week earlier and that her partner (believed to be Dave) had to perform Cardiopulmonary Resuscitation (CPR). She advised she had been suffering with chest pain and

[12] The main purpose of the meeting should be to develop a solution focussed action plan. It is important that the views of the child, young person and family are heard within the meeting and that the actions are based on these views https://safeguardingchildren.co.uk/

[13] Propranolol is a drug used to treat heart problems and can help with anxiety and prevent migraines https://www.nhs.uk/medicines/propranolol/

[14] Mirtazapine is a drug used to treat depression, obsessive compulsive disorder and anxiety https://www.nhs.uk/medicines/mirtazapine/about-mirtazapine/

breathing difficulties since then. As a result of this Helen was taken to Royal Blackburn Hospital Emergency Department by ambulance, she was unaccompanied at this time. Helen explained to hospital staff that eight days prior she had taken an overdose of sleeping tablets, became unresponsive and her partner (not named) performed CPR. Helen stated she had suffered with chest pain since this incident. Chest x-rays were completed, and no visible rib fractures identified. Helen declined to engage with offered mental health services.

5.35 On the 31st December 2020 police were called to a disturbance in the town centre. Helen was found drunk and explained that she had been involved in a verbal argument with her partner (Dave) who had left the scene prior to police arrival. No criminal offences were disclosed. Dave was located a few streets away and taken home to his parents' address to prevent escalation. A Standard Risk DA Police Safeguarding Referral Form (PSRF) was created via MASH.

5.36 There is a pattern of Helen repeatedly presenting at GP and A&E with abdominal pains.

5.37 On the 28th April 2021 Dave complained of chest pains and extreme anxiety during several contacts with his GP surgery. His repeated contacts culminated in a telephone consultation. Dave reported that he felt dizzy, had chest pain and was unstable on his feet. He was subsequently seen by paramedics who diagnosed anxiety. Anti-depressant medication recommenced, and blood tests were requested. Dave's GP asked to review Dave again in four weeks.

5.38 On the 1st May 2021 Police received a call from Helen reporting that she had been assaulted by Dave who she advised had thrown an ash tray at her. This had struck her on her head causing a lump and bruising. Helen stated that she and Dave had been drinking at the house the previous evening, during which Dave became verbally aggressive. Helen left the house and went to a friend's, leaving Dave and the children at her home address. The following morning Helen returned home and discovered Dave still in bed. Dave again became verbally aggressive and threw the ash tray at Helen causing an injury. Helen stated that Dave continued to be physically aggressive and grabbed hold of her. Helen reported that her son Tom had intervened and told Dave to let go of her. Dave then took Helen's bank card and left the address after damaging the front door. Although she initially supported the prosecution, Helen subsequently retracted her complaint. Helen indicated that she did not wish to go through the court process due to her mental health problems. She said that Dave had not been in contact with her since his arrest. Helen's son also retracted his witness statement and supported his mother's decision to retract. He was reported as advising he had just left school and was due to start work and did not want the stress of attending court.

5.39 In response to the above incident the police took the following action: officers attended the scene and commenced an investigation; they recorded crime reports for section 47 Assault (Actual Bodily Harm) and Criminal Damage; a witness statement was taken from Helen and her son; a Police Safeguarding Referral Form (PSRF) rated High Risk Vulnerable Child (VC) & Medium risk Domestic Abuse (DA) was raised via the MASH; Dave was located and arrested later the same day. During his period of detention, he was taken to hospital complaining of severe chest pains. Various tests were carried out and he was discharged having been

prescribed antibiotics. When interviewed, Dave denied the offences and was released on police bail with conditions to safeguard Helen and the children.

5.40 The case was reviewed monthly by a Sergeant and did not progress to the CPS. On the 13th September 2021 the case was authorised as 'No Further Action' by an Inspector. The reviewing officer recorded that the evidence had been poorly gathered, and that the witness statements taken by the officer were evidentially poor. Consideration was given to proceeding with an evidence led prosecution, however, this was discounted as the standard of the evidence gathered was poor. The reviewing officer recorded that *'should police proceed against the wishes of the victim this could make her hostile and she could lose trust in the police resulting in her not reporting further incidents'.*

5.41 In response to the PSRF shared by MASH, Early Help called Helen to explore the information shared. The incident was discussed, and Helen stated it was a silly argument that got out of hand. The case worker suggested it was a violent attack and that her son had to intervene. Helen replied that Dave was drunk and explained they had subsequently split up. Further discussions took place about the relationship and Helen indicated that they were on the verge of separation anyway and this incident had made the decision for her. Helen was asked if her son was hurt during the incident, she said he was not. Early Help support was discussed offering advice and support for Helen and children. Helen declined further support and thanked the case worker for the call, stating they were all ok now and ended the call.

5.42 On the 22nd July 2021 Helen's son Tom contacted police reporting that Helen had been drinking all day and had returned home shortly before 2:00am heavily intoxicated. The son indicated he had been left in the house to look after his two younger siblings, aged 13 years and 9 years. Officers attended the address, and the two sisters were in the downstairs front bedroom. One of the girls had earache, but otherwise both children appeared healthy and happy. The son was in an upstairs bedroom and appeared quiet. Helen was in another room and was tearful. She outlined that she had been drinking at a friend's house nearby and whilst she has struggled with alcohol consumption in the past, she was ok on this occasion. Dave was not present at the address on this occasion.

5.43 The attending officers told Helen that it was not acceptable to leave her children in the house alone until the early hours. A vulnerable child connect investigation was initiated which was assessed as medium risk by the MASH. Information was shared with CFWS, Health and Education. It was recorded that the children are known to CSC but closed at that time.

5.44 On the 3rd August 2021 Dave attended a face-to-face appointment with his GP. He complained of fatigue over the last 2 months along with a loss of appetite. He also indicated that he was feeling anxious, was not sleeping well and was using alcohol and cannabis to help with the symptoms he was experiencing. Dave denied taking cocaine or other illicit substances. He reported no feelings or thoughts of self-harm and indicated he lived with his girlfriend. He denied any problems at home. Blood tests were requested. The GP queried whether underlying anxiety was the reason for the symptoms he was experiencing. Dave subsequently failed to attend a scheduled appointment on the 3rd August 2021 for the blood tests that had been requested by his GP.

5.45 On the 17th August 2021 Helen had a telephone consultation with her GP. She was crying on the phone and described feeling low and anxious. Helen also advised she was experiencing some thoughts of self-harm. She was prescribed Citalopram and Diazepam and provided with the mental health crisis numbers.

5.46 Over the next two months Helen reported numerous physical and psychological issues to her GP. These are summarised as follows:

- 16th September 2021: Helen reported lower back pain, anxiety, and depression. She advised she lived alone with three children. A 'not fit for work' note was issued by the GP for a 1-month period.
- 20th October 2021: Helen had a telephone consultation with the extended access GP Hub. She requested a higher dose of Diazepam for her anxiety and depression. She was again commenced on anti-depressant medication and this was to be reviewed by Helen's own GP in two weeks.
- 2nd November 2021: Helen was issued with a further 'not fit for work' note for a 2-month period, the reasons given for this were Helen suffering with anxiety and depression.
- 10th November 2021: Helen presented at her GP surgery with rectal pain and bleeding and not being able to open her bowels. Helen was sent to hospital where she was diagnosed with a stomach infection and was prescribed Lansoprazole[15].
- 12th November 2021: Helen was referred by her GP to rheumatology in respect of a 9-year history of lower back pain and shooting pain in her left leg.

5.47 On the 14th November 2021 Helen called the Mental Health Crisis Line (MHCL) and was tearful and upset on the phone. She said she had been struggling with depression for years but was not prescribed any antidepressants as she had tried different ones and "they don't work". She stated she was in an abusive relationship and that her partner still contacted her via text messages which she felt she had to answer, otherwise he would come to her house and "kick off". She stated she wanted to "go away" somewhere to get away from the situation. She had been advised by friends and family to call the police about her partner, but she was worried that if she took out a restraining order on him his family would retaliate. Helen felt trapped in her situation. She reported she had a supportive father and grandmother but had a difficult relationship with her mother who also suffered with depression. She also had debts, but stated these were managed. Helen was able to express her feelings with MHCL practitioner and she was given a series of actions to follow:

- Helen was to contact her GP practice to discuss medication. However, when Helen advised she struggled to make appointments, she was advised to change her GP practice.
- Helen was advised to self-refer for assessment and support to START, Women's Aid and MindsMatter, and was provided with relevant contact details.

[15] Lansoprazole is a prescription drug used to for indigestion, heartburn, acid reflux and gastroesophageal-reflux-disease (GORD) as it reduces the amount of acid the stomach produces. https://www.nhs.uk/medicines/lansoprazole/

Helen said she felt calmer by the end of the call and thanked the MHCL practitioner.

5.48 On the 14th November 2021 Helen contacted MHCL again stating she had arranged for her daughters to stay with family members for a few days to give her a break and she wanted to go into hospital. She was advised that admission to hospital was a last resort and only used when someone was a danger to themselves or others. Helen stated she was a danger to herself and had been hitting herself in the head (that morning) and had superficially cut herself with a knife on her arm about two months previously. Helen was advised that she needed to self-refer to START the next day for an assessment and to MindsMatter for Cognitive Behavioural Therapy (CBT)[16]. Helen accepted the advice.

5.49 Between the 15th November 2021 and the 16th November 2021 and following the telephone consultations described above, Helen took the step to make self-referrals to Hyndburn MindsMatter and START, even following up the START referral with a phone call to ensure it had been received. When she called, Helen was frustrated and tearful, stating she felt she was not getting any help from mental health services. Helen went on to say that she had been struggling with her mental health for several years, characterised by periods of low mood and increased anxiety. Helen's history was reviewed, which described multiple overdoses with low mood and suicidal ideation. However, they also noted that Helen had not attended appointments in June 2019 and February 2020 and so was discharged from services. Helen expressed that she had several stressors in her life such as an abusive relationship with her partner as he used her for money. The practitioner discussed in depth the importance of contacting the police if Dave made threats towards her or was abusive and Helen agreed to do so. She denied any thoughts or plans of self-harm or suicide and felt that she would benefit from CBT. The practitioner agreed to make a referral to MindsMatter for CBT. Helen described how she felt her medication was not working, although she had only recently started taking it (Citalopram 20mg and Diazepam 2mg). Helen confirmed she had good support from her father. The plan from START was for Helen to continue prescribed medication and a referral was made to MindsMatter on the 18th November 2021. Helen confirmed she was aware of the START contact details and was discharged from the service.

5.50 On the 29th November 2021 MindsMatter wrote to Helen asking that she contact the service and opt-in following receipt of the referral. This was followed up with a text message to Helen's phone confirming Mindsmatter had tried to ring her to book a telephone assessment appointment but had been unsuccessful. They advised her to make contact using the details provided. Helen was also reminded that if she failed to make contact by the 13th December 2021, MindsMatter would assume she no longer wished to access the service and her referral would be closed. This was in line with the MindsMatter service operating procedure.

5.51 On the 15th December 2021 a GP telephone consultation was completed with Dave regarding an injury to his testicular area. He reported that he had been 'kneed' in the groin area by a 'girl' one week ago. From triage assessment it was established this was bruising only

[16] Cognitive Behavioural therapy is used to treat anxiety and depression by breaking down overwhelming problems into smaller, more manageable and positive way. NHS: CBT

and Dave was asked to monitor this for any changes and to seek medical intervention if necessary.

5.52 On the 15th December 2021 MindsMatter sent Helen a text message reminding her that she had a telephone appointment on the 17th December 2021 at 1:00pm.

5.53 On the 17th December 2021 Helen undertook the telephone assessment appointment with MindsMatter. Helen reported she was struggling to move on from an abusive relationship of three years. She said that in the past she suffered physical abuse but since ending the relationship it was mainly mental and emotional abuse. Helen noted that police had been involved with the situation, but she did not take this further as she was afraid social services would take her children away. Helen confirmed she was able to contact the police or safeguarding teams should she feel the need but advised she currently felt safe due to support from family and friends. Helen confirmed that Dave had received a suspended sentence and had to pay a fine for an assault against her, but that she had ended up paying the fine for him. She also suggested that a few weeks ago Dave had thrown her phone against the wall and her friend had been present. Helen confirmed she felt ready to talk about her feelings and thoughts. She confirmed she was aware of Hyndburn and Ribble Valley (HARV) domestic violence team and advised she would contact them later that day. Helen denied any plans or intentions of self-harm or any suicidal ideation at the time of the assessment. The practitioner noted that there were no safeguarding concerns for her children and that they were receiving therapy from school. Helen was advised that there was a long waiting list to access CBT, but she confirmed she wanted to be placed on the list. A CBT review call was also discussed with Helen, which was to provide any other support she may require whilst she was waiting to commence CBT.

5.54 During the assessment call, Helen was asked questions from two standard assessment tools relating to her depression and anxiety, and the results of these assessments is as follows:

- Depression Measure PHQ9[17]: (Severity: 0-4 none, 5-9 mild, 10-14 moderate, 15-19 moderately severe, 20-27 severe). Helen measured 27.
- Anxiety Measure GAD7[18]: (Scores of 5, 10, and 15 are taken as the cut-off points for mild, moderate, and severe anxiety, respectively. 21 is max score). Helen measured 21.

It was also noted that Helen did report some thoughts of not wanting to be here but she had no current plans or intent to act on these and a number of protective factors were noted. A letter was sent to Helen's GP following this telephone assessment.

5.55 On the 19th January 2022 information was logged by the High School counsellor as follows:

[17] Patient Health Questionnaire-9, a standardised assessment tool used to screen for and assess the severity of depression.
[18] Generalised Anxiety Disorder-7, a standardised assessment tool used to screen for and assess the severity of anxiety.

> '*Lisa came to see me this morning very upset about the way mum has been speaking to her. She says she is experiencing verbal abuse from mum on a regular basis and that there is an expectation that she does lots of house related tasks for the family. She was thinking of contacting her grandma on dad's side of the family to have a break from the current situation. I have advised her to hold off until I have spoken to the Safeguarding Lead. Lisa encouraged to reach out to Grandma if she wishes. Household tasks discussed with Lisa and seemed reasonable requests for a teenage child'.*

5.56 In March 2022 Helen reported several maintenance and repair issues with her rented property to the Environmental Health Office. Helen's complaint was assessed by the EH team and an officer was allocated to the case. The officer conducted a site visit and inspected the defects, resulting in a letter being written to the landlord, Sharps. The following is an extract from the letter:

> *"Mould over large areas of front bedroom wall which appears to be due to condensation will require the wall to be insulated inside to prevent this reoccurring. Rear exit door from kitchen in disrepair and allowing water ingress and needs replacing and new threshold bar. Water leak from the roof onto the rear bedroom ceiling. Hole in lounge ceiling needs re-plastering. Yard door can't be closed securely. Please ensure the repairs are actioned within the next 14 days to prevent further action."*

Several interactions subsequently took place between the EH officer and the landlord. It is believed the works were eventually completed on or about the 8th April 2022.

5.57 On the 13th April 2022 Lancashire Police were called to Helen's home following a report of a violent domestic incident. When they arrived, officers found Helen and Dave were both present and intoxicated. Helen indicated that Dave was her ex-partner and had been at the address since the previous evening. They were drinking and Dave became aggressive but still stayed with Helen overnight. Helen had asked Dave to leave the following morning, but he refused to do so. Helen and Dave began to argue during which Dave punched Helen to the right side of her face. Helen responded by punching Dave to the face in self-defence. Helen said she has been in an 'on and off' relationship with Dave for around 5 years and had recently been staying away from Dave due to his behaviour. However, she advised she had let him back on the Tuesday night as he wanted to collect his belongings. Helen had then let Dave stay and drink with her, but he became nasty towards her calling her names.

5.58 Dave was arrested at the scene for an offence of section 39 Common Assault (assault by beating). Helen provided a witness statement, and her injuries were photographed. Safeguarding matters were addressed with Helen clarifying that Dave did not have a key to her address and did not live with her. Helen was advised to keep her windows and doors locked and contact police if an approach was made from Dave's family. Helen described that she had been suffering with depression and anxiety, due to which she was off work sick and was awaiting CBT. Helen confirmed she would like support for domestic violence to help her end the relationship and not let Dave back in her life. Helen stated she was not scared or afraid of Dave and that it is a mental problem that she will always give in to him. There appears to be evidence of physical and emotional abuse towards Helen by Dave.

5.59 Officers also spoke to the children present and recorded that they were unaware of Dave's presence in the house overnight. The children reported they had heard shouting and Helen's eldest daughter received a text from her asking that she call the police. The children were collected by a maternal uncle who took them to his address. Helen stated that she would go there once she had completed her witness statement. A Police Safeguarding Report Form (PSRF) was submitted at Medium Risk.

5.60 Dave was released on police bail later the same day with bail conditions aimed at safeguarding Helen and the children.

5.61 On the 22nd April 2022 Helen contacted Lancashire Police and spoke to the investigating officer in relation to the assault on the 13th April 2022. She said she wanted to retract her victim statement. The officer obtained the retraction statement in which Helen stated that she had lied in her original statement and that Dave had accidentally elbowed her in the face whilst they were both intoxicated. Helen advised she no longer wanted to support a prosecution or attend court. Helen denied that she had been influenced by anyone to change her account of the incident.

5.62 The case was reviewed by a Sergeant, who highlighted the following points:

- During interview Dave stated Helen had assaulted him and had a physical injury to corroborate this.
- He denied assaulting Helen and provided an account that reflected her retraction statement.
- There were no independent witnesses to the incident.
- The retraction statement provided by Helen, in which she stated that she lied in interview, seriously affected the credibility of Helen as a witness and the case was undermined.

The reviewing officer concluded that the threshold test for referral to the CPS was not met, therefore an outcome of no further action was recorded. Dave's bail conditions were cancelled.

5.63 A week after the incident on the 22nd April 2022, the police MASH referral was reviewed and passed to Early Help. Early Help called and spoke to Helen who said she was not in the relationship anymore and it was over. She didn't want support around domestic abuse and didn't want support for the children as they were in receipt of support from their schools. Helen was signposted to appropriate services but declined further Early Help support. The manager made the decision not to override consent at that time.

5.64 In early May 2022, Mindsmatter sent Helen a letter and text message explaining that she needed to arrange a telephone consultation or notify them if she wished to remain on the waiting list for CBT. It went on to explain that if Helen did not respond by the 18th May 2022 the service would assume that she no longer wanted to access treatment and would close her referral.

5.65 On the 5th May 2022 Helen completed a threat of homelessness referral via the local housing on-line portal. This was because she had been served with an eviction notice by her landlord. Her case was allocated to an advisor who required documentation that confirmed her situation. A telephone appointment was arranged for the 17th May 2022.

5.66 On the 13th May 2022 Helen attended hospital with an injury to her right middle and ring finger. She explained this had been sustained fighting with Dave some six weeks earlier. Helen had not sought medical attention at the time but was now concerned about a lump on the ring finger. The working diagnosis was that the right middle ring figure was fractured and had also sustained soft tissue damage. Helen was discharged home with a suggested GP follow up. The hospital doctor documented that a safety discussion had taken place, although there was little information recorded as to the content of this within the records.

5.67 On the 17th May 2022 Helen had a telephone consultation with her GP, presumably the follow-up to the hospital attendance above. Helen stated she had low mood and thought she was better off not being here, although stated no active intent to take her own life. Helen said she was still waiting for CBT through Mindsmatter. Citalopram medication was restarted and Helen was advised that she should not stop/start this medication.

5.68 On the 17th May 2022 Helen held a telephone consultation with a housing officer from Hyndburn Borough Council. She confirmed that she had been served a Section 8 Housing Act 1988 notice seeking or requiring possession by Sharp's estate agents in respect of rent arrears to the value of around £3770.00. Helen explained that she felt the notice had been served because she had reported disrepair issues to the council. She also stated she had contacted 'Shelter', a national homeless charity, about the notice for arrears and they said it was pointless to defend the notice. The local authority accepted their homeless prevention duty and Helen was awarded priority banding[19] for her housing register application. Helen was also issued with a 'personal housing plan'.

5.69 In late May 2022, Helen had a further GP appointment complaining of persistent headaches for over for six months. She advised she was not sleeping and reported that her current medication was not helping. Helen was referred for a CT head scan and an x-ray on her cervical spine.

5.70 On the 14th June 2022 MindsMatter sent a letter to Helen's GP stating that due to Helen not responding to previous correspondence, her referral had been closed and they had referred her back to her GP. Three days later MindsMatters closed Helen's referral on their system.

5.71 The following day on the 15th June 2022, Helen had a telephone consultation with her GP during which she stated she felt weak and could barely stand, was dizzy and had no energy.

[19] Priority Banding is used to identify those in the greatest housing need and the register acknowledges that the applicant has an identified housing need and is in a reasonable preference group on the housing register. Reasonable preference simply means that certain groups are given an advantage over other group that have a lesser or no housing need.

Helen requested Gabapentin[20], advising she was already on this, although her GP could not find any records that she was prescribed this. The GP refused to prescribe the Gabapentin and stated Helen needed further blood tests.

5.72 On the 20th June 2022 health records note that Helen had failed to attend two scheduled appointments for her head and neck CT scan.

5.73 In early July 2022 the local council housing officer contacted Helen's landlord, who confirmed that her arrears stood at £4227.59. At that time no possession order had been granted to the landlord. Around this time, a Citizen's Advice Bureau (CAB) worker also contacted the local council housing officer. CAB believed Helen had been served with a section 21 notice[21] and requested a copy of Helen's 'personal housing plan'.

5.74 On the 8th August 2022 the local council housing officer contacted Helen requesting a copy of the possession order. Helen replied with the following email.

> *"Hi Karen, it's Helen from **** street I'm still having no luck finding a house as they all want guarantors and I've got my court date for possession of my house on 5th sept so looks like I'm going to be out on streets before Xmas I'm struggling and really worrying now as I have 3 kids as well."*

5.75 The following week the housing officer contacted Helen and advised her that the section 8[22] notice is not a possession order but a claim for possession, and she does not have to vacate the house on the 5th September 2022. Helen was advised to keep bidding on 'B-with-us'[23] and if she found another property the local council could assist with the rent deposit. Helen confirmed she was actively bidding on the 'B-with-us' housing register.

5.76 On the 19th August 2022 Dave had a telephone consultation with his GP. He presented with low mood, sleep disturbance, poor appetite, anger, and irritability. He disclosed that he had recently split from his partner and was of no fixed abode so was 'sofa surfing'. He was feeling helpless and hopeless but reported no thoughts of self-harm. Anti-anxiety medication was recommenced. Dave also agreed to being sent details to self-refer for counselling. The notes from this appointment suggest a deterioration in Dave's physical and mental health.

5.77 On the 22nd August 2022 Helen had a telephone consultation with her GP. Helen complained of being tired all the time, aching all over, having no energy, struggling to sleep, and feeling depressed with a constant headache. She stated she was now unemployed,

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[20] Gabapentin is a controlled drug that is used in the management of neuropathic pain, epilepsy and less commonly anxiety.

[21] A section 21 notice is a notice under section 21 of the Housing Act 1988, that a landlord must give to their tenant to begin the process to take possession of a property let on an assured shorthold tenancy. The expiry of a section 21 notice does not bring a tenancy to its end. The tenancy would only be ended by a landlord obtaining an order for possession from a court, and then having that order executed by a County Court Bailiff.

[22] Section 8 refers to Section 8 of the Housing Act 1988, under which landlords can evict tenants if the tenancy agreement has been broken or they want to change the use of the property.

[23] B-with-Us is a home renting service partnership between local councils and social landlords within the Pennine. https://www.b-with-us.com/

smoking 20 cigarettes a day, that she had 3 children and was a single mum. She also reported constant abdominal pain and diarrhoea. The GP stated further blood tests were required.

5.78 At 11.21am on the 30th August 2022 Lancashire Police were informed by the North West Ambulance Service (NWAS) of a hanging at Helen's home address. Helen had been discovered hanging from a light fitting in the living room of the house. Dave and her mother were also at the address and Helen's daughters were also present. Helen's son was not at home at this time.

5.79 As a result of Helen's death, her eldest daughter received counselling sessions from a counsellor at her school. The below is an extract of notes made by the counsellor:

> *'We explored information around her mother's boyfriend that has now been handed to the police by head of 6th form [Helen's son's letter], explain that Lisa mother's boyfriend had been verbally and physically abusive towards her mother, we explored what it was like to have to witness this. Lisa explained the relationship that she had with her mother did not always feel stable and when she thinks about her mum, she likes to think in terms of the version of her that existed before she had met her boyfriend, and the abuse began.*
>
> *Lisa explained that she has been feeling very angry towards her mother's ex-boyfriend for the way he acted towards her mother and how this feeling of anger stays with her all the time. She wrote a metaphorical letter in the session today to him with the intention to destroy and never send (then we could rip the letter up) to realise some anger.*
>
> *Lisa spoke about how she remembers a lot of the abuse her mum's boyfriend would display; she says that she did not see him hitting her however she could hear this happening. She explains that she did see him hitting and breaking the things around him such as windows and doors to try and get back into the house when mum had kicked him out. She explains how she is afraid of loud noises and puts it down to this'.*

5.80 In September 2022 staff from the sixth form at Helen's son's school met with him at his uncle's home address. The below is an extract of notes made following the meeting.

> *'Met with Tom yesterday at his uncle's house. Tom was as polite and thoughtful as ever; he was focused on his mother's funeral which is taking place today. Having spoken with both Tom and his uncle we were able to gain some understanding of the desperately sad and impossibly difficult nature of his life prior to his mother's death and the complex and distressing choices he is now faced with regarding his ongoing education and where he will live. He feels unsafe in this area due to the presence of his deceased mother's abusive boyfriend (abusive to his deceased mother). Tom is particularly concerned about his two younger sisters and where and with whom they will live. Tom's uncle thinks that there are child protection issues involved. It seems that the family is*

in danger of being split up. A staff member has offered to contact social services on the children's behalf.

Tom was encouraged by his uncle to write down his feelings following his mother's death. The allegations of abuse experienced were shared with school by the uncle. Director of Sixth Form reported this to the police and transferred the writing following discussion with Safeguarding Lead'.

6.0 Analysis

6.1 This section of the report will consider the individual terms of reference. It will examine how and why events occurred, information that was shared, the decisions that were made, and the actions that were taken or not taken. It will also reflect on whether different decisions or actions may have led to a different course of events. It will also highlight any examples of good practice.

Terms of Reference 1: To establish the circumstances surrounding the suicide and how experiences of domestic abuse contributed to this.

6.2 On the 13th January 2023 a coronial inquest was held at the local Town Hall to establish the circumstances surrounding the death of Helen. The inquest considered the specific detail of who the deceased was, where when and how Helen died and the medical cause of death. This is the primary purpose of a coronial inquest. The Coroner cannot, in law, deal with any other matters. The following account formed part of the inquest.

6.3 On the evening of 29th August 2022, Helen was in the town centre drinking with her mother Jean. Whilst out they met up with a friend of Helen's and Helen's on-off partner Dave. Approximately 11:30pm they all returned to Helen's home where they continued drinking. During the evening Helen's friend left the house and the others went to bed. Helen and Dave slept in Helen's son's room as he was away studying. Jean slept in Helen's room which is on the ground floor of the house. Also in the house were Helen's daughters, Lisa (14yrs) and Megan (10yrs).

6.4 Approximately 5:00am the following morning Helen has awoken and got up. However, there was a problem with the bedroom door as it sticks and needs to be opened from the outside. Lisa hears the knocking and let Helen out. Helen has used the toilet and goes downstairs.

6.5 Approximately 5:30am Helen is known to have sent text messages asking to borrow some money. The response to these requests is not known.

6.6 Approximately 11:00am Jean woke up and found Helen hanging from the light fitting in the living room. Helen was hanging by a belt taken from a coat on the settee. Jean shouted for help from Dave and attempted to lift Helen, but due to her weight she could not lift her.

As a result, Jean got a pair of scissors and eventually released the belt from Helen's neck. Dave and Jean begun CPR and Jean shouted for Lisa to call for an ambulance. The ambulance arrived at 11:17am and confirmed Helen's death at 11:20am.

6.7 The initial account provided by family members indicated Helen had been diagnosed with anxiety and depression. She had been prescribed medication but did not take it as it made her feel sick. Her mother Jean stated that she knew her daughter took drugs but did not know how regularly. Immediately following her death, a small bag of white powder residue was found in Helen's bag. Family members believed that this bag had contained cocaine. The residue was not analysed as part of the coronial investigation as it was deemed not necessary by the investigating officers.

6.8 The inquest concluded that Helen's cause of death was suicide by hanging.

6.9 Whilst the inquest dealt with where, when, and how Helen died, this section of the report will also consider why and how domestic abuse potentially contributed to Helen's death.

6.10 Many family members and friends of Helen have been spoken to as part of the review. A number of them provided written accounts that gave a good insight into Helen's life both before and after her relationship with Dave commenced.

6.11 Helen's mum Jean described her daughter changing from a happy social butterfly who loved her children, loved going out with friends and was always laughing and smiling. Jean described her daughter as someone who would light up a room as soon as she entered. Jean then described how her daughter subsequently went downhill with growing debts and had no interest in life and would not get out of bed some days. She describes how Helen had fallen into significant debt and was in the process of being evicted from her home. Jean indicated that this had a profound impact on her daughter's mental health and that she clearly struggled after years of financial stress and domestic abuse from Dave.

6.12 Debbie was a lifelong friend of Helen, and she also provided a written account for the information and attention of the review. She outlined how she had known Helen all her life and described how she grew up to become a vibrant young lady. Debbie indicated that she and Helen became strong friends and outlined how Helen occasionally smoked cannabis and drank alcohol on a social basis.

6.13 Debbie stated that Helen met Dave in 2017 whilst out socialising in the town centre. She indicated that she took an instant dislike to him when they first met, and he stormed out of Helen's house after an argument developed. Debbie subsequently discovered that Dave had returned after she left and assaulted Helen. Debbie warned Helen that it would happen again, but Helen was dismissive of this and played the incident down.

6.14 Debbie provided the review with further information regarding Helen's relationship with Dave and her deterioration over time. This is documented in paragraphs 4.28 – 4.37, so will not be repeated in detail here.

6.17 A short time after his mum's suicide, Tom, Helen's son, recorded his thoughts in writing as part of his bereavement process. He subsequently indicated that he was happy for these observations to form part of his contribution to the DHR process. The whole of Tom's writings are already outlined previously in the report, however, some excerpts are also outlined in subsequent paragraphs. They describe his mum Helen's spiralling physical and mental health and the domestic abuse she regularly suffered at the hands of Dave.

6.18 Tom initially indicated that despite what he had recorded in writing, he loves his mum dearly and will forever miss her. He stated that his greatest regret was that he could not help her so that she felt strong and brave enough to outline these events herself.

6.19 Tom outlined that the police were involved with the family following domestic abuse incidents on numerous occasions and that legal action could have been taken against Dave. However, his mum always dropped the charges and Dave got away with his actions.

6.20 Tom initially outlined the events between 2017 and 2019. He described his mum as being in a downward spiral and that after starting a relationship with Dave she slowly slid into depression and alcoholism. He indicated that his mum suffered constant mental and physical abuse from Dave. He also described the neglect that he and his sisters suffered and described it as 'endless crushing despair'.

6.21 Tom suggested that his mum could not fully leave Dave due to 'textbook domestic abuse reasons'. He outlined an occasion where he read texts on his mum's phone where Dave was threatening to kill himself. He described this as classic manipulation of his mum as she feared Dave would harm himself and could not therefore leave him. He suggested that Dave lowered his mum's confidence and self-esteem and as a result she became dependent on him. He stated that his mum could not escape the abusive relationship because she lacked support, was isolated and feared losing her children if she spoke out. He indicated that his mum tried to end the relationship on many occasions, but she feared Dave as he repeatedly threatened to call social services and have her children removed from her care. He indicated that his mum had no choice but to let Dave stay.

6.22 Tom described the time when Dave eventually moved into their home. He indicated that his mum suffered extreme psychological and physical abuse from Dave. He goes on to describe that more money was spent on alcohol and drugs than food and that he and his sisters were left with barely enough food. Tom stated his mum was manipulated by Dave and that she became a shadow of her former self. Dave would constantly say degrading comments and refer to his mum as a 'worthless bitch'. Tom stated that these constant comments took away his mum's confidence and that Dave was only ever nice to his mum after he had just beaten her up. Dave would shower her with compliments and would apologise for the abuse on these occasions.

6.23 Tom outlined that his mum was assaulted by Dave on the evening that Dave had first met Auntie Debbie. He described intervening when he could hear Dave striking his mum. He goes on to describe Dave saying sorry and that it would not happen again and that his mum eventually forgave him and let him stay.

6.24 Tom described 2020 as a year where he lived with relatives for lengthy periods. He outlines that he had tried to get his mum to throw Dave out of the family home, but he was accused of behaving like a 'bratty teen' and removed from the house by Dave and other extended family members. He indicated that nobody believed what he was saying and that he subsequently began living with his uncle Geoff and uncle Paul. Tom indicated that this continued through 'lockdown' during which time his relationship with his grandma Jean deteriorated significantly and he eventually returned home. Tom indicated that during this period extended family members, and his grandma in particular, refused to believe his mum was being subjected to domestic abuse and accused him of being a liar and troublemaker.

6.25 Tom goes on to describe numerous incidents of domestic abuse involving his mum and Dave throughout 2021 and 2022. These were often in the presence of the children in the house and ranged from verbal threats to coercive and controlling behaviour to physical violence. Tom goes on to outline that Dave would occasionally move out of their home but would always return despite Tom expressing his concerns to his mum. He described how on occasions some family members and close family friends would turn up at his home and would remove Dave from the house. Tom indicated that throughout this period his mum would regularly deceive people regarding the abuse she was suffering and would ask him not to make disclosures about what was happening in the house. He also outlined that the police attended his home on a number of occasions, but nothing ever came from this and the physical and psychological abuse of his mum continued.

6.26 Tom highlighted incidents of domestic abuse in 2022 in the months preceding his mum taking her own life. He also described his mum consuming significant amounts of alcohol, and on one occasion, finding 3 empty bottles of vodka on the floor next to her bed. He also outlined an occasion where his mum was arguing on the phone with his grandma and becoming upset. He spoke with his mum, and she indicated that it was all too much and that no one was helping. Tom indicated that this became a common occurrence in his home and that his mum would be tearful and crying at least 4 or 5 times a month. On one occasion Tom and his sister Lisa were woken in the middle of the night by their mum screaming for help. Tom telephoned for an ambulance as his mum had taken too many sleeping tablets and was being sick. Helen subsequently spoke with the emergency services and advised them she would be ok and the call is concluded.

6.27 Tom outlined an incident of domestic abuse on the 16th April 2022. He indicated that he was not home at the time, but his sister Lisa had taken a video of the incident. During the disturbance Lisa had received a text from her mum asking her to ring the police. Tom indicated that the police arrived and 'sorted the incident'. A relative later removed the children from the house and looked after them for a period.

6.28 On the 26th August 2022 Tom was contacted by his sister Lisa who advised that Dave was present at their home. Tom shared this information with his uncle Paul but they felt that they could not act as they had no video proof of Dave's presence and that people would not believe them. Lisa reported that Dave remained at the house on subsequent days, up to and including the day her mum took her own life on the 30th August 2022.

6.29 The accounts offered by Tom, Debbie and Jean offer an informative insight into the physical and psychological abuse that Helen suffered during her 5-year relationship with Dave. Sadly, much of this abuse went unreported and only a handful of incidents were ever reported to Lancashire Police. The five reported incidents are detailed in section 5 of the review

6.30 Whilst it should be obvious that Helen had been a victim of domestic abuse throughout her relationship with Dave, it is worth considering the official definition of domestic abuse as outlined by the UK government.

6.31 The UK government define domestic violence as;

> 'Any incident or pattern of incidents of controlling, coercive, threatening behaviour, violence or abuse between those aged 16 or over who are, or have been, intimate partners or family members regardless of gender or sexuality. The abuse can encompass, but is not limited to the following types of abuse: psychological, physical, sexual, financial, emotional.'[24]

6.32 The panel have considered the information supplied as part of the review and are fully satisfied that Helen suffered the following types of domestic abuse during her relationship with Dave:

- Psychological
- Physical
- Financial
- Emotional

The information provided to the panel at the time of writing does not outline any sexual abuse suffered by Helen during her relationship with Dave.

6.33 The panel have also considered the offence of controlling or coercive behaviour in intimate or familial relationships (section 76 of The Serious Crime Act 2015). It is important to consider the specifics of this offence in greater detail.

6.34 The Crown Prosecution Service's policy guidance [25] on coercive control states:

> 'Building on examples within the statutory guidance, relevant behaviour of the perpetrator can include:
>
> - Isolating a person from their friends and family
> - Depriving them of their basic needs
> - Monitoring their time
> - Monitoring a person via online communication tools or using spyware

[24] https://www.gov.uk/government/publications/new-government-domestic-violence-and-abuse-definition/circular-0032013-new-government-domestic-violence-and-abuse-definition
[25] Policy guidance https://www.cps.gov.uk/legal-guidance/controlling-or-coercive-behaviour-intimate-or-family-relationship

- Taking control over aspects of their everyday life, such as where they can go, who they can see, what to wear and when they can sleep
- Depriving them access to support services, such as specialist support or medical services
- Repeatedly putting them down such as telling them they are worthless
- Enforcing rules and activity which humiliate, degrade or dehumanise the victim
- Forcing the victim to take part in criminal activity such as shoplifting, neglect or abuse of children to encourage self-blame and prevent disclosure to authorities
- Financial abuse including control of finances, such as only allowing a person a punitive allowance
- Control ability to go to school or place of study
- Taking wages, benefits or allowances
- Threats to hurt or kill
- Threats to harm a child
- Threats to reveal or publish private information (for example, threatening to 'out' someone)
- Threats to hurt or physically harming a family pet
- Assault
- Criminal damage (such as destruction of household goods)
- Preventing a person from having access to transport or from working
- Preventing a person from being able to attend school, college or university
- Family 'dishonour'
- Reputational damage
- Disclosure of sexual orientation
- Disclosure of HIV status or other medical condition without consent
- Limiting access to family, friends and finances

This is not an exhaustive list and prosecutors should be aware that a perpetrator will often tailor the conduct to the victim, and that this conduct can vary to a high degree from one person to the next'.

6.35 The panel have considered this guidance and are fully satisfied that there was evidence of numerous elements of controlling and coercive behaviour from Dave throughout his 5-year relationship with Helen.

6.36 The review has not ascertained any significant mental health interventions for Helen prior to her starting the relationship with Dave. Information obtained does indicate that Helen's GP made a referral to primary care psychological services in 2010 but there is no evidence that any treatment was commenced. However, this changed after Helen started a relationship with Dave and it is clear she began to seek help from professionals on a number of occasions during the course of the relationship.

6.37 On the 24th June 2019 Helen visited her doctor and disclosed cutting her wrists and taking an overdose of tablets. Helen also indicated that this incident of self-harm was triggered by an argument with her ex-partner and went on to list a history of physical and mental abuse by

Dave. Helen suggested that she could not be bothered to live anymore and was experiencing ongoing suicidal ideation.

6.38 On the 3rd February 2020 Helen returned to her doctor and indicated that she had taken an overdose of tablets a number of days earlier and needed help. An urgent referral was made to mental health services and this referral outlined a history of domestic abuse.

6.39 On the 31st August 2020 a report was received by Helen's doctors via 111. This indicated that Helen had taken an overdose a week earlier and that her partner had to commence cardiopulmonary resuscitation (CPR). Later that day an ambulance was dispatched, and Helen was subsequently transferred to hospital. Helen again outlined that she had taken an overdose of sleeping tablets and had become unresponsive. Helen outlined Dave's actions and complained that she has suffered with chest pain since this time.

6.40 On the 14th November 2021 Helen sought help from mental health services, indicating that she had made arrangements for her daughters to stay with a relative and that she wanted to be admitted to hospital. Helen indicated that she was a danger to herself and had been hitting herself and had previously self-harmed with a knife. Helen was advised to self-refer to START[26] to enable an assessment to be made. On the 16th November 2021 Helen spoke with START. Helen was tearful and suggested that she was not getting any help from mental health services. Helen also outlined an abusive relationship with her partner and stated that he was using her for money.

6.41 On the 9th December 2021 Helen contacted HARV[27] via e-mail and outlined the following:

> '*Hi I was wondering if possible I could get some help with therapy or something as I've come out of a domestic physical first then ended mental but I just need help of letting go properly as my head can't and it's effected me a lot thanks*'

6.42 It is clear that Helen's mental health was declining at this time and she was reaching out for help on a more frequent basis. Helen also regularly outlined the domestic abuse she was suffering at the hands of Dave during her interactions with health professionals.

6.43 The National Suicide Prevention Alliance (NSPA)[28] outlines the results of collaborative research in 2018 between Refuge[29] and the University of Warwick involving more than 3500 Refuge clients. It provides detailed and substantial evidence on the prevalence of suicidal ideation and attempts amongst domestically abused people in the UK. It supports existing research in suggesting a significant association between experiencing domestic abuse and suffering negative psychological effects.

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[26] Specialist Triage Assessment and Referral Teams (START) is an NHS service that aims to provide mental health, learning disability, autism and community based services for Lancashire. https://www.lscft.nhs.uk/

[27] Hyndburn and Ribble Valley Domestic Abuse Team (HARV) is an organisation which aims to identify, support and protect adults and children from abuse, exploitation and violence. https://www.harvoutreach.org.uk/

[28] National Suicide Prevention Alliance (NSPA) is an alliance of public, private and voluntary organisations who aim to prevent and reduce suicide and self-harm, and to support those bereaved or affected by suicide. https://nspa.org.uk/

[29] Refuge is a charity which aims to help women and their children fleeing from an abuser. https://refuge.org.uk/

6.44 In a more recent study in 2023[30], experts at the University of Birmingham have identified suicide risk factors in people suffering from domestic abuse. The warning signs identified include the following:

- The experience of life-threatening abuse, sexual assault, coercion and control, and multiple or repeated abuses
- Feelings of despair and hopelessness relating to abuse
- Self-identity issues such as experiences of disrupted relationships, or childhood trauma
- Coping strategies such as self-harm, drug or alcohol abuse

6.45 When the panel have considered this information, it is clear there are significant overlaps between the risk factors and the life of Helen during her abusive relationship with Dave. The panel have considered the compelling accounts from Tom and Debbie and the data provided by the Lancashire Police and other agencies. This data outlines the numerous incidents of domestic abuse and the spiralling mental health of Helen. The panel have no doubt that the significant and sustained domestic abuse suffered by Helen over a 5-year period was a major contributing factor in her taking her own life.

Terms of Reference 2: To consider the impact of long-term domestic abuse on the wider family, particularly the children of the victim in this case.

6.46 The information provided to the panel indicates that incidents of domestic abuse were taking place on a frequent basis at the home of Helen and her three children over a 5-year period. Helen was clearly the victim of these incidents and experienced regularly physical and psychological abuse from the perpetrator Dave. Sadly, this was often in the presence of her children, and it is clear this had, and continues to have, a significant impact on them.

6.47 It is widely known that domestic abuse has a devastating impact on victims. It is also important to recognise that since the enactment of the Domestic Abuse Act 2021[31], children that have been exposed to domestic abuse are also classed as victims in their own right.

6.48 Barnardo's[32] indicate that children who are exposed to domestic abuse are at risk of serious harm to both their emotional and physical health. It suggests that children who witness domestic abuse are at risk of both short and long-term physical and mental health problems. It goes on to state that every child will be affected differently by the trauma of domestic abuse.

6.49 It is important to address this term of reference by considering the thoughts and views of Helen's children who had to endure the domestic abuse for a 5-year period. Sadly, only Tom

[30] University of Birmingham Research document - https://www.birmingham.ac.uk/research/crime-justice-policing/projects/the-relationship-between-domestic-abuse-and-links-to-suicide
[31] Section 3 Domestic Abuse Act 2021, which came into force on 31 January 2022 - https://www.legislation.gov.uk/ukpga/2021/17/section/3
[32] Barnardo's is a charity that aims to protect and support children and young people in the UK https://www.barnardos.org.uk/

has made a specific contribution to the review albeit Lisa has made some disclosures to professionals working within education which have also been considered.

6.50 The detailed account from Tom has been referred to throughout this report. Whilst it will not be repeated again, I do believe that some excerpts are highly relevant to this specific term of reference. They give a clear indication of what it was like for Tom and his sisters living in their home during this period. A number of Tom's comments are outlined below:

- *'These years are highlighted with witnessing mental and physical abuse my mum had to endure from Dave constantly, neglect me and my sisters faced and nothing but an endless crushing despair of a house'.*
- *'They would often spend £20 on alcohol and £10 on food, this left me and my sisters with barely enough food so they could drink heavily'.*
- *'My mum would barely get out of bed unless it meant going out to drink, leaving me and my sisters to care for ourselves'.*
- *'Dave is screaming at my mum and my mum is just whimpering and crying begging him to stop. I remember standing at the top of the landing listening to my mum beg. I was only 13 or 14 and had never felt so helpless in my life.'*
- *'That night Dave ordered 4 takeaways. We had no money to buy food the next day'.*
- *'I underwent mental torment throughout this year and was manipulated into believing that Dave had done nothing wrong and that I was worse than him. A stigma was created against me for telling the truth, just because I was young'.*
- *'During the main part of lockdown I ended up living with Uncle Paul and Uncle Geoff as once again we found Dave at the house and Uncle Paul took me away from the situation'.*
- *'During this time I felt isolated in my own head. It felt that nothing I did was ever right and that I was in the wrong for trying to keep Dave out of the house. My spirit was broken'*.
- *'While at a relative's house I get a call from my mum, she sounds scared and tells me that Dave has come back and asks me to call the police. I can hear Megan crying in the background and Dave shouting. My mum tells me that Dave has smashed Megan's breakfast bowl in front of her'.*
- *'He begins to square up to me but my mum steps in and tells Dave to go and also tells me to call Uncle Paul to pick me up because she doesn't want me anymore'.*
- *'I ended up in hospital due to bell's palsy. It is delusional to think my school work is the reason I was under intense stress, as school was my only escape from everything. For 6 hours a day I got to pretend I've got a normal life and no one knows about what goes on at home. Most bell's palsy cases are caused by extreme stress. To this day my face slumping stills comes back when I'm stressed out. This is something I will have to live with my whole life'.*
- *'I come down to my mum in tears. I give her a hug and ask her what's up. She says it's all too much and no one is helping. I tell her I'm here to help and she has lots of support. Mornings like this were common in the house'.*
- *'I wake up in the morning and hear my mum puking. Me and Lisa come downstairs to help her. At first I'm concerned but then I noticed three empty bottles of vodka on the floor next to her bed. She had just drank too much'.*

- *'In the middle of the night me and Lisa wake up to my mum screaming for help. I notice she is being sick into a pan and grab my phone to call the emergency services. My mum is feeling a little bit better at this point and says she just panicked and explained that she took too many of her sleeping tablets'.*

6.51 On the morning of Helen's suicide, both Lisa and Megan were present in the family home. Whilst it is not clear what Megan witnessed at this time, we know that Lisa was present when her mum was found in the living room and as Dave and Jean attempted to perform CPR. We also know that Lisa made the 999 call and was extremely distressed as she spoke with the operator. The overall impact that this incident has had on Lisa is not fully known at this time. It is clear she was distraught at the time of her mum's suicide and was exposed to significant domestic abuse for the preceding 5 years. Lisa is currently receiving support from appropriately trained staff at her high school.

6.52 The information obtained during this review indicates that Lisa continues to meet with the high school counsellor since her mother's death. During these meetings Lisa has outlined that her mother's boyfriend had been verbally and physically abusive to her mum. Lisa was asked about what it was like to witness this and was encouraged to write down her feelings in a letter. Lisa has suggested that the relationship with her mum did not always feel stable and that she preferred to think of her before she had met her boyfriend, and the abuse began. Lisa had explained that she feels very angry towards Dave for the way he treated her mum and that this feeling of anger stays with her all the time. Lisa explained that whilst she did not always see Dave hitting her mum, she could hear it happening. She also outlined that she did see Dave hitting and breaking things around the house on some occasions. This was normally windows and doors when her mum had thrown Dave out of the house, and he was trying to get back in. Lisa stated that she now has a fear of loud noises and attributes this to the abuse that she has been exposed to.

6.53 The impact that 5-years of domestic abuse has had on the children of Helen should be obvious to anyone reading this review. Both Tom and Lisa have articulated this to professionals and have recorded their views and feelings in writing. This is not as clear for Megan as a result of her young age and her additional support needs. It is also evident that the domestic abuse and subsequent suicide of Helen has had a massive impact on other family members and close friends. The panel have no doubt that the impact of the domestic abuse suffered by Helen and the children has been substantial. It is also clear that the wider family and close friends of Helen have been impacted and are struggling with the loss of a much-loved friend and family member.

Terms of Reference 3: To establish whether the concerns and responses by professionals and their organisations were appropriate both historically and, in the time, leading up to the suicide.

6.54 It is clear from the information provided during this review that Helen and Dave had significant contact with various agencies during their 5-year relationship. It is also evident that the three children also had contact with various professionals on occasions during this timeframe. This section of the report seeks to consider these points of contact to establish if responses and interventions were appropriate. The section will focus primarily on the

reported incidents of domestic abuse and interactions with health professionals. Other agency contact will be summarised where appropriate.

6.55 On the 15th July 2018 Police Officers attended a report of a domestic violence incident at the home address of Helen. On this occasion Dave had physically attacked Helen and had thrown her around the bedroom by her hair and had strangled her. Helen sustained bruises to her arm and neck. Specific details of police response and action are detailed at paragraphs 5.3 – 5.8.

6.56 This is an example of good but expected practice from the officers involved. They arrived promptly and immediately sought to arrest Dave. They also commenced an effective and prompt investigation and shared information appropriately. It is clear that Helen and the children were safeguarded, and positive action was taken in seeking the early arrest of Dave. He quickly appeared before the court and received an appropriate disposal.

6.57 At this time the Probation Officer who prepared the pre-sentence report relating to Dave recommended the completion of a Domestic Abuse Safer Relationships Programme. This was a short, non-accredited programme suitable for domestic abuse perpetrators. There is no evidence to indicate that this was considered by the Magistrates nor included as part of their disposal of the case. There is also no evidence that Dave completed this course.

6.58 On the 16th July 2018 the PVP referral was received in CSC. The contact record suggested that this was the first reported domestic incident and that Helen was working with police and IDVA, albeit the matter had only been referred to the IDVA service at that point. It continued suggesting that Helen had stated the relationship had ended, and should she remain separated it is likely that domestic abuse will not reoccur. The contact record indicated that the children's history was used to inform decision making and that Helen had been spoken to. Partner information was also gathered and the 'risk sensible model' (used to assess risk) was utilised with a clear analysis being recorded. The children were not spoken to on this occasion and all information was obtained during a telephone conversation with Helen. CSC have indicated that expectations were met.

6.59 On the 18th July 2018 the IDVA service contacted Helen who indicated this was a 'one off' incident and that she had plenty of friends and family for support. Helen advised the IDVA service that no help was required at this time. The following day the IDVA service made a further call and again Helen declined support. Helen was provided with relevant contact details for future reference and the case was closed.

6.60 Although it is evident that this matter was referred to MARAC for consideration. No minutes or details of any actions arising from the MARAC could initially be located and it was therefore not possible to identify if any additional safeguarding measures for Helen and/or the children were identified. After extensive enquiries a digital audio recording of the MARAC was located but this was of limited use due to the poor quality of the recording and the fact that no introductions were made at the start of the MARAC. The very scant details of this recording will be outlined later in the report.

6.61 On the 9th August 2018 and following conviction, Probation allocated Dave's case to Cumbria and Lancashire Community Rehabilitation Company (CLCRC). Dave was assessed as posing a medium risk of harm and the matter was flagged as a domestic abuse case. On the 20th August 2018 Dave attended his initial appointment. The CLCRC record indicates this meeting focussed on employment and that various referrals relating to education, training and employment (ETE) were discussed. This theme continued throughout the meetings with CLCRC, with ETE and 'thinking skills' being the primary topics of discussion. When considering the 25 recorded meetings with CLCRC it appears that only a limited number of them have domestic abuse recorded as a topic of conversation.

6.62 During a meeting with CLCRC on the 8th November 2018 a discussion took place regarding Christmas. Dave indicated how 'they' were organised and also the budget available for Christmas presents. This infers that Dave may have been back with Helen and having contact with the children. 'They' does not appear to have been explored further. It is clear that a home visit should have been conducted in these circumstances and it is clear that there are no records of any home visits during the course of Dave's supervision order. Upon confirming that Dave and Helen were back together, a referral should also have been made to CSC.

6.63 On the 28th November 2018 CLCRC sent a domestic abuse disclosure check to Lancashire Police. Whilst this is good practice it should have been done much earlier due to the nature of the offence. On the 12th December 2018 Dave indicated that he and Helen had already bought the children's Christmas presents so were not under financial pressure at that time. Nothing in the CLCRC records indicate if a discussion had taken place regarding his relationship with Helen. Such a discussion eventually took place on the 20th December 2018, when a conversation took place regarding managing stress, anxiety or anger over the festive period. It should have been clear at this point that Dave was back in a relationship with Helen and he was clearly having contact with the children. There is no evidence or records to indicate that this information was shared with other agencies.

6.64 During the meeting with CLCRC on the 26th February 2019 Dave indicated he should be living with his grandmother and not having contact with the children. The CLCRC records suggest that Dave appeared to be spending the majority of his time with Helen and her address was requested as well as the details of the children. Later that same day a safeguarding check was submitted to the local authority. It is positive that this request was made but disappointing that no record exists of it being answered or followed up or any home visit being conducted. A 'referral' to CSC could have been made in these circumstances rather than just a safeguarding 'check'.

6.65 On the 31st May 2019 Dave attended his appointment with CLCRC with a heavily bandaged hand and indicated he had cut himself with a knife whilst cooking. Dave continued to outline a caring and supportive relationship with Helen throughout his appointments with CLCRC. There are no records to suggest that this relationship was explored further. A home visit to meet with Helen and/or the children may have provided more accurate information and this information could have been shared with other relevant agencies. CLCRC's dealings with Dave were superficial at times and lacked an element of professional curiosity.

6.66 A further incident of domestic assault at Helen's home took place on 31st August 2019. During the early hours of the morning Dave had been arguing with Helen before throwing her to the floor and rendering her unconscious. This was done in the presence of her son Tom. During the incident Dave had also smashed an internal window and had drawn a piece of the broken glass across his throat. Again, Police Officers deployed appropriately as a grade 1 response but again Dave had already fled the property by the time they arrived. Helen disclosed to officers that she may have been pregnant at this time. The officers subsequently raised a high-risk DA with the MASH and overrode the requirement for Helen's consent to share the information with appropriate support agencies. This was the correct course of action. Unfortunately, a supervisor within the MASH re-categorised the referral as medium risk, despite the fact that this was the second serious domestic abuse incident in just over 12 months, the offence had been committed in front of the children, the victim had been rendered unconscious and she may have been pregnant. The supervisor did however raise a high-risk VC to share with EDT. The case was not referred to MARAC due to it having been lowered to medium risk. The report was stepped up to CSC and shared with Health and Education services.

6.67 Dave was quickly arrested later that same morning and subsequently released on police bail for further investigations to be carried out. Bail conditions were imposed to safeguard Helen and the children. Helen subsequently retracted her complaint on the 30th October 2019 stating she did not wish to attend court and that the incident was just a drunken argument. The case failed CPS triage as a result of the retraction statement and no further action was taken against Dave. During the two months between commission of offence and retraction, there is no information to indicate that the investigating officer endeavoured to pursue or considered an evidence led prosecution without the support of Helen.

6.68 This referral is recorded at CSC on the 3rd September 2019. The records indicate it was referred to Early Help but that Helen did not consent to their involvement. It also highlighted that Helen was spoken to and had suggested that both her and Dave were at fault. Helen also suggested that a restraining order and bail conditions were in place to prevent Dave contacting her. This was not accurate however, as no restraining order existed. Helen had also commented that it would never happen again. Despite this, she was provided with details of Lancashire Victim Support to access support around domestic abuse as well as details of Children and Family Wellbeing Service (CFWS) who could work with Helen and the children. The children were not spoken to at this time as Helen had not given consent for further action to be taken. Consideration could have been given to overriding Helen's consent, but those dealing felt that the threshold for significant harm was not met and Helen was also indicating that she would seek support if it was required. It is interesting to note that since 2019 MASH has employed a 'participation officer' who would be responsible for consulting with children in circumstances such as those described.

6.69 The referral is also recorded on the school nursing/HCRG Care Group electronic health system for clinical records (EMIS) on the 5th September 2019. Although there is evidence to suggest this had been viewed and documented by a practitioner, there is no evidence of analysis or consideration of previous domestic violence and abuse concerns. Consideration should have been given to seeing Tom, particularly as he witnessed the incident and had previously reported witnessing domestic abuse on his school health needs assessment.

6.70 During the early hours of the 31st December 2020, the police attended a report of a disturbance in the town centre. On arrival Helen was spoken to and she indicated that she has had a verbal argument with Dave who had since left the scene. Helen was described as drunk and made no allegations against Dave. Dave was located a few streets away and was conveyed to his parents' home address to remove him from the scene and safeguard Helen. This was an appropriate course of action at this time. The officers subsequently shared a standard safeguarding report with the MASH.

6.71 On the 1st May 2021 a further domestic incident took place at Helen's home address. On this occasion Dave had thrown an ashtray at Helen and it had struck her on the head causing a lump and bruising. Dave had taken hold of Helen causing Tom to intervene, and Tom had told Dave to release his mum. Dave had then taken Helen's bank card and left the address. Officers attend promptly and statements were taken from Helen and Tom. Dave was quickly arrested and later released on police bail with conditions aimed at safeguarding Helen and the children, and to allow a file of evidence to be presented to the CPS.

6.72 This file of evidence was subsequently reviewed by a Sergeant. The case was not submitted to the CPS as the Sergeant concluded that the evidence obtained as part of the investigation by the officers was 'poorly gathered,' and the content of the witness statements obtained from Helen and her son were 'evidentially poor'. The supervisor's assessment of the standard of the evidence was correct. There was clearly a lack of professional curiosity from the investigating officers which had led to insufficient details being contained within the statements from Helen and her son. Helen later stated that she wished to retract her statement as she did not wish to go through the court process due to her mental health. Helen informed the officers that she was happy for her son to continue to support the investigation which he later declined to do.

6.72 The Sergeant indicated that he considered an evidence led prosecution but concluded that 'such an action could make Helen hostile and she could lose trust in the police resulting in her not reporting further incidents'. The officer could have explored this further and recorded Helen's rationale for her not continuing her support for the prosecution. There was insufficient evidence to pursue an evidence led prosecution owing to the poor standard of evidence gathered, however, the reason given for not pursuing such a prosecution in terms of the victim's future response to reporting domestic abuse may be considered flawed. An option for the Sergeant could have been for further additional statements to be obtained. Indeed, the case was only authorised as NFA (no further action) by an Inspector some months later on the 13th September 2021. This is almost 18 weeks after the offence was committed and clearly sufficient time to conduct a thorough investigation and build an evidence led prosecution, regardless of the lack of support from Helen and Tom. The way this incident was investigated illustrates a potential training need for the officers concerned, but there is no record of what, if any action was taken to address the poor performance of the investigating officers.

6.73 On the 5th May 2021 the HCRG Care Group received the safeguarding referral for the afore mentioned incident. The information was uploaded to Helen and the children's community health records and assessed by the duty school nurse. No action for follow up or SMART action plan was recorded. It is expected practice that the police safeguarding referral

form (PSRF) is assessed by the practitioner considering the wider context of the family's circumstances, previous domestic violence, abuse concerns and information reported on the notification. A SMART action plan should then be produced highlighting the way forward. On this occasion there was no action plan to follow up the referral. This would have been expected practice, as Tom had intervened during the incident and had previously witnessed domestic abuse. This was a missed opportunity to initiate safeguarding measures for Helen and the children.

6.74 Also on this date, the safeguarding referral was also passed on to Early Help. As a result of this, a call was made to Helen by Early Help and a discussion took place regarding the domestic incident. It is evident with hindsight that Helen played this down and advised that she had now separated from Dave and that Tom had not been injured during the assault. Helen declined any support and concluded the call. At this time and based on the domestic abuse history, consideration should have been given to overriding Helen's lack of consent to gather and share information with other agencies. This may have produced additional information and provided a clearer picture of exactly what was taking place at the home address of Helen and the children.

6.75 Again on the same date, the safeguarding referral was received by Lancashire Victim Support (LVS). The following day an IDVA attempted to speak with Helen but she ended the call. 3 additional calls were made during subsequent days and on each occasion, Helen terminated the call. On the 20th May 2021 LVS closed the case and recorded that the client did not want to engage with the service. If Helen had engaged with the IDVA service this may have been an opportunity for them to lead on coordinating services and providing an appropriate support plan. It may have also prevented Helen being overwhelmed by numerous calls from different agencies, all offering different information, which can often be confusing for a victim of domestic abuse.

6.76 On the 7th May 2021 the safeguarding report was also received by Tom's high school. This was shared with the school safeguarding lead and the school counsellor was requested to speak with Tom. This process is consistent with the school safeguarding policy, but it is not clear what, if any, interventions actually took place with Tom.

6.77 In the early hours of the 22nd July 2021 Tom called Lancashire Police and complained of being home alone looking after his two sisters. He indicated that his mother had just returned and was heavily intoxicated. Officers attended and ensured the children were safeguarded. Advice was given to Helen who was tearful and apologetic. The officers raised a vulnerable child referral which was classed as medium risk at the MASH. The information was shared with CFWS, Health and Education. It was recorded that the children were known to CSC but 'closed' at this time. This is expected practice from the police. Information sharing had taken place and appropriate services were made aware of the situation. However, no actions or interventions had subsequently taken place by other agencies as a result of the sharing of information.

6.78 On the 27th July 2021 the safeguarding referral was received by the high school of the children. A decision was made that the children would be spoken to when they resumed school in September after the school holidays. Information indicates that these conversations

took place with the children being spoken to by pastoral staff when they resumed at school. It is clear that a significant period of time elapsed between the incident and the children resuming school and there is no evidence to indicate that any other agency had spoken to the children during this period.

6.79 On the 30th July 2021 the safeguarding referral was shared with CSC. A telephone call was made to Helen and after discussions, a decision was made that there was no role for the CFWS at that time. Whilst Dave was not present at the time of this incident it is clear that no consideration was given to the history relating to Helen and Dave and the wider family.

6.80 On the 13th April 2022 Lancashire Police attended the home address of Helen and the children. Helen and Dave were at the address and were intoxicated. Dave had punched Helen in the face and he was immediately arrested for a section 39 Common Assault. The children were subsequently collected by a relative to ensure they were safeguarded. Helen provided a statement to the officers and outlined that she was suffering from anxiety and depression and that she needed support to end her abusive relationship with Dave. These were significant disclosures from Helen and a clear opportunity for robust interventions to be implemented to provide her with such support. Despite the prevalence of significant alcohol use throughout the interactions with the police and other agencies, there does not appear to be any records of discussion of, or referrals to substance misuse services. A safeguarding referral was made to MASH which was classed as medium risk. Consideration could have been given for a high-risk referral owing to the violence used, the presence of children and the fact that Helen asked the children to contact the police. Dave was later released on police bail with conditions aimed at safeguarding Helen and the children.

6.81 The high school received the encompass alert on the 14th April 2022 and the 'Heads of Year' were notified to conduct welfare checks at school. Whilst this is following procedure it would be helpful to understand what the children shared with the teachers and if this was shared with other agencies. This would have given a clearer picture of what was taking place in the family home and possibly encouraged greater interventions by agencies.

6.82 LVS received this safeguarding referral on the 18th April 2022 and the IDVA contacted Helen the following day. Helen indicated that she was fine and did not need any help and the case was closed. This is another occasion where Helen had declined to engage with the IDVA service despite the disclosures made earlier in the month.

6.83 Helen retracted her complaint on the 22nd April 2022. A retraction statement was obtained, and Helen indicated that she had told lies in her previous statement. As a result of this the investigation was reviewed by a Sergeant who recorded that there were no independent witnesses and the account provided by Helen in her retraction statement corroborated the account provided by Dave during his interview. The fact that Helen had indicated that she had told lies was considered to undermine her credibility as a witness. The Sergeant indicated that the threshold for referral to CPS was not met and that the case would be closed with no further action taken against Dave. Whilst this is frustrating considering Helen's attitude and disclosures made on the 13th April 2022, it is understandable why this outcome occurred.

6.84 The contact record for this safeguarding referral was only recorded by Early Help on the 27th April 2022 (14 days after the incident). Records indicate Helen was spoken to but stated she was no longer in a relationship with Dave and she did not need support around domestic abuse. Helen was also reported as indicating that she did not need support for the children as this was being provided by their school. Helen was appropriately signposted to other services and indicated she did not want Early Help support. The manager made the decision not to override the requirement for Helen's consent at this time. This was the second time that the children had called the police following violence within the home. A chronology should have been produced which highlighted concerns, and would have provided further evidence for analysis and to support consideration of overriding the need for Helen's consent to share information. There was also little in the analysis about the impact on the children and what they were telling professionals. Indeed, whilst teachers at school were speaking to the children, we have no detailed recorded accounts of what they were saying. This would clearly be beneficial to any information sharing and would potentially provide additional detail of what was taking place within the family home.

6.85 On the 10th June 2019 Helen attended a GP appointment in the company of her mum Jean. Helen indicated that she was suffering from low mood and struggling to sleep. She highlighted that the children offered no help and asked for antidepressant medication. Appropriate medication was subsequently prescribed. Whilst this appears to have been a reasonably comprehensive consultation regarding Helen's health conditions, limited discussion took place regarding her social and domestic circumstances and other issues such as alcohol or substance misuse, that may have contributed to Helen's low mood. As with other interventions within this review, this consultation lacked professional curiosity.

6.86 On the 24th June 2019 Helen attended a further GP appointment and outlined low mood and suggested 'she couldn't be bothered living anymore and had constant thoughts of suicide'. Helen indicated she had become so overwhelmed that she had cut her wrist and overdosed on some tablets. Helen indicated that this was triggered by an argument with her ex-partner. She did not go to A&E as her partner looked after her. Again, this was a good thorough consultation appropriately recorded, with an urgent referral to mental health services and the Crisis Team made as a result. A mental health appointment was made for Helen and crisis numbers were provided. However, once again, no discussions took place regarding potential contributing factors to Helen's low mood or about the wider family dynamic and any pressures within the family home. This consultation could have been an opportunity to explore domestic abuse and the GP should have considered the 'think family' approach in much more detail during the consultation. There is no information to indicate if the GP considered sharing this information with other agencies.

6.87 On or about the 24th July 2019 the START team (mental health team) sent a letter to Helen (which was copied to her GP) to advise that she had missed her mental health appointment and that she needed to make contact to book a further appointment. The letter warned Helen would be discharged from the service if she failed to make contact and book a further appointment. Despite this, there does not appear to have been any intervention, or contact made with Helen, by her GP.

6.88 On the 5th September 2019 Helen attended a GP appointment with her partner stating they were trying for a baby. Helen offered confusing information regarding her periods. Advice was given to both parties. It is important to consider that this visit was only six days after the domestic incident where Helen was rendered unconscious following the attack by Dave. Dave was on bail conditions at this time not to contact Helen. No professional curiosity was displayed and the information was not shared with other agencies.

6.89 On the 27th January 2020 Helen visited her GP accompanied by her mother. Helen indicated that she had just come out of an abusive relationship and was again struggling with low mood. The GP records indicated the family 'is known to children's services'. Helen presented with low self-esteem and stated she was suicidal at times. The GP prescribed anti-depressants and crisis contacts were given to Helen. Mental health interventions were robust and appropriate but limited discussion appears to have taken place regarding domestic abuse and the wider family dynamics. It is not clear if this information was shared with other agencies. It would also have been prudent for the GP to consider the most recent interactions Helen had with the GP service. A professionally curious intervention may have explored whether Helen had felt coerced into trying to conceive as discussed at the appointment in September 2019.

6.90 On the 3rd February 2020 Helen advised her GP that around 7 days previously she had intentionally overdosed on medication (unsure of quantity taken) but had refused to go to A & E. She stated she regretted this refusal with hindsight and was open to accepting help. The GP intervention at this time appears to demonstrate good practice around access to urgent mental health support. The GP also took proactive steps to safeguard Helen through the reduction of prescription medication quantities to reduce the risk moving forward. Again, documentation in the consultation notes states the family is 'known to children's services'. Whilst mental health support was appropriate during the consultation, again there is no evidence that children within the home or wider domestic circumstances were explored any further. This information was not shared with other agencies.

6.91 On the 4th February 2020, Lancashire and South Cumbria Foundation Trust (LSCFT) received the GP referral requesting support for Helen with low mood. It is suggested in the subsequent LSCFT Internal Serious Incident Investigation that Helen did not attend her mental health appointment in February 2020. On the 7th February 2020, LSCFT sent a letter to Helen's GP practice advising that Helen did not attend her scheduled mental health appointment. The letter was also sent to Helen and warned that she could be discharged from the service if she did not make contact. This was the second time that Helen had been referred to mental health services and had found herself unable to attend any scheduled appointments. Again, despite processes being available for escalation, no interventions were made to safeguard Helen and the children.

6.92 On the 31st August 2020, Helen telephoned 111 and stated she was experiencing central chest pain. The 111 health advisor transferred the incident electronically to the Paramedic Emergency Service for an ambulance response. This outcome was correct due to a potential cardiac presentation which required a guaranteed face-to-face clinical assessment rather than a referral to an alternative service such as a walk-in centre or GP services, which would have required Helen to take action herself. The subsequent medical examination and interventions

were appropriate. The paramedics ascertained that Helen had taken an overdose of tablets eight days earlier. She indicated that her partner had found her unresponsive at home and he had completed chest compressions. Helen indicated she had experienced pain over her sternum and her chest since. Helen disclosed during the assessment that she never sought medical attention or contacted the mental health team following the incident. Helen outlined that she'd suffered with anxiety and depression and had suffered with very low mood. Helen was advised to attend hospital due to the potential trauma that may have been caused by the chest compressions and to be reviewed following her overdose.

6.93 On the 3rd August 2021 Dave visited his GP complaining of fatigue and loss of appetite. He stated he was anxious and was drinking alcohol and using cannabis to help him cope. Dave denied using cocaine or other illicit substances. He outlined that he lived with his girlfriend and stated there were no problems at home. Blood tests were requested and it was queried whether anxiety could be the reason for the symptoms he was experiencing. This was a very thorough consultation that was well documented by the GP. Environmental factors were considered and explored, including any issues in Dave's relationship and home life. There was very clear documentation around Dave's presentation during the appointment. This consultation and the recording of it is a highlighted example of good practice.

6.94 On the 17th August 2021 Helen had a telephone consultation with her GP. Helen was tearful on the telephone and reported feeling low and anxious. Medication was prescribed and mental health crisis numbers were given to Helen. There is no documentation to indicate that home life, other environmental factors or domestic abuse was explored or considered during this consultation.

6.95 On the 20th October 2021 Helen had a further telephone consultation with the GP hub. Helen asked for higher doses of her medication for her anxiety and depression. Again, there is no recorded exploration of Helen's domestic circumstances or other environmental factors, which could be considered to have been contributing to Helen's presentation.

6.96 During the morning of the 14th November 2021 Helen contacted the mental health crisis line (MHCL). Helen was tearful and upset and stated she had struggled with depression for years. Helen indicated that the antidepressant medication she had been prescribed did not work. Helen outlined that she was in an abusive relationship and that her partner still contacted her and she was frightened that he would 'kick off' if she tried to further disengage from him. She stated that she wanted to go away somewhere and that she felt trapped in her situation. Helen also advised that she had a difficult relationship with her mum and was in debt. Helen was supported to express her feelings with the MHCL practitioner, who then offered her a number of actions to support her moving forward. Helen was advised to change her GP practice, and was provided with contact details for START, MindsMatters and Women's Aid to self-refer to. The panel considered that advising Helen to change her GP practice was not appropriate in these circumstances. No safeguarding concerns were noted despite Helen reporting she was frightened of Dave and he was controlling her. A more appropriate response would have been to undertake a DASH risk assessment and consider the threshold for a MARAC referral. Discussion should have taken place about support from domestic abuse services and potentially referring Helen with her consent to IDVA services. No 'think family' principles were applied. It would have been appropriate to contact the LSCFT safeguarding

team for advice and support in this situation, however there is no evidence this occurred. Other considerations should have included a referral to CSC and the practitioner could have made numerous onward referrals on behalf of Helen who was clearly vulnerable.

6.97 Later that day Helen contacted the MHCL again and advised that she had arranged for her daughters to stay with a relative and that she wanted to go in hospital for a break. The practitioner advised that hospital admittance on mental health grounds was a last resort when someone was a danger to themselves or others. Helen indicated that she had been hitting herself and had previously self-harmed with a knife and felt she was a danger to herself. Helen was advised to self-refer to START for an assessment and to also contact MindsMatter for CBT. It is clear that Helen was self-harming at this stage and had children living with her at home. This was not considered by the MHCL practitioner and the obvious safeguarding concerns were not appropriately managed. It is also evident that Helen had organised child-care so she could spend time accessing support at a time she clearly needed help. The practitioner could have made urgent referrals to START on behalf of Helen. This would have allowed for risk assessments to be undertaken to determine whether Helen was able to maintain her own safety.

6.98 On the 15th November 2021 Hyndburn MindsMatter received a self-referral from Helen and she was accepted into the service.

6.99 On the same date, Helen also self-referred to START. Helen subsequently contacted START on the following day (16th November) to establish if her referral had been received. Helen was tearful during this conversation and suggested she was not getting any help from mental health services. The practitioner reviewed Helen's history and noted multiple overdoses alongside low mood and suicidal ideation. It was also noted that Helen had not attended appointments in June 2019 and February 2020 and had therefore been discharged. Helen outlined an abusive relationship with her partner and indicated she was potentially experiencing financial abuse. Helen denied any thoughts about self-harm and believed she would benefit from CBT. The practitioner agreed to make a referral to MindsMatter for CBT. Discussion took place regarding medication and Helen was reportedly reassured when she was advised it can often take time for the medication to start working fully. The plan from the START practitioner was for Helen to continue taking her medication, for a referral to be made to MindsMatter for CBT and to provide Helen with START contact details. Helen was then discharged from START. Not enough professional curiosity was demonstrated during this interaction. The practitioner did not ask additional questions relating to the safety of the children, and did not seek advice or share information with the safeguarding team or external agencies. It is also a known fact that victims of domestic abuse may be prevented from accessing health appointments. Helen had outlined her abusive relationship and also that Dave was financially exploiting/abusing her. This abuse could clearly have been a barrier to Helen accessing support. It was also noted that Helen felt unable to contact the police due to concerns of retaliation from Dave or his family. Despite this, there is no evidence of a DASH risk assessment being discussed with Helen or completed.

6.100 On the 29th November 2021 MindsMatter sent a text to Helen indicating they had tried to ring her to book a telephone assessment appointment (2 week delay). Helen was advised that if she did not make contact by the 13th December 2021 they would assume she did not

wish to access the service and her referral would be closed. No professional curiosity was demonstrated here and there was no sharing of information to maximise the safeguarding of Helen and her children. A discharge letter sent to Helen's GP was also lacking in relevant information.

6.101 On the 17th December 2021 Helen engaged in a telephone assessment appointment with a practitioner from MindsMatter. Helen explained that she was struggling to move on from an abusive relationship and that she had suffered physical and mental abuse. Helen went on to indicate that the police had been involved but she always withdrew her complaints as she feared Dave would report her and social services would take her children away. Helen also indicated that Dave had received a suspended sentence and a fine but she had actually ended up paying the fine on his behalf. Helen suggested she was now ready to talk about her thoughts and feelings. The practitioner from MindsMatter noted that there were no current safeguarding concerns for Helen's children and that they were having therapy in school. Helen was advised of a long waiting list for CBT and she confirmed she was happy to go on the waiting list. Helen was provided with CBT review call details and a letter was forwarded to her GP. Whilst Helen was offered advice and information about the domestic abuse she was suffering, safeguarding issues were not followed up thoroughly. No referral was made to any domestic abuse service or to children's social care. Surprisingly, the letter to the GP did not highlight the domestic abuse that Helen had raised during her consultation. During this interaction it appears that Helen had begun to fully disclose the domestic abuse and controlling behaviour she had experienced from Dave. Helen appeared to have offered a full and honest account of the problems within her home, however the opportunity for appropriate support and referrals to relevant services was not taken.

6.102 Notes dated the 21st December 2021 by MindsMatter outline the previous telephone consultation with Helen and the content of a letter. The letter outlined that Helen wanted to learn coping strategies and would be allocated 1:1 CBT (Cognitive Behaviour Therapy) but acknowledged the waiting list for this service was long. Helen's scores on the PHQ-9 depression screening tool and the GAD-7 anxiety screening tool were noted, highlighting she had scored the maximum in both, indicating she was experiencing severe depression and anxiety. It was noted that Helen did have some thoughts of not wanting to be here but reported no current plans or intent and protective factors were noted. Whilst Helen's scores were the highest possible scores for anxiety and depression, it is noted that the MindsMatter service did not have a process for RAG[33] rating the waiting list. If a person attempting to access the service like Helen needed greater support, they would typically liaise with the IRS[34] and/or the home treatment team about escalating support. All letters and texts sent to Helen would also have included the relevant crisis numbers.

6.103 On the 25th February 2022 MindsMatter sent Helen a letter apologising for the delay in starting her CBT. A letter was also sent to her GP.

[33] RAG - NHS England uses a RAG matrix rating system. RAG stands for red, amber, green. To achieve a RAG rating, each risk first needs a likelihood and impact score. Using the risk "RAG" rating system for scoring risks means risks can be ranked so that the most severe are addressed first. Red is normally prioritised in this process indicating a high risk and a prompt need for service.

[34] IRS - the Initial Response Service is 24 hour access to mental health care, advice , support and treatment

6.104 On the 4th May 2022 MindsMatter sent a letter and text message to Helen asking her to contact them to arrange a telephone review appointment to remain on the waiting list for CBT. The letter warned Helen that if she did not make contact by the 18th May 2022 they would assume she no longer wished to access the service and would close the referral. It is suggested that this is in line with service policy.

6.105 On the 17th May 2022 Helen contacted her GP and discussed her ongoing low mood and thoughts of suicide. She stated she was still waiting for CBT. Helen's antidepressant medication was restarted. Despite the documented history of domestic abuse previously being shared with the GP practice, there was no discussion regarding potential ongoing domestic abuse or other environmental factors that may be contributing to Helen's presentation. This is a further example of a consultation and intervention that lacked professional curiosity.

6.106 On the 14th June 2022 MindMatter sent a letter to Helen's GP to advise that Helen had not engaged with them and her referral had been closed, and Helen was being referred back to her GP. This letter did not advise the GP that Helen had been experiencing domestic abuse and that there were safeguarding concerns identified.

6.107 On the 17th June 2022 an LSCFT letter stated that they had contacted Helen to offer her an appointment but she had failed to respond and her referral had been closed.

6.108 On the 19th August 2022 Dave had a telephone consultation with his GP. During this discussion Dave outlined low mood, anger and irritability. He indicated that he had split up from his partner and that he had nowhere to live. He suggested he was feeling helpless and hopeless. This consultation is documented thoroughly and the exploration of Dave's home life is recorded, although there is minimal documented exploration of the comments he made regarding anger. Anti-anxiety medication was recommended, and details of a local counselling service were sent to Dave via text. This was viewed as good practice.

6.109 On the 20th August 2022 Helen telephoned 111 and stated she was struggling with her mental health. Helen was tearful and indicated that she was at home alone and her children were in bed. Helen denied any recent self-harm but suggested she had been having suicidal ideation. Helen indicated she would not act on this due to her children. Whilst Helen was struggling with her mental health the health advisor behaved appropriately during this call. Helen declined the initial proposal to attend hospital, but the health advisor then looked at alternative options to support Helen. Helen was provided with the 24-hour telephone number for the crisis line which would provide NHS mental health specialist support. Consideration could have been given for a child safeguarding referral, but it was the view of the NWAS 111 advisor that Helen was putting the needs of her children first. Helen had indicated that she needed to get the children breakfast and off to school.

6.110 On the 22nd August 2022 Helen contacted her GP by telephone. Helen complained of being tired all the time, aching all over her body and a lack of energy. She indicated that she could not sleep, felt depressed and had a constant headache. Helen continued by outlining that she was unemployed, smoked 20 cigarettes a day and was a single mum bringing up 3 children alone. Helen concluded by telling her GP that she had constant abdominal pain and

diarrhoea. The GP indicated that further blood tests were required. The discussion and recording of this consultation are below the level of expected practice. This is obviously a significant cry for help from Helen. There was no exploration of her domestic circumstances or whether the previously disclosed domestic abuse was ongoing. No consideration was given to what was causing her anxiety, low mood and depression and there was no exploration regarding alcohol use or the use of illicit substances. No questions were asked about thoughts, or the risk, of self-harm or suicide ideation. Helen subsequently committed suicide 8 days later.

East Lancashire Hospital Trust (ELHT) Summary

6.111 In the two years leading up to Helen's death, she attended the Emergency Department, Urgent Care Centre and the Minor Injuries Unit at local hospitals on numerous occasions. These attendances were with both medical concerns and with injuries. On most attendances to hospital her mother was listed as next of kin, however on some occasions she was also accompanied by an unnamed male who she stated was her partner.

6.112 There were never any safeguarding concerns raised for Helen around her injuries or a referral made to the hospital's Independent Domestic Violence Advisor (IDVA) who may have been able to support her. It was documented that Helen had children at home, but no referral was made to the Safeguarding Children's Team and professional curiosity was not evident in any of these interactions. Staff did not even undertake basic enquiries into the names and ages of the children and who was looking after them whilst Helen was at the hospital.

6.113 Throughout her medical notes, there are repeated documented entries of Helen disclosing that she had anxiety and depression; however, there does not seem to be any recognition of how this may have been affecting her everyday life. Clinicians did not assess her mood or ask if she required any further support. From accessing the electronic and paper records for this case, it is apparent there are clear lessons to be learnt and improvements to be made within the Trust. These points are listed in subsequent sections of this review.

6.114 During Helen's visits to local hospitals, some disclosures were made around 'historic' domestic abuse. Despite this, clinicians did not use professional curiosity to explore this further. At no point was a DASH risk assessment completed, nor does it appear a referral to the hospital IDVA to support Helen was considered. It is noted in records that she did disclose domestic abuse, but that she also reported she had separated from the perpetrator. Helen was due to attend for a medical procedure and staff documented that if she failed to attend to notify 'safeguarding'. The Safeguarding Team and IDVA should have been notified regardless, as Helen had children in her care, and the IDVA could have supported with the recent separation. When Helen did not attend for her appointment, 'safeguarding' were not contacted.

6.115 Helen attended hospital on the 31st August 2020 complaining of chest pain. Helen stated eight days previously she had attempted to end her life by taking an overdose of medication. She stated that her partner, again unnamed, found her unresponsive and performed cardiopulmonary resuscitation (CPR). It was not questioned why medical attention was not sought after the alleged successful CPR. Helen would have no doubt needed medical attention

after the overdose and the attempts of resuscitation. Again, the safeguarding of Helen and her children did not appear to have been considered.

6.116 Helen declined to see 'Mental Health' and therefore a referral was not made, however this could have been discussed with the Mental Health Team for more advice. It was not apparent that staff considered her mental capacity, and if her depression, or potential coercive control, was influencing her decision making. Again, the Children's Safeguarding Team were not contacted to discuss concerns around Helen and her children.

6.117 On some occasions when Helen visited the hospital, COVID-19 guidelines and protocols were in place and patients were not permitted anybody to accompany or visit them in the hospital. These occasions could have provided opportunities for a safe discussion with Helen around any injuries sustained, her low mood and her environmental and family circumstances. Unfortunately, no staff completed such routine enquiry or a DASH risk assessment.

6.118 Helen also visited the hospital during the school summer holidays. Helen was unemployed at the time and potentially feeling overwhelmed with three children to look after. Clinicians did not seem to link up her anxiety and depression and suicidal ideation with the added stress of home life at that time. There was no consideration for a safeguarding referral to be made to either the Children or Adult Teams.

6.119 Dave's attendances at hospital were more sporadic and did not involve a particular pattern. Dave did attend with a police escort on one occasion after he had assaulted his 'partner' and was in police custody. Whilst the partner was not named in the records, information obtained during the review suggests the partner was Helen. There appears to be no communication or discussion between the police and ELHT staff around the safety of the victim, or if any multidisciplinary enquiries or work needed to be undertaken to keep the victim safe.

Education Summary (High School)

6.120 The information outlined has been shared with the police and the DHR panel following Helen's death. This largely relates to Tom's subsequent written disclosure about the family's experiences of living with domestic abuse over a 5-year period, but also when limited disclosures had been made by either Tom or Lisa. Referrals from other agencies have also been received relating to domestic abuse within the family and these have largely been dealt with appropriately with interventions made with the children.

6.121 It is clear school staff were at the time, and have been since, supportive and sensitive to the needs of the family. Initially the most notable issue being brought to their attention was financial difficulties. Tom and Lisa both qualified for and benefited from pupil premium funding (for disadvantaged pupils) with Lisa being bought a new school coat from this fund in 2020. The extent of domestic abuse within the home only became clear after Helen's death when Tom wrote his letter.

6.122 Actions undertaken by the school during the relevant period adhere to best current practice and were taken in line with the school's Safeguarding Policy. This follows guidance from:

- Lancashire County Council.
- Department for Education document – Working Together to Safeguard Children.
- Department for Education document – Keeping Children Safe in Education.
- Department for Education Teacher Standards.

6.123 Actions taken were always in support of the children. In 2019, Helen attended a team around the family (TAF) meeting and indicated she was content with the school support in place. Otherwise, there had been limited contact between Helen and school professionals. On occasions, the children's parents had been difficult to contact and on occasions when the children were absent from school, home visits undertaken by school staff to check on their welfare were often met with no reply.

6.124 Interactions with the children during the relevant period have been reviewed and no actions fell below what would be expected and all were in line with relevant guidance. Appropriate procedure was followed and all interactions with and about the family were logged on the school's secure record keeping system, 'Synergy'.

6.125 A sensitive approach was, and continues to be, taken to monitor the children's well-being and progress in school. When police 'encompass alerts' were received relating to domestic abuse, the children's wellbeing was checked and monitored by appropriate staff members. Since Helen's death the children have been provided with counselling and pastoral support as needed.

Citizen's Advice Bureau Summary

6.126 The records held by the local Citizens Advice Bureau (CAB) indicate that Helen contacted them for advice over an 8-month period. Helen was an existing client at the time of her death. CAB found it difficult to engage with Helen and closed relevant files on occasions due to non-engagement. No disclosures were made by Helen regarding the domestic violence she was experiencing at home. Helen was facing both significant financial debt and eviction from her home at the same time. CAB were working with Helen and appear to have been actively contacting and working with the local council on Helen's behalf regarding re-housing options and considering various options regarding debt management. The actions of CAB were appropriate throughout their dealings with Helen.

HCRG Care Group Summary

6.127 The response by the duty school nurse service following receipt of notification of the incident on the 1st April 2021 was not in line with organisational procedures. The role of the practitioner is to utilise their skills and knowledge when assessing a police safeguarding referral form (PSRF). The practitioner should consider the wider context of the family's circumstances, previous domestic violence and abuse concerns, the children's health and wellbeing, and the information reported on the notification. The practitioner should then

identify any escalation of risk and consider sharing information with relevant agencies. This did not take place.

HBC Environmental Health Summary

6.128 After undertaking an initial visit and notifying Helen's landlord by letter of the required work, the officer closed the case without further visiting the property or receiving photographic evidence that the required work had been carried out. The officer closed the case having received email communication from the landlord that the work had been completed. If resources allow, re-visits should be carried out, and where this is not possible, as a minimum, photographic evidence should be received prior to closing requests for service.

Terms of Reference 4: To establish whether there are any lessons to be learned from the case about the way in which professionals and organisations worked together and carried out their duties and responsibilities.

6.129 In considering this TOR the panel first examined when and how agencies worked together in support of Helen, Dave and the children that comprised this family unit.

6.130 Firstly, let us examine what constitutes "working together" in the context of Domestic Abuse, Safeguarding and Mental Health.

The definitive guidance on working together comes from the Department for Education's statutory guidance "Working Together to Safeguard Children". At the relevant period, the July 2018 version of this guidance was in place, although it is noted this has now been superseded by the December 2023 version.

The introduction to the 2018 guidance states:

> Whilst it is parents and carers who have primary care for their children, local authorities, working with partner organisations and agencies, have specific duties to safeguard and promote the welfare of all children in their area. The Children Acts of 1989 and 2004 set out specific duties: section 17 of the Children Act 1989 puts a duty on the local authority to provide services to children in need in their area, regardless of where they are found; section 47 of the same Act requires local authorities to undertake enquiries if they believe a child has suffered or is likely to suffer significant harm.
>
> These duties placed on the local authority can only be discharged with the full co-operation of other partners, many of whom have individual duties when carrying out their functions under section 11 of the Children Act 2004. Under section 10 of the same Act, the local authority is under a duty to make arrangements to promote co-operation between itself and organisations and agencies to improve the wellbeing of local children. This co-operation should exist and be effective at all levels of an organisation, from strategic level through to operational delivery. The Children Act 2004, as amended by the Children and Social Work Act 2017, strengthens this already

> important relationship by placing new duties on key agencies in a local area. Specifically, the police, clinical commissioning groups and the local authority are under a duty to make arrangements to work together, and with other partners locally, to safeguard and promote the welfare of all children in their area. Everyone who comes into contact with children and families has a role to play.

6.131 Safeguarding and promoting the welfare of children is defined for the purposes of this guidance as:

- protecting children from maltreatment
- preventing impairment of children's mental and physical health or development
- ensuring that children grow up in circumstances consistent with the provision of safe and effective care
- taking action to enable all children to have the best outcomes

6.132 In identifying children and families who would benefit from early help in accordance with Working Together the following criteria is described:

> Practitioners should, in particular, be alert to the potential need for early help for a child who:
>
> - is in a family circumstance presenting challenges for the child, such as drug and alcohol misuse, adult mental health issues and domestic abuse.

6.133 As part of fulfilling the obligations set out above, agencies across Lancashire have established a Multi-Agency Safeguarding Hub (MASH). The function of the MASH is described by Lancashire County Council as follows:

The Multi-Agency Safeguarding Hub (MASH) service was established in 2013 and is the single point of access in Lancashire for all safeguarding concerns across all service areas for both children & adults with care and support needs aged 18 years and over. The MASH consists of representatives from the county council's adult safeguarding and children's social care departments working alongside the police, health, Education, Children's Youth Justice Service, Early Help Officers, Lancashire fire and rescue, probation and other partners.

> Children's Social workers within the Children's Services Support Hub (MASH) undertake initial screening / safeguarding checks to determine the level of need or safeguard. This is in line with the Lancashire working well with children and families document, working together to safeguard Children 2018 and the Children's Act 1989 & 2004. This includes information sharing, information gathering, risk assessing and analysis and decision making.

6.134 A further statutory function that brings agencies together to address Domestic Abuse and safeguarding of families is the Multi Agency Risk Assessment Conference (MARAC). Lancashire Safeguarding Adults Board (LSAB), Domestic Abuse Guidance dated November 2018, describes MARAC as follows:

A MARAC meeting is where information is shared on the highest risk domestic abuse cases between representatives of local police, probation, health, children and adult safeguarding, housing, substance misuse services, independent violence advocates (IDVAs) and other specialist statutory and voluntary sectors. If a practitioner identifies that an individual they are, or have been working with, is a victim of domestic abuse they should complete a DASH risk identification checklist with the individual. Where an individual is assessed as being at high risk, the completed DASH checklist should be forwarded to the MARAC Coordinator and domestic abuse support services and discuss any immediate safety actions with the Independent Domestic Abuse Advisors (IDVAs).

If a professional has serious concerns about a victim's situation, they should use their professional judgement to decide whether to refer the case to MARAC. There will be occasions where the particular context of a case gives rise to serious concerns, even if the victim has been unable to disclose the information that might highlight their risk more clearly.

SafeLives, a national organisation working to end domestic violence and abuse, describes MARAC in the following terms:

A MARAC is a multi-agency meeting which domestic abuse victims who have been identified as at high risk of serious harm or homicide are referred to. The MARAC is attended by representatives from a range of agencies including police, health, child protection, housing, Independent Domestic Violence Advisors (IDVAs), probation, mental health and substance misuse and other specialists from the statutory and voluntary sectors. During the meeting relevant and proportionate information is shared about the current risks, enabling representatives to identify options to increase the safety of the victim and any other vulnerable parties such as children. The MARAC then creates a multi-agency action plan to address the identified risks and increase the safety and wellbeing of all those at risk. The primary focus of the MARAC is to safeguard the adult victim. However, taking in to account the UK law which prioritises the safety of children, the MARAC will also make links with other multi-agency meetings and processes to safeguard children and manage the behaviour of the perpetrator. At the heart of a MARAC is the working assumption that no single agency or individual can see the complete picture of the life of a victim to be able to identify and manage the risks, but all may have insights that are crucial to their safety. The victim does not attend the meeting but is represented by an IDVA who represents their views and wishes and ensures that victim's safety remains the focus of the meeting.[35]

6.135 The DHR panel identified one referral to MARAC and a number of referrals to MASH following agency interaction with Helen and her family.

6.136 The initial MARAC referral was made following the reported violent domestic incident on the 15th July 2018. The attending officers submitted a High-Risk DA PVP (Protecting

[35] SafeLives MARAC FAQS for Professionals. Available at: https://safelives.org.uk/sites/default/files/resources/MARAC_FAQs_for%20MARAC%20practitioners_2013%20FINAL.pdf

Vulnerable People) report via the MASH. Following review, details of the incident and those involved were shared with LCC CSC, IDVA and a MARAC referral was made.

The panel has experienced difficulties in obtaining any minutes, action plans or outcomes of the MARAC. As a last resort, the audio recording of the meeting was located and a transcript prepared by Lancashire Constabulary.

The meeting was held on the 21st August 2018, Helen's case was discussed for approximately 8 minutes and 30 seconds. The meeting was chaired by a safeguarding supervisor from Lancashire Constabulary. Also present were representatives from Lancashire Constabulary Safeguarding Team, LVS IDVA, HARV, Social Workers, Inspire, Lancashire NHS, ELHT. It is important to note that the audio recording was very poor and not all attendees were audible. It was confirmed that consent to share information had been gained from Helen and address details were confirmed. Dave was referred to as "sofa-surfing". Helen's level of engagement was categorised as 'low'. Details of the incident were discussed and are consistent with information provided earlier in this document. The following information was provided to the meeting, although it is unclear by which agency:

> "She believes that his behaviour is escalating and if she stays in a relationship with him there will be further issues. She says he's a lovely person until he drinks and then he becomes aggressive and yells. He always tried to stop her from seeing her friends and due to this she decided to end the relationship. And since the incident he text her once apologising. After this she'd blocked his number so it's unknown whether he's tried to contact her again."

Reference was also made to one of the female children being very upset about witnessing the incident and a referral to social services being made.

An update from the IDVA representative was as follows:

> "Yeah my colleague (name) spoke to Helen. The offender is her ex-partner since the incident and she's not had any trouble since. Gave her safety advice. She said there was no help needed but took our contact details for future reference."

There was discussion about assisting Helen to obtain a non-molestation order against Dave, and that the IDVA service may have been best placed to assist her with this. The following excerpt is believed to be from the IDVA representative:

> "We are likely to have one more contact when the victim declines support, obviously we don't want to keep ringing them. We'll give her an update and we can mention about a non-molestation order / injunction. Sometimes the police refer to an ABP bail[36], so I don't know."

The chair requested an update following the above contact and suggested as much support as possible should be given to Helen in respect of the injunction. There is no information available that suggests an injunction, or other order, was ever pursued or obtained against

[36]ABP Bail is not a recognised term and it is not clear what the IDVA representative was referring to.

Dave. Before closing the case discussion, a police representative indicated they would submit an intelligence report and flag that the children were present and that any future incidents should result in a referral to CSC. This intelligence report was submitted on the 28th August 2018 outlining that Helen was a high risk victim of domestic abuse, highlighting the presence of the children and that any further incidents should be reported to CSC.

Although brief, there were positive steps suggested at the MARAC; however, there is no record that any of the actions were completed, or what outcomes resulted. It appears the process was hindered by Helen's limited ability to engage at that time.

6.137 In the absence of MARAC documented records, individual agency records can be examined to establish what action took place following MASH information sharing. In the case of CSC the following is recorded:

> 'There are no concerns raised regarding mother's ability to meet the children's basic needs at present. This is the first reported DA regarding mother and a partner and mother has reported the incident to police and is working with the police and IDVA. Mother states the relationship has ended and that she does not wish to re-engage in a relationship with Dave. Should mother remain separated from Dave and continue to engage with service regarding DA it is likely that DA will not reoccur.'

6.138 It is understood that Helen was spoken to by CSC as part of this assessment, which is a positive factor. However, the assessment made at that point of time is based on a number of future assumptions, that is:

> Helen would remain estranged from Dave.
> Helen would continue to support the police action against Dave.
> Helen would continue to engage with IDVA services.

6.139 Unfortunately, two key factors did not continue for any meaningful period. Whilst Helen followed through with the prosecution and Dave was subsequently convicted of assault against her, their relationship rekindled very soon after. Additionally, Helen did not feel able to engage with the services offered by IDVA. Indeed, the following extracts suggests Helen rejected any support from IDVA when they made contact:

> "Rang and spoke to victim who said that the offender was her ex-partner. She said that it was a one-off and that she hasn't had any trouble since. The police arrested him but she hasn't heard anything since. Suggested she ring 101 if would like an up-date. She has plenty of friends and family for support. Has 3 children and says they are fine. No help needed but agreed to text details for future reference."

The following day:

> "Call to victim, all is OK she has separated from partner and has declined support, she has accepted LVS contact details if needed for future reference. Case closed."

6.140 CSC could not have known this, as their assessment was completed and closed two days prior to IDVA contacting Helen. There is no evidence to suggest CSC re-checked with IDVA services to confirm that Helen was working with them.

6.141 None of the agencies involved at this point in time knew, or had a mechanism to find out, whether Helen and Dave remained estranged. Evidence suggests Helen and Dave were back together by late August 2018.

6.142 This poses the following question: *If CSC were to re-visit their initial decision only a few weeks later, would their assessment of risk and the course of action taken have remained the same, given that Helen and Dave were back together, and Helen was not being supported by IDVA?* There is no information to suggest that CSC or IDVA talked to each other to confirm Helen's ongoing work with the other.

6.143 This sequence illustrates that decisions were taken in isolation by single agencies at a particular point in time, with no strategy to follow-up and confirm the conditions upon which decisions were made remained. The MARAC process could have been the conduit for this process but this opportunity was clearly not utilised.

6.144 The four further violent domestic abuse incidents reported to the police all resulted in submission of Police Safeguarding Report Forms (PSRF) to the MASH.

6.145 The PSRF submitted relating to an incident on the 31st August 2019, was graded as high risk. However, following review in the MASH the risk was downgraded to medium DA with high-risk vulnerable child (VC). It is not clear by what rationale the DA risk was reduced, although the DASH risk assessment contained limited detail. Despite this limited detail, the full details of the incident were documented in the PSRF.

6.146 Whilst information was shared with CSC, IDVA, Health and Education, the fact that the DA was reduced to medium risk negated it being automatically referred to MARAC. This could be considered an additional missed opportunity for structured, accountable, joint working, focused on protecting Helen and her children from continued domestic abuse. Supervisors in the MASH could have reviewed this and the previous DA incident together, to consider the wider picture, and referred to MARAC based on professional judgement.

6.147 A further violent domestic abuse incident occurred on the 1st May 2021. On this occasion Dave threw an ashtray at Helen causing injury. Whilst the level of injury was not particularly serious, Dave used a weapon in the form of an ashtray. The assault was also witnessed by Helen's son Tom, who bravely intervened. These were clearly significant aggravating factors. Even though this was also the third reported violent domestic abuse incident involving Helen and Dave, the PSRF was graded as medium risk DA. Therefore, once again, the matter was not referred to MARAC, the recognised mechanism for joint working in high-risk domestic abuse cases.

6.148 The fourth, and final recorded/reported, violent domestic abuse incident prior to Helen's death occurred on the 13th April 2022, less than twelve months after the previous incident.

6.149 This incident followed a similar pattern. Alcohol was a contributing factor, and the children were at home and may have witnessed the incident. Helen was violently assaulted by Dave, and she asked her eldest daughter to call the police. During her interaction with the attending officers, Helen stated she was keen to seek support from agencies to help her break the cycle of abuse and sever ties with Dave once and for all. The police attended and Dave was arrested. However, just nine days later Helen retracted her witness statement and proceedings against Dave were dropped.

6.150 A medium risk PSRF was submitted to the MASH. This was not upgraded to high-risk, nor was a MARAC referral made. The following factors could have been considered in escalating to high-risk and referring to MARAC:

- This was the fourth reported violent assault on Helen by Dave.
- It had been less than twelve months since the previous violent domestic abuse incident.
- The children were present at the time of the incident. This was also the case in all other incidents.
- Helen disclosed mental health issues to the attending officers.
- Alcohol was an aggravating factor.
- Helen expressed that she was open to working with support agencies.

6.151 Sadly, the response from agencies with whom the PSRF was shared was probably the least effective of all the reported incidents. LVS IDVA made a single call to Helen, basic questions were asked and there is no evidence of the pattern of abuse being discussed. Helen declined support and the case was closed at that point. It is not clear if the previous incidents were considered, either at all or as a collective, and if a referral to MARAC (when considering the pattern of Helen's behaviour that was emerging) was considered at this time.

6.152 CSC contacted Helen who declined any support, the following is an extract from records:

> "Mother was spoken to but stated she is not in a relationship anymore and this is over, she doesn't want support around the domestic abuse and doesn't want support for the children as they get support from their schools. Mother was appropriately signposted and did not want Early Help support, the manager made a decision not to override consent at this time."

6.153 Whilst extensive information sharing has taken place by established mechanisms, it is not evident that any significant interventions occurred as a result. It appears that Helen and her family may have fallen just short of the 'threshold bar'. This may be a result of timescales involved or the level of physical injury. Was psychological trauma – for Helen and/or the children - ever considered? Information sharing appears to have been process driven, with an emphasis on compliance rather than displaying professional curiosity and seeing the true risk and vulnerabilities of Helen and her family. Would a single agency lead or trusted professional in Helen and her family's life have made a difference?

Terms of Reference 5: To establish whether organisations have appropriate policies and procedures to respond to the circumstances identified in this case and to recommend any changes because of the review process, with the aim of better safeguarding families.

6.154 In analysing this TOR the panel focused on those agencies whose contact with Helen and her family were most prevalent during the relevant timeframe. Whilst it is apparent that there were appropriate policies and procedures in place in many instances, there is evidence that these policies or procedures were not followed.

East Lancashire Health Trust (ELHT)

6.155 Helen attended ELHT hospitals on five occasions during the relevant time period for varied reasons. Some of these presentations are thought to have been due to domestic abuse incidents, although there is no direct evidence to indicate that Helen disclosed current domestic abuse to professionals who were treating her. Disclosures were made about historic domestic abuse. Gynaecology notes indicate Helen did disclose previous domestic abuse but stated she had separated from the perpetrator. Clinicians failed to exercise appropriate professional curiosity and explore this further. No DASH risk assessment was completed and no referrals to the hospital IDVA were considered.

6.156 The provision of the IDVA service to victims whilst in hospital is a very proactive approach. It has the potential to enable victims to access support services in a safe and controlled environment, often very soon after abuse has taken place, thereby increasing the likelihood of meaningful engagement and effective intervention. However, in the case of ELHT, the on-site IDVA service is only available at Royal Blackburn Hospital and to individuals who reside in the Blackburn with Darwen local authority area. If a victim does not reside in these areas an external referral must be made. This is another potential missed opportunity, frustrated by the patchwork provision of services dependent on local provision.

6.157 It was documented that Helen had children at home. No referral was made to the Safeguarding Children's Team at ELHT and professional curiosity was not exercised. There were no questions asked as to the names and ages of her children, or who was looking after them whilst Helen was at hospital.

6.158 Throughout her medical notes, it is documented that Helen disclosed she had anxiety and depression. However, there doesn't seem to be any recognition of how this may be affecting her everyday life. Clinicians did not assess her mood or ask whether she required any further support with managing this.

6.159 Helen attended hospital on the 31st August 2020 complaining of chest pain. She stated she had attempted to end her life by taking an overdose of medication eight days earlier. Her partner, again unnamed, found her unresponsive and performed Cardiopulmonary resuscitation (CPR). It was not explored why medical attention was not sought immediately after the CPR. This delay could be an indicator of coercive/controlling behaviour. Helen would have no doubt required medical attention in a medical setting after an overdose that required CPR.

6.160 Helen declined to see the Mental Health Team at the hospital and therefore no referral was made. However, this could have been discussed with the Mental Health Team for more advice. It was not apparent that practitioners considered Helen's mental capacity or whether her depression, or coercive control in her relationship, was influencing her decision making. The children's safeguarding team was not contacted to discuss concerns around Helen and her children.

6.161 What is clear from this analysis is that ELHT did have appropriate policies and procedures in place to address issues present in Helen's life. However, their effectiveness in supporting vulnerable individuals and families is dependent on practitioners and professionals knowing such policies and procedures and putting them into practise. As described above, the review found that this did not happen effectively, resulting in Helen and subsequently her children, not being supported or protected effectively. The opportunities to intervene and protect Helen and her family were sadly missed.

LSCFT – Mental Health Provision

6.162 As referred to earlier in this report, Helen was diagnosed with mixed anxiety and depressive disorder. Helen was scored as having the highest scores possible on the relevant assessment and scaling tools for depression (PHQ-9) and anxiety (GAD-7). She remained on a waiting list for CBT for six months under Hyndburn MindsMatter. Indeed, information suggests Helen believed she was still on the waiting list at the time of her death. Sadly this was not the case, as on the 14th June 2022, she had been discharged from MindsMatter for not responding to their letter. This was approximately 10 weeks before she took her own life.

According to the MindsMatter Standard Operating Procedure:

> *"For 2023 the National Waiting Times standard is for 75% of people to enter treatment within 6 weeks and 95% to enter treatment within 18 weeks".*

Clearly in Helen's case these standards were not met.

6.163 An internal review conducted by LSCFT into Helen's case states:

> *"Hyndburn MindsMatter are currently struggling to retain staff. One of the main reasons for this is that trainee CBT therapists do not stay on with the team and prefer, for career progression, to go to work for other organisations when they are qualified CBT therapists. Due to the lack of staff, waiting times for therapies increase. The current waiting list concern for Hyndburn MindsMatter is on the Trust's Risk Register."*

6.164 Records of telephone consultations between Helen and START/MindsMatter practitioners provide the most insightful first-hand accounts of her family situation. During these consultations, Helen described physical and psychological abuse, her struggles with physical and mental health as well as a dire financial situation.

Under section 5.8 of the MindsMatter Standard Operating Procedure:

> "*If there are grounds about the neglect or abuse of children/vulnerable adults and there are sufficient grounds to justify information sharing on a 'need to know' basis and/or 'in the public interest' this information should be shared with GPs/referrers …*".

However, the letter provided to Helen's GP following the telephone assessment completed on the 21st December 2021 made no reference to the issue of domestic violence and abuse or potential safeguarding concerns; though other matters related to the assessment were noted, including that Helen had "*no current plans or intention to self-harm or end life".*

6.165 Further responsibilities regarding safeguarding children are also contained within the MindsMatter Standard Operating Procedure:

> *"MindsMatter staff have a responsibility to safeguard children when they become aware of a child at risk of harm. Managing these issues begins with completing the 'safeguarding' section of the patients' clinical records where indicated".*

Helen's abusive relationship increased the likelihood of harm to her children. This should have been considered by practitioners and the issues further explored and addressed. The 'Think Family' safeguarding agenda relates well to Helen's family circumstances. Whilst mental health practitioners who had contact with Helen considered risk and harm to her, they failed to consider risks to others, and particularly her children.

6.166 MindsMatter and CBT therapists complete online LSCFT Safeguarding Level 2 training, but this does not include the 'Think Family' safeguarding package.

6.167 Again, what is clear from this analysis is that LSCFT did have appropriate policies and procedures in place to address issues present in Helen's life. However, their effectiveness in supporting vulnerable individuals and families is dependent on practitioners and professionals knowing about such policies and procedures, having received training in relation to them, and putting this into practise. As described above, the review found that this did not happen effectively, resulting in Helen not being supported or protected effectively. The opportunities to intervene and protect Helen and her children were sadly missed.

Northwest Ambulance Services (NWAS)

6.168 Northwest Ambulance Services (NWAS) provided pre-hospital care and treatment to Helen on six occasions in the relevant time period prior to her death. These included a mixture of face-to-face Paramedic contacts and telephone triage through the NWAS 111 service (a national service but delivered locally by the relevant NHS service). During those contacts Helen never made any disclosures around domestic abuse and there were no indicators that she was a victim of domestic abuse. Helen had described her social circumstances during consultations, with her consistently saying she lived alone with her children.

6.169 All patient facing clinicians within NWAS receive safeguarding training to level 3. The content is written by the NWAS Safeguarding Team in line with the intercollegiate document. The training package is updated annually and includes scenarios to encourage discussions and is delivered by the learning and development team. Safeguarding training is a yearly mandatory training requirement. Educating staff around the wider elements of domestic

abuse and the emotional and psychological effects that control and coercive behaviours have on victims has been a focus for the Safeguarding Team. The aim is to ensure staff utilise professional curiosity with every patient and especially when faced with a patient who may be in mental health crisis to explore the reasoning behind the presentation and provide a safe and supportive environment to ease any disclosures that the patient is able and willing to make. Often patients do feel able to disclose abuse they are suffering during transport to hospital as it is predominantly one to one and away from the home environment, relatives, or partners.

6.170 It is clear from this analysis that NWAS had a number of interactions with Helen and that these callouts were varied in nature. It is evident that NWAS have appropriate policies and procedures to deal with the circumstances as outlined. Helen received appropriate care and support during the six interactions she had with NWAS prior to her death. No relevant disclosures were made, and Helen was treated for specific health conditions.

Lancashire & South Cumbria ICB – GP Services

6.171 Helen contacted and accessed GP services on a regular basis, mainly due to her complex physical conditions. She also sought advice and treatment to gain better coping strategies in relation to her depression and anxiety. Helen was keen for CBT sessions to be started through LSCFT MindsMatter.

6.172 Helen disclosed in her GP consultations that there were periods of time when she thought she would be 'better off not here'. Helen did not, however, give a clear indication that she had any intent to end her life. Helen had disclosed to GP services on a number of occasions concerns around previous incidents of domestic abuse, as well as attending appointments at 'crunch' points when her life stressors were exacerbated. For example, during the school holidays when she was caring for three children at home full-time.

There appears to have been little professional curiosity demonstrated by the GPs Helen saw at times, and the discussions noted appear to indicate a lack of review of notes from previous consultations. Had this been done, it may be that the GP service had been able to build up a clearer picture of Helen's situation. It appears that there was little account taken of the combination of these previous disclosures, her physical and mental health conditions, and her presentation at consultations. Helen's records indicate there was, at best, little exploration of Helen's family and environmental factors, her housing and financial circumstances, her diet, alcohol consumption or use of illicit substances. All of which are known factors that can, individually and more so in combination, contribute to physical and mental health issues.

Sadly, Helen was unable to engage with the CBT appointment that was finally offered to her through LSCFT MindsMatter. Helen was therefore closed to this service in June 2022.

6.173 There was a pattern of services struggling to engage Helen and subsequently her being unable to access support offered by LSCFT Mental Health services. On occasion, she was sent 'opt-in' letters due to missed appointments. It is important to understand possible drivers behind non-attendance, especially where individuals who are suffering multiple, complex, and

intersecting challenges and disadvantages, such as domestic abuse, financial difficulties and mental health problems.

6.174 Further consideration should be given to "cycle of behaviour" escalation when a patient is ceasing anti-depression medications without medical consultation and struggling to engage with Mental Health referrals and pathways. Alternative methods of contact with service users who are unable to attend/do not manage to attend pre-arranged mental health appointments should be considered. This may support ensure individuals to be provided with the best opportunity to benefit from services and improve outcomes.

Lancashire Constabulary

6.175 Lancashire Constabulary had four main contacts with Helen and Dave. These followed violent domestic incidents at the home address of Helen and her 3 children. The Lancashire Constabulary domestic abuse policy covering the time parameters of this review had three main aims:

- To provide a clear framework that ensures all incidents of Domestic Abuse are dealt with effectively.
- To ensure positive action is taken at all domestic abuse incidents to protect victims and children and challenge offenders.
- To outline the minimum standards of investigation and safeguarding for domestic abuse

6.176 There are several good examples of the policy being followed and appropriate actions being taken by officers investigating the reported incidents including:

- Prompt arrest of the perpetrator.
- Appropriate safeguarding of Helen and her children.
- Appropriate information sharing via the MASH and referral to MARAC.
- Effective investigation and prosecution in a timely fashion.

6.177 However, there are also examples when the police response fell below expected practice.

- There is a pattern of poor-quality DASH risk assessments being completed by attending officers. In one example, only 3 questions were answered 'yes' on the 27-question report. These questions related to the severity of the incident, the presence of children during the incident, and recognition there had been a previous incident just over 12 months previously. All other questions were left blank. This lack of depth makes accurate risk assessment challenging, possibly resulting in referrals - to MARAC for example - not being progressed. This can ultimately lead to missed opportunities to support and safeguard victims and their families.

- Absence of quality and consistency of investigation is also evident from analysis of the handling of these incidents. Various factors may influence this. This can include the experience, knowledge, confidence, and capacity of the investigating officer. It may

also stem from the quality and effectiveness of supervision, and failure to pursue evidence led prosecutions. There appears to be a willingness to accept retraction statements at face value, with little exploration of the reasoning or the potential consequences of retraction. The pattern of Helen retracting prosecution support does not appear to have been considered or explored and on occasion, the receipt of retraction statements appears to be process driven.

6.178 Greater supervisory oversight of domestic abuse investigations ought to lead to improvements in quality and timeliness of such investigations, both important factors in securing and maintaining victim engagement throughout the criminal justice process. Lancashire Constabulary's Domestic Abuse policy was reviewed and updated, with the current version published in May of 2023. This emphasises the need for greater supervisory oversight and is a recurring theme throughout the policy. The failings highlighted above should be addressed. Lancashire Constabulary have appropriate policies and procedures to deal with the circumstances identified in this case. That said, it is imperative that officers are trained in, and comply with these policies and procedures. This will ensure victims like Helen and her children are supported and always safeguarded and receive the best possible service.

Victim Support – IDVA

6.179 Victim Support received 3 referrals from the police for incidents between July 2018 and April 2022. Timely contact was initiated on all the referrals as follows:

The first referral was received by Lancashire Victim Support (LVS) IDVA service on the 15th July 2018, which was a Sunday. Contact was attempted on Wednesday the 18th July, which is within the agreed window. The second referral was received on the 5th May 2021, contact was attempted the following day, however Helen hung up on the support worker without entering into conversation. The third referral was received on the 18th April 2022 and contact was attempted on the following day.

In each of the instances above, Helen declined to engage further with LVS. As a voluntary opt-in service, LVS cannot compel victims to engage with their service or impose interventions upon them. However, LVS highly skilled and experienced staff will do their utmost to ensure victim safety and encourage engagement wherever possible.

Analysis would also suggest Helen provided initial information to LVS indicating she had split from Dave and was not intending to reconcile. It was subsequently apparent this was not the case. LVS suggest this is not an uncommon situation. Had Helen continued to engage with them and this fact come to light, they would have probed further and challenged Helen's decision to continue her relationship with Dave. As Helen was not able at that time to engage with LVS, there was no opportunity for them to revisit her circumstances or reassess level of risk.

Lancashire County Council – Children's Social Care (CSC)

6.180 During the 4-year time parameter identified by the review, Helen was contacted by CSC MASH on 5 occasions and she was supported by Early Help for a short period. Referrals were assessed using the correct model of practice (risk sensible or strength based). However, there are some instances that could have been explored further and information shared internally, overriding consent if needed. It appears that referrals were considered in isolation, without reference to previous referrals with a process driven approach being employed. Requiring the review of previous referrals when triaging may have focussed the assessors professional curiosity about what had been happening within the home between the referral;, what day-to-day life was like for the children; and supported the assessor in considering whether these were indeed 'one-off' incidents (of which there were five), or whether these were just the incidents that had resulted in contact with professionals. This approach may have given a clearer analysis of what was taking place within the home and resulted in an intervention. It is evident that the children were present and witnessed the domestic abuse that took place in April 2022 and, under section 3 of the Domestic Abuse Act 2021, should have been treated as victims of domestic abuse in their own right. This does not appear to have been recognised and an opportunity for intervention was not taken.

CSC have recognised that the MASH service needs development and therefore work has been ongoing to review the use of thresholds and when to override consent. This will hopefully ensure a robust multi-agency response when concerns are escalating for a family. MASH have recognised that children's voices are not always evident and therefore in the last two years a 'participation officer' has been employed to ensure that children's voices are heard throughout referrals and in order to shape the service offered. It is envisaged that these actions will lead to more effective interventions and meaningful support for children and families. CSC continue to invest heavily in the training of staff around being trauma informed and are leading on the use of *Tom's Story* to ensure staff are receiving 'child centred' domestic abuse training on a pan-Lancashire footprint.

Terms of Reference 6: All enquiries are to be restricted to a period of no more than 4 years prior to the date of the suicide, and until the review has concluded. However, any historical information or convictions of domestic abuse outside of this timeframe should be considered.

6.181 This TOR is a direction offered to all members of the review panel. All agencies complied with this request during the period of the review.

Terms of Reference 7: To provide details of additional records concerning domestic abuse and medical issues including mental health or physical injury or disability that may have a relevant impact on the review.

6.182 This TOR is a direction offered to all members of the review panel. All agencies complied with this request during the period of the review

Terms of Reference 8: To consider any cultural, environmental, or mental capacity issues which may have contributed to any barriers the victim faced in accessing protection, and learning why any interventions did not work for them.

6.183 Helen was clearly suffering from significant anxiety and depression and had scored the maximum on the standardised anxiety and depression assessment and scoring tools. It is also now known to professionals that Helen was using drugs and alcohol on a frequent basis, and this was undoubtedly contributing significantly to her mental health challenges. Whilst it is not totally clear how this may have impacted on her ability to access services to safeguard her and the children, her levels of anxiety around 'losing her children' were evident. Indeed, Helen had stated that she was reluctant to access further family support from CSC as she was concerned that her children might be taken away. Dave was aware of this and used it repeatedly to control her. This, combined with a possible lack of proactive questions, interventions, and referrals, may have impacted on the extent to which the whole family's needs could have been assessed and thus appropriately supported. Regarding seeking mental health support, clinical notes indicate a pattern of Helen seeking help in crisis, but then perhaps struggling to prioritise attendance at appointments once things were more settled or less urgent.

6.184 The impact of COVID-19 has already been highlighted in a separate TOR and will not be repeated.

6.185 It is clear there were some environmental and mental capacity issues that may have contributed to Helen not accessing services to safeguard her and her children.

Terms of Reference 9: To consider the impact that the COVID-19 pandemic had on the victim accessing support to domestic abuse services, and how the pandemic may have led to increasing episodes of domestic abuse, and the deterioration of the victim's mental health.

6.186 Members of the panel and contributing agencies were asked to consider whether their responses to Helen and her family, or service provision, was adversely impacted by COVID-19 restrictions. UK Government imposed lockdown commenced on 23rd March 2020. Restrictions fluctuated before all restrictions were fully lifted in February 2022. The area in which Helen lived was, predominantly, an area that was subject to the highest levels of restrictions – Tier Three – for the majority of the time when there was variation in these restrictions.

The below agencies provided the following for consideration:

ELHT

6.187 During the period where COVID-19 restrictions were in place, patients were not permitted anybody to accompany them to, or visit them, in hospital. This could have been an opportunity for a safe discussion with Helen around the injuries she had sustained, had anybody completed routine enquiries or a DASH. This opportunity was not taken and the domestic abuse she was experiencing at home was not shared. That said, this could also be

viewed as Helen being somewhat isolated in a hospital setting and this may have been detrimental to her mental health. The review has not identified any evidence to suggest that Helen was adversely affected in this way.

6.188 Delays in Helen seeking medical attention on occasions could also be explained through not wanting to attend hospital due to a fear of catching COVID-19. Again, the review has not identified any evidence to suggest that this influenced Helen seeking medical intervention.

6.189 The period under consideration would have included the school summer holidays. Helen was unemployed at the time and potentially feeling overwhelmed with three children to look after. Clinicians did not seem to link up her anxiety and depression, suicidal ideation, and added stress of home life. There was no consideration for a safeguarding referral to be made to either Early Help, CSC or Adult Social Care for Helen. The periods of lock-down and fluctuating restrictions could potentially have contributed further stress to an already pressurised environment.

LSCFT

6.190 It is not evident from LSCFT records how COVID-19 may have impacted on Helen or her ability to access services. That said, we do know that Helen stated that she had difficulties getting GP appointments and this may have caused Helen further anxiety. It may also be the case that there were periods where other services offered less outreach and Helen therefore struggled to access services. As stated previously, there may also have been times of spending more time as a whole family, with increased pressures of home schooling and an impact on family relationships. This could all have had a detrimental impact on Helen's mental health. When combined with difficulties in accessing services due to increased need, and the lack of face-to-face support opportunities, COVID-19 may well have impacted on Helen's mental health and ability to access support.

LSCFT – ICB

6.191 During the period covered by this DHR, Helen had 10 GP appointments in respect of her feeling overwhelmed and low in mood. Three of these were face-to-face appointments prior to the COVID-19 pandemic. However, from 2020 onwards these moved to telephone appointments. The fact consultations were conducted over the telephone may have clearly impacted on the clinician's ability to fully assess risk and gain a greater understanding of what was contributing to Helen's declining mental health. Observations of body language and a person's presentation were all inaccessible to clinicians during this time and could have provided significant clues to what was happening in Helen's life. Whilst restrictions placed on face-to-face appointments were understandable and necessary for the protection of wider public health during this time, the impact this had on a clinicians' ability to thoroughly assess Helen cannot be overlooked.

Housing Situation

6.192 Significant rent arrears in relation to Helen's private rented property had been an issue since December 2019. This escalated and became a very prominent financial problem in the

12 months leading up to her death. Indeed, a notice of a possession hearing, scheduled to take place on the 5th September 2022, could well be considered to have been the catalyst that led to Helen taking her own life when she did.

6.193 On the 23rd March 2020 the UK government introduced emergency legislation to suspend new evictions from social or private rented accommodation, whilst the COVID-19 emergency legislation was in place. These measures remained in place until 31st May 2021. The measures also ensured no new possession proceedings could be sought through the courts.

6.194 There is no evidence that the introduction of the above measures influenced Helen's financial management. However, one hypothesis might be that she avoided paying rent (and arrears) in favour of other household costs, as she believed that she could not be evicted from the property. This could have contributed to the debts increasing to levels that Helen was subsequently unable to manage and it is evident from the information contained within this report that this had a huge impact on her mental health.

Conclusion

6.195 There is no direct evidence to indicate that the COVID-19 pandemic had an impact on Helen accessing support from domestic abuse services. That said, it is clear that the environmental circumstances at the time made it very difficult for the public to access support, including domestic abuse services. There is also no direct evidence to indicate that the pandemic contributed to increasing episodes of domestic abuse within the home, albeit this may have been the case. There is, however, clear information to indicate that the pandemic impacted on Helen's ability to obtain support for health issues, including her declining mental health. There is also information to indicate that the pandemic may have played a part in Helen's rent arrears rising to an unmanageable level. This clearly had a significant impact on Helen's mental health and the prospect of her and her children becoming homeless potentially contributed to Helen taking her own life.

Terms of Reference 10: To consider the impact of financial debt and potential financial abuse on the victim and the wider family.

6.197 There is clear evidence that Helen was having significant financial difficulties in the three to four years leading up to her death. It may be reasonable to assert that her financial position significantly worsened during her relationship with Dave. Indeed, there is evidence that Dave influenced, and possibly abused/coerced Helen's spending priorities, away from providing for her children and other household expenses, towards alcohol and drug consumption.

6.198 During interactions with mental health practitioners, Helen made some disclosures:

- Nov 21 – "Helen expressed that she had a number of stressors in her life such as an abusive relationship with her partner as he used her for money."

- Dec 21 – “Helen confirmed her partner received a suspended sentence and had to pay a fine, but she ended up paying it for him.”

This information indicates the presence of financial abuse; although no direct complaints of financial abuse were ever made by Helen to the police. The lack of professional curiosity demonstrated by many of the agencies involved with Helen in the four years prior to her death means that there were many missed opportunities for exploration of this area. It is noted however, the children were entitled to pupil premium and had been provided with additional support, which means that at least one service was aware of some of the financial difficulties Helen was experiencing.

6.199 There were frequent interactions between Helen and the Department for Work and Pensions (DWP) in relation to her Universal Credit (UC) arrangements and payments. Key interactions that provide a sense of Helen’s deterioration and financial problems are summarised below.

- Helen claimed UC as a single parent to three children. She did not declare a partner living with her throughout her claim.

- From the outset of her claim, Helen gave no indication she had a partner or was subject to domestic abuse during her interactions with DWP.

- February 2021 - Helen left a message on her UC journal asking for an early payment of her UC as she had no electricity and had no family that could help her out. She was signposted to local charities.

- March 2021 - A work coach recorded a history note stating that Helen did not feel she was fit to be looking for work due to her health. She was advised on how to start the health journey.

- May 2021 - Helen reported a change in her work details via her journal stating she stopped working on 20 May 2021.

- October 2021 - Work Capability Assessment (WCA) process was initiated with health conditions stated as anxiety, depression, bad legs, and really painful back. The WCA was deferred until 29 days later as per WCA process. Helen was referred for the WCA process and a letter was uploaded to Helen’s UC journal by a UC agent asking for more details of her health conditions.

- January 2022 - Helen enquired about her WCA stating her anxiety and depression were high and she could not face going to the restart scheme. A UC agent explained that restart is for people who have been out of work for over 12 months and are waiting for a WCA. They further informed her that until she had been to her medical assessment, she was required to attend appointments with the Job Centre and with Restart.

- March 2022 - Helen attended her WCA health assessment. Helen's health issues were listed as mental health problem, back problem, leg problem and vitamin D deficiency. She stated that she had previously self-harmed and taken overdoses but had never attended hospital for them, instead being helped at home by her mum. She stated she had 'daily thoughts of not wanting to be here,' but at the time of the assessment did not have any current intent to end her own life. She stated her GP was aware of her suicidal thoughts. Helen described having daily support from her mum to take care of her and her children. Helen stated she had taken an overdose 11 months prior to the assessment 'due an argument with her ex-partner at that time and having money worries.'

- March 2022 - Helen was informed via her UC journal of the outcome of her WCA, and that she had 'Limited Capability for Work and Work Related Activity' (LCWRA) and that she would not be asked to look for or prepare for work.

- May 2022 - UC received a call from Helen who gave consent for her mother to talk on her behalf. Helen's mother asked UC to stop paying 'their' landlord as 'they' are being evicted. UC called Helen back to inform her that they were unable to cancel the payments to the landlord as the landlord requested them due to rent arrears.

- 22nd August 2022 - Telephone assessment undertaken with Helen relating to an application for a Personal Independence Payment (PIP). Health conditions were recorded as depression and anxiety and leg pain. The notes from this assessment state, 'she has had suicidal thoughts in the past due to her depression. She has told her GP. No current plan (to carry out suicide) and her children are a protective factor'. The Healthcare Professional advised Helen had expressed previous suicidal ideation throughout the call but recommended no points for the daily living or mobility components of the PIP allowances.

6.200 Helen committed suicide on the 30th August 2022.

6.201 In addition to the information above, Helen also applied for, and received, several budgeting advances (loans) repayable via UC over a 12-month period. In her applications for the advances, Helen stated the loans were to purchase 'white goods'. Indeed Helen applied for a new cooker on three occasions. It is inferred these advances never went towards new 'white goods' but were diverted to other expenses.

6.202 As Helen's financial situation worsened, she sought debt management advice from Hyndburn Citizens' Advice Bureau (CAB). As part of this process she completed a 'client budget sheet'. This provides the most accurate snapshot of Helen's financial position in May 2022. The headlines of this assessment are as follows:

Total Income:	**£1560**	UC	£1434.33
		Child Benefit	£125.45
Outgoings:	**£1050**	Utilities	£120
		Transport/Travel	£20
		Groceries	£433.33
		Alcohol	£173.33
		Smoking	£303.33

Priority Debts		**Monthly Payments**
Credit Union Loan	£1137	£82.33
E-on Electricity	£400	£0 - Paid via UC
HBBC Council Tax	£1479.93	£0 - Paid via UC
Rent Arrears	£3742.55	£32.48
	Total	**£6759.48**
Non-priority debts	**£11630.03**	**£268.67**
Total debts:	**£18389.51**	**£383.48**

6.203 The CAB worked with Helen over an 8-month period and she was an existing client at the time of her death. However, it was difficult to maintain contact with Helen, and CAB closed their files on a few occasions due to non-engagement. Helen made no disclosures regarding domestic violence or her chaotic home life. She was facing both debt (non-housing) and eviction problems simultaneously. However, CAB and Helen appear to have been actively working with the local authority regarding re-housing options at the time of her death.

6.204 The letting agency managing Helen's tenancy was Sharp's of Accrington. According to information provided by them, Helen began to fall behind with her rent in August 2019. There appears to have been prompt and frequent correspondence between Sharp's and Helen as soon this became a problem. A series of payment plans were put in place, however Helen failed to maintain the required payments. In August 2020 arrears stood at £2125.00. This pattern continued and by February 2021 arrears had risen to £4225.67.

6.205 Whilst there were several defects with the property in 2022, causing Hyndburn Borough Council Environmental Health to become involved, evidence suggests Sharp's, at least superficially, corrected these defects when asked to do so.

6.206 Sharp's served a 'notice to vacate' on Helen in May of 2022. Whilst Helen was looking for alternative accommodation, she struggled with references due to outstanding arrears.

Solicitors acting on behalf of Sharp's confirmed a court issued a 'claim for possession' on the 5th August 2022. The possession hearing was scheduled for the 5th September 2022.

6.207 In her account to the review, Helen's mother made the following comments:

> "Then out of nowhere Helen got a letter from the landlord's estate agents to say her rent was being increased by £50 a month. About 3 days later she received another letter stating they wanted more money paying off her arrears, around £80 a month which she would clearly struggle to afford. She offered to pay £60 a month off her arrears but never received a response from them. After this she started to receive multiple eviction notices which had a profound effect on Helen's mental health, which she was struggling with due to years of financial stress and domestic abuse from her partner Dave, who did not help the situation."

6.208 Further accounts provided to the review by Helen's son Tom, and her close friend Debbie, probably provide the best insight into Helen's financial challenges and the impact Dave had on her and the family in this regard.

Debbie stated:

> "It was becoming clear that she was in significant debt and that any money they had was being spent on either alcohol or drugs. Helen was dismissive about this and began to tell numerous lies to cover up the violence and the lifestyle she was living. She was becoming unrecognisable from the vibrant and fun young lady I used to know.
>
> Family and friends stopped buying the children presents at Christmas and on birthdays as they knew that Dave would simply sell them to get extra money for alcohol and cocaine."

Tom also outlined:

> "My mum and Dave would drink at least 3-5 times a week, in the house in or out at the pub. As I will further elaborate, the nights they went to the pub were far worse than those they drank in the house. They would often spend £20 on alcohol and £10 on food, this left me and my sisters with just barely enough food so they could drink heavily.
>
> Many people liked to mention during this time that my mum was doing nothing wrong because we never went without food, but this entire time she was the creator of her own problems, manipulated by Dave. As she always had enough money for food, gas, and electricity, she just chose to spend it on alcohol, during this time we could have lived comfortably but we lived day by day with just enough food due to how my mum and Dave spent their money on drugs and alcohol. When Dave went to the shop it was 'let me spend £10 on Stella and £4 on food'."

6.209 There is clear and substantial evidence to indicate that Helen was having serious financial problems for some time prior to her death. This had a significant impact on her

psychological well-being and her sense of desperation is evident in a number of interactions with professionals. It is also worthy of note that Helen's last known text communication was with a relative and seeking support with her financial situation. It may be reasonable to assume that the impending court proceedings for eviction, with the associated potential for becoming homeless, was the catalyst that led to Helen taking her life when she did. However, there is no evidence to fully corroborate this hypothesis.

Terms of Reference 11: To consider the impact the victim's substance misuse had on their deterioration of mental health, and the impact the substance misuse had on the increasing episodes of domestic abuse.

6.210 It is important to consider the information that has been obtained during the review that relates to substance misuse by both Dave and Helen. We know that Dave has a criminal conviction for drug use (cannabis) and we know that alcohol was a factor on the occasions he was arrested for assaulting Helen. Indeed, on one occasion Helen advised the officers attending that Dave only assaulted her when drunk. Alcohol was also a factor for Dave when being managed by CLCRC. Helen has no convictions for drug related offences, but again Helen had often consumed alcohol at the time of the reported incidents of domestic abuse. The information concerning substance misuse by Dave and Helen largely comes from friends and family who have contributed to the review.

6.211 Helen's close friend Debbie offered the following observations in her written account to the review.

- *'Debbie was aware that she smoked cannabis'*

- *'Debbie became aware that Helen had started using cocaine and believes that Dave had introduced her to this drug. Debbie initially thought that it was just infrequent social use, but it became clear that both Helen and Dave were using cocaine on a daily basis. Debbie describes a time when she had broken up with her partner and that Helen had come to see her to offer some support. Debbie was horrified when she saw Helen and describes her as being skinny and looking like a 'smackhead''*

- *'At this point it became evident that Helen was in significant debt and Debbie believed that any money they had was spent on either alcohol or drugs'*

- *'Debbie indicates that family and friends stopped buying the children presents as they knew that Dave would simply sell them to get more money for alcohol and cocaine'*

- *'Jean was also aware of the life that her daughter was living but that Helen would always minimise the levels of violence, alcohol, and drugs'*

- *'Helen was suffering from mental health problems and was seeking support from her GP. It was clear she was in a downward spiral where she was abusing alcohol and cocaine, she was suffering from depression and was failing to manage an ever-increasing debt with her landlord'*

6.212 Helen's son Tom also offered an insight into the domestic abuse and substance misuse involving his mother Helen and Dave. In his written account provided after the death of his mother, he made the following comments.

- *'After starting to date Dave, my mum slowly slid into depression and alcoholism'*

- *'My mum and Dave would drink at least 3-5 times a week, in the house in or out at the pub. As I will further elaborate, the nights they went to the pub were far worse than those they drank in the house. They would often spend £20 on alcohol and £10 on food, this left me and my sisters with just barely enough food so they could drink heavily'*

- *'she just chose to spend it on alcohol, during this time we could have lived comfortably but we lived day by day with just enough food due to how my mum and Dave spent their money on drugs and alcohol. When Dave went to the shop it was "let me spend £10 on Stella and £4 on food". This is only scraping the surface though. From the constant drinking and drug usage my mum began to slip into a shadow of herself which Dave further pushed her into. My mum would barely get out of bed unless it meant going out to drink'*

- *'I wake up for school in the morning at about 8:00 and get ready. I then proceed to check on the girls and see that neither of them is ready for school. I ask them "why are you not ready" to which Lisa replies "Mummy said we don't have to go". It is obvious to me why, as I already hear talking downstairs. I walk downstairs and stand at the last step outside my mum's room listening. Some lady I'd never met before is drunkenly rambling about how she doesn't want to leave her boyfriend because she loves him even though he beats her almost to death. I walk into the room to see the lady chugging a bottle of vodka and my mum next to her just as drunk'*

- *'I wake up in the morning and hear my mum puking. Me and Lisa come downstairs to help her. At first, I'm concerned but then I noticed three empty bottles of vodka on the floor next to her bed. She had just drank too much'*

6.213 This information suggests that Helen and Dave were both consuming large quantities of alcohol and cocaine on a frequent basis. Information from the coronial investigation also indicates that a small bag with white powder residue was found in Helen's handbag on the morning of her death. Whilst this was not tested, family members believe this white powder was cocaine. No toxicology was taken following Helen's death.

6.214 Research suggests that prolonged use of cocaine and alcohol can have a significant impact on an individual's mental and physical health.

The UK Addiction Centre website suggests[37]:

> *'Addiction develops when drugs such as cocaine are used as a coping mechanism for unresolved issues such as trauma or grief. Just like comfort eating or obsessive gaming, the effects of cocaine are used to escape the reality that you may not be ready to face.'*

6.215 It is a possibility that Helen was using cocaine to 'escape' her increasingly difficult personal circumstances. Helen was suffering regular physical and psychological abuse from Dave and was struggling to manage an increasing debt whilst bringing up 3 children as a single mum.

6.216 The website goes on to identify several consequences of cocaine use including a loss of appetite and weight loss, difficulty sleeping and anxiety and depression. These are all symptoms that Helen outlined when speaking with her GP.

6.217 The website also suggests that regular cocaine use can also lead to chronic anxiety, depression, and paranoia, which can result in increased cases of violence, domestic violence, and suicide. Extensive cocaine abuse can also result in serious financial issues. We know there was significant domestic abuse between Helen and Dave and that this also involved financial coercion and control and significant financial debt.

6.218 It is also important to consider the use of alcohol and cocaine together as various research suggests that it can lead to impulsive and violent behaviour as well as heightened anxiety and depression. We know that Dave suffered from significant anxiety and depression. Did his use of alcohol and cocaine also contribute to his use of physical and psychological abuse against Helen?

6.219 The review panel have given this TOR consideration and believe that Helen's use of cocaine and alcohol contributed to the deterioration of her mental and physical health. The panel also believe that substance misuse by both Helen and Dave contributed to increasing levels of domestic abuse within the relationship.

Terms of Reference 12: To identify clearly what those lessons are, how they will be acted upon and what is expected to change as a result. Agencies will also identify good practice and how that enabled partners to work together in this case.

6.220 This TOR will be dealt with in section 7 of the report.

[37] UK Addiction Centre (UKAT) website guidance – https://www.ukat.co.uk

7.0 Lessons Identified and Recommendations

7.1 From analysis carried out during this review, a number of learning opportunities have been identified. These are listed below along with specific recommendations to the areas of practice where improvements are required.

Overarching Learning and Recommendations

All agencies to embed a culture of professional curiosity and equip practitioners with skills to establish the full facts.

7.2 What is professional curiosity?

> *Professional curiosity is the capacity and communication skill to explore and understand what is happening within a family rather than making assumptions or accepting things at face value. Professional curiosity is a golden thread through all safeguarding partnership learning reviews and audits and is an essential part of safeguarding. Nurturing professional curiosity is a fundamental aspect of working together to keep children, young people and adults safe. Professional curiosity can require practitioners to think 'outside the box' and consider families' circumstances holistically*. [38]

7.3 There are multiple examples within this review that demonstrate either a lack of, and/or a superficial exploration of the situation before them, alongside a willingness amongst practitioners to take things at face value.

7.4 Greater professional curiosity could have been demonstrated by accessing the history of previous incidents and asking basic questions. This would have identified a pattern of abuse that represented a greater risk to Helen and her children than that assessed within individual incidents. Professionals need to 'look for the bigger picture' and recognise that what they see before them at any given time is a snapshot of the 'feature film'.

7.5 Significant risk factors such as alcohol misuse, mental health issues and the presence of children were identified in each of the reported violent domestic abuse incidents. Greater professional curiosity by all agencies involved should have identified this pattern, escalated the risk and ensured appropriate support was provided to Helen and her family.

Underline ability to override criteria and use professional judgement to refer cases to dedicated joint working forums.

7.6 Helen's case was not referred to MARAC on a number of occasions due to individual practitioners assessing the individual situation to not meet the relevant criteria. On each occasion, these decisions appeared to be based on prescriptive rule following such as whether repeated incidents fell outside the prescribed timeframe, or the individual DASH risk assessment score being too low. It appears that limited thought was given to the wider

[38] Professional Curiosity as defined by the Rotherham Clinical Commissioning Group.

historical context, which when considered as a whole, would have demonstrated the physical and psychological trauma Helen and the children were likely, or at risk of, suffering.

The following criteria is provided by a Lancashire MASH supervisor.

Consideration for MARAC:

Bespoke consideration based on history and nature of allegation, or fear of victim - less rigid regarding number of crimes in 12-month period.

The referral is high-risk

- 14 or more 'yes' answers to the DASH Risk Assessment (please seek advice from supervision).

Re-referral criteria

- A further incident involving violence/threats of violence/sexual offences within 12 months of being heard.
- A pattern of stalking/harassment within 12 months of being heard. Escalation of behaviour.

7.7 LCC Domestic abuse policy[39] provides:

If a professional has serious concerns about a victim's situation, they should use their professional judgement to decide whether to refer the case to MARAC. There will be occasions where the particular context of a case gives rise to serious concerns even if the victim has been unable to disclose the information that might highlight their risk more clearly.

7.8 Supervisors, and in most cases all practitioners, have latitude to use professional judgement and refer cases that fall outside the set criteria; however, in this case there appears to have been a reluctance to do so, or perhaps a limited understanding of the *ability* to do so. This clearly reduced opportunities to work with Helen and her family and make meaningful interventions.

7.9 Significant work has been ongoing in Lancashire to enhance the MARAC process. This has included:

- Desktop reviews of available documentation, policies, procedures and reports.
- Analysis of the latest HMICFRS PEEL inspection reports in relation to MARAC.
- Direct engagement with other police forces and partner agencies with regards to their practices.

[39] Lancashire County Council Adults Domestic Abuse Policy (lancashiresafeguarding.org.uk)

- Focus groups involving practitioners involved in MARAC/MARRAC on a pan-Lancashire footprint.
- Mapping of current MARAC processes, systems and documentation and demand in relation high-risk DA cases.

7.10 The information obtained identified a number of issues for consideration within the Lancashire footprint:

- Inconsistent offer across Lancashire with LCC operating the MARAC model whilst the two unitary authorities (Blackburn with Darwen and Blackpool) operate the newer MARRAC model.
- LCC held virtual MARAC conferences every four weeks and cases could take up to 51 days to be heard.
- LCC dealt with a MARAC caseload of approximately 3000 cases in 2023.
- SafeLives[40] guidance suggests that 10% of DA crime is expected to be high-risk and therefore referred to MARAC. The proportion of high-risk cases, and therefore those referred to MARAC, in Lancashire was 16%. A review of these cases in September and October of 2023 indicated that only 45% were appropriately graded as high-risk.
- Issues around governance and accountability. Resource constraints resulted in no capacity to monitor, chase or hold agencies to account for completion of agreed actions. The system did not make it possible to review the effectiveness of MARAC interventions.

7.11 As a result of these identified issues, the MARRAC pan-Lancashire model will be adopted throughout Lancashire. The following are believed to be some of the key benefits of this new approach:

- Consistent approach pan-Lancashire.
- Referrals into high-risk MARRAC will be assessed every morning and will be formally dealt with at MARRAC within 7 days.
- MARRACs will be held on a Monday, Wednesday and Friday of each week.
- Daily referrals will be assessed by a Detective Sergeant in conjunction with a LVS IDVA.
- MARRAC will run virtually via Teams and additional administrative support will be provided.
- A Teams Power App will be utilised which allows for agenda setting, minuting and action tracking. Documents can be uploaded to this App and shared with MARRAC members. A data dashboard is also being developed to support this process.
- The MARRAC Strategic Board to be considered in the wider Lancashire strategic governance arrangements.

Devise strategies to engage with victims that are flexible and designed to meet the needs of the individual.

[40] Safelives.org.uk - A UK-wide charity dedicated to ending domestic abuse, for everyone and for good.

7.12 Throughout the analysis of domestic abuse incidents involving Helen, it appears evident that multiple agencies tried and in the main failed, to engage with her to any meaningful extent. Other than a brief period of 'Early Help' intervention, no other agency worked with Helen to tackle her exposure to domestic abuse. How might domestic abuse focused services such as IDVA and MARAC had more significant involvement in the life of Helen and her children to ensure they were safeguarded? It is important to note that LVS receive fifteen thousand DA referrals each year and that these referrals are dealt with by twenty eight DA staff, including sixteen IDVA's. This makes it incredibly challenging to engage with victims who are unwilling to seek ongoing support and repeatedly decline help offered.

7.13 LVS IDVA were informed of each DA episode via MASH or automated referral and contacted Helen by phone to discuss their services on each occasion. Unfortunately, Helen was reluctant to engage with the service and provided reassurances that she was separating from David. On each occasion, she declined any further contact or intervention, other than the initial contact call.

7.14 There may be a myriad of reasons why Helen felt unable to engage with IDVA services at each point of contact. How might IDVA services develop an approach to improve meaningful and sustained engagement with DA victims, having considered full case history prior to support workers contacting victims? This may be possible but would clearly require significant investment and additional resources.

Single Agency Learning and Recommendations

7.15 East Lancashire Hospital's Trust

Learning Identified

- Lack of professional curiosity throughout Helen's attendances.

- Lack of exploration and escalation of potential safeguarding concerns for Helen, her situation was not discussed with ELHT's Adult Safeguarding team or with hospital IDVA.

- Lack of consideration for Helen's children who were reported to be at home when Helen disclosed previous domestic abuse. The situation was not discussed with ELHT's Children's Safeguarding Team.

- Documentation in both cases was of a poor standard, limited facts around partner details were recorded in notes. In Helen's case, despite her partner being present for most of the attendances and remaining with her, staff took no steps to gain or record his name.

- No evidence of routine enquiry regarding relationship circumstances and domestic abuse from Gynaecology or Emergency / Urgent care departments.

- ELHT's use of high risk patients 'flags' was inconsistent and were not effective in Helen's case.

- Helen's disclosures of depression and anxiety were documented throughout her attendances; however, no action was taken, nor does there appear to have been any discussion or exploration of her alcohol consumption or possible substance misuse, or indeed her personal domestic circumstances. The review discovered the trust had not adopted a depression screening tool. This needs to be addressed, so patients accessing the trust who have depression and anxiety, or are experiencing alcohol or substance misuse issues, are supported appropriately.

Recommendations

- ELHT is taking steps to ensure routine enquiry is embedded in services, in particular gynaecology. However, this should be embedded across all directorates.

- ELHT to ensure up to date adult and child safeguarding information is available on intranet pages and more accessible to **all staff**.

- ELHT began transferring over to electronic patient records in June 2023, currently the trust uses primarily paper records with only some systems are online. The system change aims to improve accuracy in patient records and collaborate multiple systems into one. Safeguarding concerns will be more easily identified, and patients classed as high-risk domestic abuse and on the special register will be alerted to practitioners accessing their records.

- The special register is a positive tool that can be used to flag multiple factors, ranging from MARAC to learning disability patients. However, MARAC patients are removed after twelve months, and it is not possible to identify why the patient was on the special register in the first instance once removed. ELHT should review this process, so professionals are able to access full history and risks.

- The innovation of 'Safeguarding Champions' has been established within the trust and they meet every two months. The 'Safeguarding Champions' meetings explore key themes such as domestic abuse, sexual violence, MCA and DoLS, and use expert speakers to provide up to date information to staff. This information is then cascaded to departments via the 'Safeguarding Champions'. This initiative should continue and focus on DA related matters as a standing item.

- Depression and anxiety screening tools should be implemented to support patients disclosing depression and anxiety issues.

- Consider using Tom's Story during induction training for all new staff and it could also be included as part of regular safeguarding training for all staff.

7.16 Children's Social Care - Lancashire County Council

Learning Identified

- There has been reflection with the team manager in MASH about the use of information sharing and when we can allow this, overriding consent. The team manager will develop this going forward.

- It is not clear if the five domestic abuse incidents involving Helen and Dave and the children were ever considered as a collective at the point of referral in to MASH. It appears that they were considered on an individual basis and this does not afford the assessor the opportunity to obtain the true picture of what has been taking place within the home.

Recommendations

- As part of any referral, MASH practitioners should be required to consider previous referrals to ensure they have the 'full picture' and can offer a more informed professional assessment of the domestic abuse taking place and risk within the home. This would hopefully help support the identification of patterns of abuse and remove the risk of parents dismissing individual reports as 'one-off incidents' when there is evidence to show they are not.

- Children are now identified in law as victims of domestic abuse in their own right where they are related to the suspected perpetrator or the victim, and they see, hear or experience the effects of domestic abuse[41]. Safeguarding checks should be undertaken by MASH practitioners with ALL agencies involved with the children and the agency working most closely with them should be required to undertake enquiries and offer pastoral support even without parental consent. Where there is no such agency in place, this responsibility should fall to CSC. It is posited that current legislation supports this course of action as the Adoption and Children Act 2002 broadens the definition of significant harm under section 47 of the Children Act 1989 to include the emotional harm suffered by those children who witness domestic violence or are aware of domestic abuse within their home environment. Local authorities are required, under section 47 Children Act 1989, where they have 'reasonable cause to suspect that a child is suffering, or is likely to suffer, significant harm,' to make enquiries to enable them to decide what action may be required to safeguard or promote the welfare of the child. Any report of domestic abuse received by the local authority therefore, should warrant elements of a section 47 response. The local authority could consider the implementation of a specific children and families IDVA team who oversee this work and can undertake the work when there is no other agency involved with the children. Had Tom or Lisa had such contact following each of the reported incidents of domestic abuse, it is possible that a much clearer picture of the situation within the family home would have been known to professionals at a much earlier stage. This may have allowed for greater support for

[41] Section 3 Domestic Abuse Act 2021, which came into force on 31st January 2022.

Helen and the children and helped them break free from the domestic abuse they were all experiencing.

- All CSC, CFSW and Early Help staff to undertake mandatory safeguarding and domestic abuse training that incorporates Tom's Story. Such training should also form part of induction training for all new staff for CSC, CFSW and Early Help.

7.17 Lancashire & South Cumbria NHS Foundation Trust

In response to Helen's death and the extended CBT waiting time she experienced, LSCFT carried out an internal review and produced a Comprehensive Incident Investigation Report. This report is extensive and details several lessons identified and recommendations.

Learning Identified

- Practitioners need to adopt a 'Think Family' approach when working with or assessing service users. This approach will identify any potential harm to members of the family and ensure appropriate support for all members struggling to cope.

- The adult services safeguarding children assessment on RiO should be completed during assessments.

- The domestic abuse, stalking and honour (DASH) based violence risk assessment should be completed when supporting service users who report domestic abuse.

- The importance of sharing risk information when discharging service users to GP. Practitioners must ensure information relating to domestic abuse or safeguarding are included in discharge notes.

- Consideration must be given to processes that copy letters to service users as a matter of course, as their abuser may have access to victim's mail.

Recommendations

- MindsMatter staff to be trained in 'Think Family' approach.

- Develop an alternative approach to "opt-in" final warning letters. There may be many reasons why service users do not respond to correspondence, other than not wanting to continue with treatment.

- Continue to emphasise the importance of completing DASH when consulting with service users disclosing domestic abuse.

- Carry out periodic sampling of discharge letters to ensure GPs are being fully informed of risk information, especially domestic abuse, safeguarding and mental health issues.

- Consider using Tom's Story during induction training for all new staff and it could also be included as part of regular safeguarding training for all staff.

7.18 The Probation Service

Learning Identified

- Home visits should be an integral part of probation supervision so addresses and relationship situations can be confirmed.

- Enquiries to Children's Social Care should be followed up to provide Probation with a fully informed understanding of the family situation and to ensure that children are being protected.

- Management oversight should apply to all cases involving domestic abuse. This is a very challenging subject matter and practitioners require support and guidance to ensure their management of the perpetrator is effective.

Recommendations

- All the above lessons identified are covered within existing policy in the unified Probation Service. Supervisors and managers must ensure they are adhered to.

- There is a home visit framework which directs home visits in every case – supervisory oversight required.

- Dedicated probation staff have been embedded within the Lancashire MASH to undertake domestic abuse enquiries and ensure police intelligence is available and acted upon when appropriate.

- Embedded MASH staff also ensure CSC enquiries are processed in a timely manner.

- The Senior Probation Officer (SPO) to ensure that all staff are aware of and utilising the above policy/processes.

- Probation should consider incorporating Tom's story into their required induction training for all new staff and it should be included as part of regular safeguarding training for all.

- It was clear that Dave did not attend his final scheduled appointment with CLCRC. As a result it appears there was no 'final sign off' and no assessment of his personal circumstances at this specific time. This is not satisfactory and should be a requirement in all cases where an individual is directed to fulfil a court imposed sanction.

7.19 High School – secondary school for Tom and Lisa

Learning Identified

- School staff have developed strong, trusting professional relationships with the children, from which they have felt safe to talk about distressing family experiences.

- School has been a constant and a safe place for both children, echoed by their attendance at and commitment to school life.

- Encompass alerts are fundamental to providing a prompt insight, therefore helping staff to safeguard and support children through education.

Recommendations

- Positive interventions adopted by the school should be shared wider and adopted accordingly.

- All Lancashire schools should consider incorporating Tom's Story into their required induction training for all new staff and it should be considered as part of regular safeguarding training for all staff.

7.20 Citizens Advice Rossendale & Hyndburn

Learning Identified

- Helen was advised by experienced debt caseworkers who were skilled at eliciting information from clients. However, it was still difficult for them to maintain engagement with Helen and see through an effective debt management plan. This may have had a positive impact on Helen's stress and anxiety levels.

Recommendations

- Citizens Advice has a 'Supporting Vulnerable Clients' Policy and staff have regular safeguarding training. Ensure all staff are aware of and fully utilising the above policy and procedures. Consider strategies to secure consistent engagement with service users.

- Consider using Tom's Story during induction training for all new staff and it could also be considered as part of regular safeguarding training for all staff.

7.21 HCRG Care Group

Learning Identified

- HCRG Care Group has focussed on completion of appropriate SMART action planning when addressing the impact of domestic abuse on wider family members, in particular children.

- 'Bite-size' training on completing SMART action plans has been provided and the internal SOP on Responding to Domestic Violence and Abuse updated.

- An internal audit is ongoing to assess whether appropriate PSRF follow up is taking place, including completion of SMART action plans.

Recommendations

- Continue annual audit programme in relation to response to PSRFs and SMART action planning.

- We have produced bitesize domestic abuse training including Non-Fatal Strangulation (NFS), in line what has been produced via the Pan-Lancashire Domestic Abuse Sub-Group (PLDASG).

- Tom's Story should be considered as part of regular safeguarding training for all staff.

7.22 Lancashire and South Cumbria Integrated Care Board (ICB) GP practices

Learning Identified

- Opportunities for further Think Family approach within GP consultations to be considered.

- Opportunities for professional curiosity in some of the GP consultations to be considered.

- Opportunities for domestic abuse considerations were present within several GP consultations.

- Overall GP response was robust. Further consideration to external factors could have been strengthened within some of the consultations.

- Further consideration to cycle of behaviour escalation when a patient is ceasing anti-depression medications and not engaging with Mental Health referrals and pathways.

- There was limited consideration regarding the children or liaison with CSC.

- No follow up on significant events (CPR) (overdose on medications).

Recommendations

- Ensure Primary Care can recognise and respond appropriately to safeguarding concerns and incidents, including referral to the local authority.

- Make sure GPs practice training around safeguarding and domestic abuse is effective and up to date and incorporates Tom's Story.

- Review of all safeguarding policies and procedures including domestic abuse.

- Explore further learning opportunities for 'professional curiosity' and 'Think Family' approach for GP practices.

- Consider cycle of behaviour escalation when a patient is ceasing anti-depression medications and not engaging with mental health referrals and pathways.

- Review policies and consider whether these adequately outline appropriate support actions/next steps that are required when GP surgeries receive letters from other services (particularly mental health, domestic abuse, and substance misuse services) regarding patient's being discharged due to non-attendance or non-engagement.

- Tom's Story should be considered as part of regular safeguarding training for all staff.

Hyndburn Borough Council

7.23 Environmental Health – Housing Standards in the Private Rented Sector

Learning Identified

- The officer closed the case without visiting the property or receiving photographic evidence that the housing standards work had been carried out.

- The officer closed the case having received email communication by the landlord that work had taken place.

Recommendations

- If resources allow re-visits should be carried out, photographic evidence as a minimum prior to closing requests for service. Tenants should also be required to confirm the work has been completed rather than sole reliance on the word of the landlord and/or letting agency.

- Consider using Tom's Story during induction training for all new staff and it could also be considered as part of regular safeguarding training for all staff.

7.24 Lancashire Constabulary

Learning Identified / Recommendation

- When poor investigation and evidential file preparation relating to domestic abuse is identified, action should be taken to address quality and learning to ensure positive outcomes, effective safeguarding of victims and the prosecution of perpetrators. This should be on an individual and organisational level.

Narrative

Helen reported an assault on the 1st May 2021 in which Dave threw an ashtray, striking her on the head causing an injury. Dave then assaulted Helen further. The assault was witnessed by one of Helen's children, Tom. Helen and Tom provided witness statements supporting an investigation. Dave was arrested and given conditional police bail to allow further enquiries to be made and a file to be prepared for the Crown Prosecution Service (CPS) to consider.

The file of evidence was reviewed by a Sergeant. The case was not submitted to the CPS as the reviewing Sergeant concluded that the investigation by the officers was 'poorly gathered' and the content of the witness statements obtained from Helen and Tom were 'evidentially poor'. There was a lack of professional curiosity from the investigating officers, that led to insufficient evidential detail being included in the witness statements.

Helen retracted her statement as she did not wish to go through the court process due to her mental health. However, she was content for Tom to continue to support the investigation, but he declined to do so. It is not known what conversation took place between officers and Helen, when probing her decision to withdraw her earlier support. The reviewing Sergeant indicates that he considered an 'evidence led' prosecution but concluded that; "such an action could make Helen hostile and she could lose trust in the police resulting in her not reporting further incidents." The reviewing officer could have explored further and recorded Helen's rationale for withdrawing support for the prosecution.

There was insufficient evidence to pursue an 'evidence led' prosecution due to the poor standard of evidence gathered. However, the reason given for not pursuing such a prosecution in terms of the victim's future response to reporting domestic abuse may be considered flawed. An option for the supervisor could have been for further additional statements to be obtained to correct the initial omissions.

Recommendations

- Tom's Story should be considered and incorporated into safeguarding and domestic abuse training for new recruits and as part of all staff's regular training.

- Training for officers attending domestic abuse incidents should be reviewed to ensure it includes a focus on the importance of collecting relevant evidence with a view to the need for building evidence-led prosecutions, given research demonstrating the higher

likelihood of victims and witnesses possibly retracting their statements in domestically abusive situations.

- Training for staff/officers responsible for receiving and processing victim/witness statement retractions should be reviewed to ensure that it leaves them equipped to recognise the impact of domestic abuse, psychological abuse and manipulation and coercive control. Professional curiosity and reassurance should be integral parts of interactions with victims/witnesses who express that they want to retract their statement.

- Information provided to victims/witnesses about statement retraction should include information about support services available to them.

8.0 Conclusions

The panel have considered the significant amount of information obtained as part of this review and believes there are 4 significant contributors to Helen taking her own life.

8.1 Domestic Abuse

It is evident that Helen suffered significant physical and psychological abuse during her 5-year relationship with Dave. The compelling accounts from Tom and Debbie and the data provided by the Lancashire Constabulary offer a good insight into this. Information from other agencies, and Health in particular, offers a further insight into the spiralling mental health of Helen during her abusive relationship with Dave. There can be little doubt that this ultimately contributed to Helen taking her own life.

8.2 Mental Health

It is clear from the analysis conducted that Helen began to seek help for her deteriorating mental health on several occasions. Unfortunately, her chaotic lifestyle often led to her struggling to maintain this engagement thereby preventing her from getting the support she desperately required. The significant delays in obtaining CBT also contributed and Helen was not supported or protected effectively. There were several opportunities to intervene and protect Helen but sadly these were missed.

8.3 Substance Misuse

Helen's use of alcohol had clearly escalated since she began her relationship with Dave. Information provided to the review also suggests that Dave 'introduced' Helen to cocaine and that she and Dave were possibly using this drug on an almost daily basis. It is reasonable to suggest that the significant use of both in the final stages of her life contributed to the deterioration in Helen's physical and mental health. It is also likely that Dave's use of alcohol and cocaine resulted in lowered inhibitions and the possibility of increased aggression, further

contributing to his predilection for domestic abuse. This potentially contributed to Helen taking her own life.

8.4 Significant Financial Debt

There is clear and substantial evidence to indicate that Helen was having serious financial problems for some time prior to her death. This had a significant impact on her psychological well-being and her sense of desperation is evident in several interactions with professionals. It is also worthy of note that Helen's last known text communication was with a relative, from who she was seeking support with her financial situation. It may be reasonable to assume that the impending court proceedings for eviction, and the potential for becoming homeless, were the catalyst that led to Helen taking her life when she did.

8.5 Helen had numerous interactions with various agencies during the last years of her life. These interactions were opportunities for interventions but sadly on many occasions these were missed and Helen's life and that of her children became increasingly difficult. It is clear from the information obtained during this review, that agencies specifically established or commissioned to support women and children in this situation could have been more effective in supporting Helen and her 3 children. It is imperative that these agencies learn from these missed opportunities and adapt to offer a collective and enhanced bespoke service to vulnerable victims of domestic abuse.

There is evidence of extensive information sharing via established mechanisms, yet no significant interventions occured as a result. Did Helen and her family fall just short of the "threshold bar"? It appears information sharing was process driven, with an emphasis on compliance rather than cutting through process to see the true risk and vulnerabilities of Helen and her family. Professional curiosity was lacking across all agencies.

The review highlights no single agency lead or trusted professional in Helen's life. No agency took responsibility to lead or coordinate a safeguarding plan for Helen and the children to ensure they were protected from the abuse they were experiencing.

8.6 National and local processes should also be subject to regular review to ensure they are effective and delivering what is required to protect vulnerable victims of domestic abuse. It is clear that many of these were ineffective and inconsistent and failed to deliver the necessary services required. The MARAC process in Lancashire at the time of the domestic abuse was a prime example of this. Helen's case was only heard at one MARAC meeting, with no evidence of effective activity as a result. Referral criteria appears to have prevented or dissuaded professionals from referring Helen and professional judgement was not applied to override this. It is hoped that the recent review and investment in the new pan-Lancashire MARRAC process will help to improve the service offered to victims of domestic abuse in the future.

8.7 The Pennine Lancashire Community Safety Partnership wishes to express their gratitude to the family and friends of Helen for their contribution, support and patience during this review. The contribution they have made has given a significant insight into the life of Helen and the children in the lead up to her death. As a result they have helped all the agencies involved to learn lessons and improve the overall response to domestic abuse. This will ensure that partner agencies work more effectively and collaboratively to make the public safer in the future. Thank you!

Glossary

Barnardo's: A charity that aims to protect and support children and young people in the UK

B-with-Us: a home renting service partnership between local councils and social landlords within the Pennine.

CFWS: The Children and Family Wellbeing Service (CFW) offers a wide range of support across the 0-19yrs+ age range (25 years for SEND) with a 'whole family' approach.

Changing Futures: is a 4-year, £77 million programme aiming to improve outcomes for adults experiencing multiple disadvantage – including combinations of homelessness, substance misuse, mental health issues, domestic abuse and contact with the criminal justice system.

Citalopram: is a type of antidepressant known as a selective serotonin reuptake inhibitor (SSRI).

Cognitive Behavioural Therapy (CBT): is used to treat anxiety and depression by breaking down overwhelming problems into smaller, more manageable and positive way.

Diazepam: a prescription only drug used to treat anxiety, muscle spasms and seizures or fits.

Domestic Violence Disclosure Scheme (DVDS): also known as 'Clare's Law' enables the police to disclose information to a victim or a potential victim of domestic abuse about their partner's or ex-partner's previous abusive or violent offending.

Early Help: Support work with families where they identify their needs and plan appropriate responses.

Hyndburn and Ribble Valley Domestic Abuse Team (HARV): an organisation which aims to identify, support and protect adults and children from abuse, exploitation and violence.

Inspire Services: an organisation which aims to encourage individuals to find the strength and resources within themselves to achieve and sustain the life and behavioural changes they seek.

IRS: The Initial Response Service is 24 hour access to mental health care, advice , support and treatment

Lansoprazole: a prescription drug used to for indigestion, heartburn, acid reflux and gastroesophageal-reflux-disease (GORD) as it reduces the amount of acid the stomach produces.

MindsMatter: NHS psychological therapies services (IAPT), including cognitive behavioural therapy (CBT) treatment and services at this clinic.

Mirtazapine: is an antidepressant medicine that is used to treat depression in adults. It is also used to treat obsessive-compulsive disorder (OCD) and anxiety.

National Suicide Prevention Alliance (NSPA): an alliance of public, private and voluntary organisations who aim to prevent and reduce suicide and self-harm, and to support those bereaved or affected by suicide.

Propranolol: a drug used to treat heart problems and can help with anxiety and prevent migraines.

Refuge: A charity which aims to help women and their children fleeing from an abuser.

Specialist Triage Assessment and Referral Teams (START): an NHS service that aims to provide mental health, learning disability, autism and community based services for Lancashire.

Specialist Triage Assessment Referral and Treatment Team (START): Provides timely triage, assessment, onward referral/signposting and treatment for service users referred without the need for multiple assessments. The team screens and assesses the needs of all referrals and signposts on to other services, creating a seamless and timely care pathway. The team provide functions which include ongoing assessment, brief interventions and a case management function for some service users.

Women's Aid: A National charity working to end domestic abuse against women and children.

PENNINE LANCASHIRE COMMUNITY SAFETY PARTNERSHIP

Appendix A: Executive Summary

Domestic Homicide Review

EXECUTIVE SUMMARY

In respect of Helen, who took her own life
On the 30th August 2022

Report produced for Pennine Lancashire Community Safety Partnership by
Paul Withers, QPM & Neil Ashton
Independent Review Chair and Joint Authors
December 2024

Contents

1. Executive Summary

The Pennine Lancashire Community Safety Partnership wishes to express their condolences to the family and friends of Helen.

1.1 Review Process

1.1.1 This summary outlines the process undertaken by Pennine Community Safety Partnership in reviewing the death of Helen, a resident of East Lancashire.

1.1.2 In the early hours of 30th August 2022, Helen took her own life whilst at home. Her mother, on/off partner Dave and two children were also in the house at the time. Paramedics and the Police were called, but Helen could not be revived.

1.1.3 A subsequent police investigation into Helen's death concluded that there was no third-party involvement in the hanging. A coronial inquest was held, the cause of death being concluded to be death by hanging.

1.1.4 This DHR has been anonymised in accordance with the statutory guidance. Only the Independent Chair (hereafter 'the chair') and Review Panel members are named.

1.1.5 The following pseudonyms have been used in this review to protect the identities of the victim, other parties, those of their family members and the perpetrator:

Individual	Pseudonym
Deceased	Helen (35 years)
Son of deceased	Tom (17 years)
Daughter of deceased	Lisa (14 years)
Daughter of deceased	Megan (10 years)
Brother of deceased	Paul
Brother of deceased	Geoff
Sister of deceased	Tina
Mother of deceased	Jean
Father of deceased	Frank
Friend of deceased	Debbie
Partner of deceased – perpetrator	Dave
Relative	Len
Relative	Neil
Relative	Stuart
Friend	Susan
Friend	Julie

Relative	Norman

1.1.6 The circumstances of the Helen's death and other domestic abuse incidents involving her were referred to the Pennine Lancashire Community Safety Partnership (PLCSP) by Lancashire Constabulary on 24th January 2023. This DHR was commissioned on 3rd February 2023, having deemed to meet the criteria in accordance with section 9 (3) of the Domestic Violence, Crime and Victim's Act 2004. Paul Withers QPM and Neil Ashton were appointed as Independent Chair and joint author of the DHR respectively.

1.1.7 The DHR panel met on six occasions between March 2023 and January 2024.

1.1.8 The Review Panel would like to thank those who contributed to the DHR process for their participation, especially those family and friends members who provided written submissions to the panel.

1.2 Contributors

1.2.1 This DHR has followed the statutory guidance issued following the implementation of Section 9 of the Domestic Violence Crime and Victims Act 2004, as well as the local DHR protocols.

1.2.2 The following agencies provided Individual Management Reviews to inform the review:

- Children's Social Care – Lancashire County Council
- Citizens Advice
- Department for Work and Pensions
- East Lancashire Health Trust
- Environmental Health – Hyndburn Borough Council
- Housing – Hyndburn Borough Council
- Integrated Care Board
- Lancashire 0-19 Service HCRG Care Group
- Lancashire and South Cumbria NHS Foundation Trust
- Lancashire Constabulary
- Lancashire Victim Support
- National Probation Services
- North West Ambulance Service
- St Christopher's Church of England High School

1.2.3 The following agencies provided short reports to inform the review:

- Sharps Letting Agency

1.2.4 Both IMRs and Short Reports produced by agencies enabled the Review Panel to analyse the contact with Helen, Dave and Helen's children and to produce the learning for this DHR. Where necessary further questions were sent to agencies and responses were received.

1.2.5 Significant contributions were also made by Helen's family and friends in the form of written submissions. These accounts were considered in detail by the panel and provided a unique insight into Helen's life and struggles due to the domestic abuse she was subjected to. They also provided a voice to Helen's children, whose accounts were detailed, frank and often moving. The panel was struck by these first-hand accounts and how clearly they illustrated the severe and lasting impact domestic abuse has upon children. Helen's son Tom provided a detailed account describing years of abuse and the steady decline of his mother as a result. So compelling was his account that the panel have agreed to include it, in its entirety, as part of the main report at section 4.19. With the agreement of Tom, extracts have been used to develop a training package for practitioners, focusing upon the impact domestic abuse has on children.

1.3 Panel Members

1.3.1

Independent Chair and Author
Joint Author
Senior Manager Safeguarding, Inspection & Audit – Lancashire County Council
Review Officer – Lancashire Constabulary
Named Nurse Safeguarding – HCRG Care Group
Head of Environmental Health – Hyndburn Borough Council
Housing Manager – Hyndburn Borough Council
Head of Policy – Hyndburn Borough Council
Community Safety Manager – Hyndburn Borough Council
Pennine Partnerships Manager – Blackburn with Darwen Borough Council
Business Support – Blackburn with Darwen Borough Council
Chief Executive - Citizens Advice East Lancashire
Head of Probation Delivery Unit – National Probation Service
Senior Probation Officer – National Probation Service
Named Nurse Safeguarding – East Lancashire Hospitals NHS Trust
Named Nurse Safeguarding – Lancashire and South Cumbria NHS Foundation Trust
Deputy Safeguarding Lead – Integrated Care Board
Assistant Head Teacher – St Christopher's High School

1.3.2 DHR panel members were independent of the line management of any staff involved in the case. The panel met on six occasions on 3rd March 2023, 12th May 2023, 20th June 2023, 18th September 2023, 24th November 2023 and 30th January 2024.

1.4 Authors of the overview report

1.4.1 Neil Ashton and Paul Withers were appointed as the joint authors of the overview report. Paul was also appointed as the independent chair of the DHR panel established to oversee the review. Both are retired senior policers and completed the AAFDA DHR chair accreditation in February 2023.

1.4.2 In 2019 Paul Withers retired as a Detective Superintendent from the Lancashire Constabulary. As a senior investigating officer, he dealt with numerous domestic homicides throughout the last 10 years of his service. Paul was awarded the Queen's Police Medal in 2020 for outstanding services to British policing. Since April 2020, he has performed the role of independent chair of Lancashire's Reducing Reoffending boards. He holds no other position that may impair his independence whilst conducting this review.

1.4.3 In 2020, Neil Ashton retired as a Detective Chief Superintendent from the Lancashire Constabulary. In his role as Head of Crime, he was portfolio lead for local investigation (including domestic abuse), safeguarding (both adult and child) and criminal justice. He holds no other position that may impair his independence whilst conducting this review.

1.4.4 Neil Ashton and Paul Withers have no current connection to services in Pennine Lancashire.

1.5 Terms of Reference of the Review

1.5.1 Members of the review panel decided to consider agency contact with Helen and her partner, Dave, between July 2018 and Helen's death in August 2022 as the period for the review. This timeframe includes all reported incidents of domestic abuse between Helen and Dave. Additional events that are relevant to the review that occurred outside this timeframe were also considered.

1.5.2 The terms of reference for the DHR are as follows:

13. To establish the circumstances surrounding the suicide and how experiences of domestic abuse contributed to this.

14. To establish whether there are any lessons to be learned from the case about the way in which professionals and organisations worked together and carried out their duties and responsibilities.

15. To identify clearly what those lessons are, how they will be acted upon and what is expected to change as a result. Agencies will also identify good practice and how those enabled partners to work together in this case.

16. To establish whether the concerns and responses by professionals and their organisations were appropriate both historically and, in the time, leading up to the suicide.

17. To establish whether organisations have appropriate policy and procedures to respond to the circumstances identified in this case and to recommend any changes because of the review process, with the aim of better safeguarding families.

18. All enquiries are to be restricted to a period of no more than 4 years prior to the date of the suicide, and until the review has concluded. However, any historical information or convictions of domestic abuse outside of this timeframe should be considered.

19. To provide details of additional records concerning domestic abuse and medical issues including mental health or physical injury or disability that may have a relevant impact on the review.

20. To consider any cultural, environmental, or mental capacity issues which may have contributed to any barriers the victim faced in accessing protection, and learning why any interventions did not work for them.

21. To consider the impact that the COVID-19 pandemic had on the victim accessing support to domestic abuse services, and how the pandemic may have led to increasing episodes of domestic abuse, and the deterioration of the victim's mental health.

22. To consider the impact of long-term domestic abuse on the wider family, particularly the children of the victim in this case.

23. To consider the impact of financial debt and potential financial abuse on the victim and the wider family.

12. To consider the impact the victim's substance misuse had on their deterioration of mental health, and the impact the substance misuse had on the increasing episodes of domestic abuse.

1.5.3 The key purpose for undertaking a DHR is to enable lessons to be learned from homicides where a person is killed because of domestic violence, or alternatively where a person takes their own life as a result of domestic violence and abuse. For these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each homicide or suicide, and most importantly, what needs to change to reduce the risk of such tragedies happening in the future.

1.6 Summary of Chronology

1.6.1 Helen, aged 35 years, lived at an address in East Lancashire with her three children aged 10, 14 and 17 years. The perpetrator Dave is not the father of any of the children. Helen's family described her as a loving and caring mother and someone who enjoyed social events prior to meeting Dave.

1.6.2 Police records indicate Helen has been a victim of domestic abuse with a former partner, prior to the timeframe of this review. There is also a record indicating that her son Tom attended hospital seeking to talk with the police suggesting Helen may have been involved with local drug dealers. The police attended and officers described smelling cannabis, Helen explained that she did not use drugs, but a friend had visited who openly smokes cannabis which explained the smell.

1.6.3 There are records held by Lancashire Constabulary indicating that Dave was considered a vulnerable child within a family subjected to domestic violence (2010). He received

a penalty notice for the possession of cannabis on 6th August 2014. There are primary mental health records relating to Dave experiencing anxiety and depression.

1.6.4 An examination of Lancashire Constabulary databases outlined numerous incidents of domestic abuse involving Helen and Dave in the years leading up to Helen's suicide.

2018

1.6.5 On 15th July 2018, Helen reported to the police that she had been assaulted by her partner Dave after they had been out drinking in Accrington town centre. Helen stated that she had been thrown around the bedroom by her hair and that Dave had tried to strangle her. This had caused reddening and bruising to her neck and arms. Helen stated that she was okay with Dave if he had not been drinking but indicated that he regularly assaulted her when he had consumed alcohol. Dave was arrested and charged with an offence of a section 39 assault (common assault by battery). He was convicted and received a sentence of 3 months' imprisonment that was suspended for 12 months.

1.6.6 On 17th July 2018, the PVP was received by Children's Social Care (CSC). Upon review, there were no concerns regarding Helen's ability to safeguard her children effectively. Helen was recorded as stating the relationship had ended and was engaging with IDVA and Police. Records indicate that CSC assessed DA as being unlikely to reoccur if Helen remained separated from Dave.

1.6.7 Between 13th August 2018 and 7th August 2019, there are extensive records of interactions between Dave and Cumbria & Lancashire Community Rehabilitation Company (CLCRC). Dave had been allocated to a Community Probation Practitioner (CPP), who had assessed him as posing a medium risk of harm and flagged his offence as a domestic abuse case.

1.6.8 The primary focus of initial meetings between Dave and CLCRC was on Dave's unemployment situation and exploring activities to improve his prospects of gaining employment. Records indicate that Dave had secured employment by 30th October 2018, no further details are listed. There appears to have been little discussion around relationships or Dave's alcohol consumption.

1.6.9 By 29th November 2018, it is evident from the records that Helen and Dave were back in a relationship and living together. By 7th December 2018, Dave had lost his job, no further details were recorded. On 20th December 2018, a discussion took place with Dave regarding managing the relationship over the Christmas period. The following is an extract:

"states she is supportive and not putting him under pressure as they have purchased all presents and Christmas food prior to him losing job. Discussed risk factors over Christmas including managing any increase in stress, anxiety, or anger. Dave spoke positively of his plans for Christmas with family coming round. Understood the potential risks and confident that Christmas will go well."

2019

1.6.10 On 26th February 2019, reference is made to Dave residing with Helen. This appeared to be a surprise to the CPP, even though it had been evident, as per the entry at para 1.6.9 above. Extract as follows:

"Discussion around his relationship – it would appear that he is supposed to be living with his grandmother and having no contact with children, but it would appear he may be spending the majority of his time with Helen, so her address requested together with details of everyone living there. Dave provided address details and details of

stepchildren. Described a positive relationship with stepchildren and their birth fathers."

1.6.11 A safeguarding check was submitted to local authority, but no response was received.

1.6.12 During March 2019, Dave secured steady employment and described his relationship with Helen as 'strong'. Helen was also reported to be in employment at this time. Discussions took place regarding triggers, risk factors and avoiding future DA situations.

1.6.13 By early May 2019, Dave had lost his job due to a sickness episode, whilst Helen remained employed. Discussions with Dave took place regarding managing his alcohol consumption in terms of being a trigger for DA incidents, as well as managing the stress and anxiety he was experiencing due to being unemployed.

1.6.14 Within the seven days between the 28th May 2019 and the 3rd June 2019 Dave presented twice at his GP complaining of anxiety and depression. It would appear a suggestion by the GP of a referral to mental health services was declined by Dave. No further details of the discussions were recorded, it is not known if alcohol consumption or substance misuse were explored.

1.6.15 On 10th June 2019, Helen attended her GP accompanied by her mother, complaining of anxiety, depression, and irregular sleep. Helen also indicated she was struggling to cope with the children and requested diazepam. This request was declined but she was prescribed mirtazapine. There is no record of any discussion regarding relationship issues, Helen's domestic circumstances or alcohol and substance misuse.

1.6.16 On 24th June 2019, Helen attended her GP once again regarding her mental health. Helen explained that Mirtazapine had helped for a few days, but she had then become so overwhelmed and frustrated that she cut her left wrist and overdosed on tablets. Helen indicated she did not attend A&E and that Dave had looked after her. This incident was reported to have been triggered by an argument with Dave. The GP's consultation notes detail Helen was experiencing physical and mental abuse from Dave. Helen indicated she couldn't be bothered to live anymore and was having thoughts of suicide all the time. A liaison took place with the STAR team (MH Team) and an appointment was made for Helen and crisis team numbers were provided.

1.6.17 On 16th July 2019, Helen was sent a "START" letter offering her an appointment. A subsequent letter was sent to Helen and copied to her GP stating that Helen had failed to attend the planned appointment. The letter requested that Helen make contact to book a further appointment; otherwise, she would be discharged from the service.

1.6.18 On 31st August 2019 Police received a report of a domestic assault at Helen's home address. In the early hours a verbal argument between Helen and Dave escalated resulting in Helen being 'thrown' to the floor. Helen was knocked unconscious for a short time before coming round on the living room floor. The incident was witnessed by Helen's son Tom (aged 14 years). Her son contacted his uncle asking for him to be collected from the address stating that he did not want to stay there anymore.

1.6.19 During the same evening, Dave returned to the address on several occasions to collect items of property. On the last occasion, he threw his training shoe through an internal glass window, before picking up a shard of glass and drawing it lightly across his throat before leaving for the final time. Officers attended as an emergency, but Dave had left the premises before they arrived. He was arrested later that morning but released on conditional police bail for further enquiries to be conducted. The bail conditions were imposed to safeguard Helen and the children. However, on 30th October 2019, Helen

retracted her complaint stating that she did not wish to attend court and that the incident was a result of a drunken argument between her and Dave. Helen went on to say that she and Dave had separated. During the investigation, Helen disclosed to officers that she may be pregnant, although she had not confirmed this with a test or appointment with a GP. Despite the retraction statement the case was referred to CPS for consideration of charge. The case failed the CPS triage as Helen had provided a retraction statement. No further action was taken.

1.6.20 The investigation was flagged as a High-Risk DA to MASH and the need to obtain consent from Helen to share information with agencies was over-ridden due to the identified safeguarding risks. However, the case was reduced to a medium risk DA by MASH and the High-Risk Vulnerable Child notification was shared with Emergency Duty Team (EDT). This incident was not referred to MARAC. The MASH referral was shared with CSC, IDVA, Health and Education.

1.6.21 In response to the referral from MASH, CSC initiated an Early Help episode, however Helen did not consent to work with Early Help. Helen was spoken to as part of the referral but minimised the nature of the abuse and described it as a drunken argument.

1.6.22 On 30th October 2019, Helen retracted her statement of complaint against Dave in relation to the DA assault on 31st August 2019. The associated bail conditions were also removed.

1.6.23 On 4th December 2019, Helen attended the hospital for a termination of pregnancy. Helen disclosed previous domestic abuse over the past two years. She advised she did not want to continue with the pregnancy as she had three children already and did not want an ongoing connection with Dave. Helen also disclosed she was experiencing depression. Helen was advised that if she did not attend a subsequent appointment the clinic safeguarding team would be informed. Helen did not attend the planned follow up appointment for long-term contraception.

2020

1.6.24 On 27th January 2020, Helen attended her GP due to low mood and depression. Helen stated she had just come out of an abusive relationship, was experiencing low mood, was struggling to get out of bed, and that her mother was helping with the children. Notes refer to Helen having low self-esteem and self-worth, sleeping all the time and expressing suicidal ideation at times. Anti-depressants were prescribed, and crisis contacts were discussed with Helen. During the consultation, the following issues and resources were also discussed; domestic abuse; Think Family support; further liaison with CSC; and further urgent MH support.

1.6.25 On 3rd February 2020 Helen visited her GP and reported that she had taken an overdose four to seven days previously, but she had refused to attend A&E. Helen reported her mother had looked after her and the children. Helen indicated she subsequently regretted not attending A&E and that she was now willing to accept help. An urgent referral was made to MH services. The quantity of medication Helen was taking was reduced to safeguard her from future overdose attempts. Helen's mother was also reported to be helping safeguard her and the children, and crisis numbers were reinforced.

1.6.26 It appears that an urgent appointment was set up for Helen to engage with mental health services, however she failed to do so. An opt-in letter was sent to Helen advising that she would be discharged from the service if she did not respond. This was the second occasion that Helen had been referred to MH services and did not attend

scheduled appointments. There is no further information suggesting Helen accessed MH services after this point.

1.6.27 There are no recorded incidents between Helen and Dave between March and June 2020. It is possible that they were estranged during this period or that as Tom was not living in the house, there was no one reaching out to family or services for support. There are some reports to police of disputes between Helen and her mother, and between Helen and the father of her youngest daughter Megan regarding parental responsibilities.

1.6.28 On 31st August 2020, Helen contacted 111 and reported that she had taken an overdose one week earlier and that her partner (believed to be Dave) had to perform Cardiopulmonary Resuscitation (CPR). She advised she had been suffering with chest pain and breathing difficulties since then. As a result of this Helen was taken to Royal Blackburn Hospital Emergency Department by ambulance, she was unaccompanied at this time. Helen explained to hospital staff that eight days prior she had taken an overdose of sleeping tablets, became unresponsive and her partner (not named) performed CPR. Helen stated she had suffered with chest pain since this incident. Chest x-rays were completed, and no visible rib fractures were identified. Helen declined to engage with offered mental health services.

1.6.29 On 31st December 2020, police attended a report of a disturbance on Lodge Street in Accrington. Helen was present at the scene and indicated that she had been involved in a verbal argument with her partner Dave. Dave had left the area but was located nearby. Dave was taken to an alternative address to avoid any escalation of the disturbance. No criminal offences were disclosed. A Standard Risk DA Police Safeguarding Referral Form (PSRF) was created via MASH.

2021

1.6.30 On 1st May 2021, the police attended the home address of Helen. Dave had been verbally aggressive towards her and had then thrown an ashtray at Helen, striking her on the head and causing a lump and bruising. Helen's son, Tom (aged 15 years at the time of this incident) intervened, forcing Dave to leave the address. At this time, Dave was in possession of Helen's bank card. Dave was arrested and subsequently released with police bail conditions, aimed at safeguarding Helen and her children. Dave was later released without charge as Helen and Tom retracted the statements and declined to support a prosecution. Helen suggested she did not wish to go through the court process due to her mental health problems. She said that Dave had not been in contact with her since his arrest. Tom retracted his witness statement and supported his mother's decision to retract. He explained he had just left school and was due to start work, he did not want the stress of attending court.

1.6.31 On 13th September 2021, the case was authorised as 'No Further Action' by an Inspector. The reviewing officer recorded that the evidence had been poorly gathered and that the witness statements taken by the officer were evidentially poor. Consideration was given to proceeding with an "evidence led prosecution", however, this was discounted as the standard of the evidence gathered was inadequate. The reviewing officer recorded that *'should police proceed against the wishes of the victim this could make her hostile and she could lose trust in the police resulting in her not reporting further incidents'.*

1.6.32 A Police Safeguarding Referral Form (PSRF) rated High Risk Vulnerable Child (VC) and Medium risk Domestic Abuse (DA) was raised via the MASH.

1.6.33 In response to the PSRF, Early Help called Helen to explore the information shared. The incident was discussed, Helen stated it was a silly argument that got out of hand. The case worker suggested it was a violent attack and that her son had to intervene. Helen replied that Dave was drunk and explained they had subsequently split up. Helen indicated that they were on the verge of separation anyway and this incident had made the decision for her. Helen was asked if her son was hurt during the incident, she said he was not. Early Help support was discussed, offering advice and support for Helen and children. Helen declined further support and thanked the case worker for the call, stating they were all ok now and ended the call.

1.6.34 On 17th August 2021, Helen had a telephone consultation with her GP. She was crying on the phone and described feeling low and anxious. Helen also advised she was experiencing some thoughts of self-harm. She was prescribed Citalopram and Diazepam and provided with the mental health crisis numbers.

1.6.35 On 14th November 2021, Helen called the Mental Health Crisis Line (MHCL), she was tearful and upset. She said she had been struggling with depression for years but was not prescribed any antidepressants as she had tried different ones but "they don't work". She stated she was in an abusive relationship and that her partner still contacted her via text messages which she felt she had to answer, otherwise he would come to her house and "kick off". She stated she wanted to "go away" somewhere to get away from the situation. She had been advised by friends and family to call the police about her partner, but she was worried that if she took out a restraining order on him his family would retaliate. Helen felt trapped in her situation. She reported she had a supportive father and grandmother but had a difficult relationship with her mother who also suffered with depression. She also had debts, but stated these were managed. Helen was able to express her feelings with MHCL practitioner and she was given a series of actions to follow:

•Helen was to contact her GP practice to discuss medication. However, when Helen advised she struggled to make appointments, she was advised to change her GP practice.

•Helen was advised to self-refer for assessment and support to START, Women's Aid and MindsMatter, and was provided with relevant contact details.

Helen said she felt calmer by the end of the call and thanked the MHCL practitioner.

1.6.36 On 14th November 2021, Helen re-contacted MHCL, stating she had arranged for her daughters to stay with family members for a few days to give her a break and she wanted to go into hospital. She was advised that admission to hospital was a last resort and only used when someone was a danger to themselves or others. Helen stated she was a danger to herself and had been hitting herself in the head (that morning) and had superficially cut herself with a knife on her arm about two months previously. Helen was advised that she needed to self-refer to START the next day for an assessment and to MindsMatter for Cognitive Behavioural Therapy (CBT) . Helen accepted the advice.

1.6.37 Between the 15th November 2021 and the 16th November 2021 and following the telephone consultations described above, Helen took the step to make self-referrals to Hyndburn MindsMatter and START, even following up the START referral with a phone call to ensure it had been received. When she called, Helen was frustrated and tearful, stating she felt she was not getting any help from mental health services. Helen went on to say that she had been struggling with her mental health for several years,

characterised by periods of low mood and increased anxiety. Helen's history was reviewed, which described multiple overdoses with low mood and suicidal ideation. However, they also noted that Helen had not attended appointments in June 2019 and February 2020 and so was discharged from services. Helen expressed that she had several stressors in her life such as an abusive relationship with her partner as he used her for money. The practitioner discussed in depth the importance of contacting the police if Dave made threats towards her or was abusive and Helen agreed to do so. She denied any thoughts or plans of self-harm or suicide and felt that she would benefit from CBT. The practitioner agreed to make a referral to MindsMatter for CBT. Helen described how she felt her medication was not working, although she had only recently started taking it (Citalopram 20mg and Diazepam 2mg). Helen confirmed she had good support from her father. The plan from START was for Helen to continue prescribed medication and a referral was made to MindsMatter on 18th November 2021. Helen confirmed she was aware of the START contact details and was discharged from the service.

1.6.38 On 29th November 2021, MindsMatter wrote to Helen asking that she contact the service and opt-in following receipt of the referral. This was followed up with a text message to Helen's phone confirming Mindsmatter had tried to ring her to book a telephone assessment appointment but had been unsuccessful. They advised her to make contact using the details provided. Helen was also reminded that if she failed to make contact by 13th December 2021, MindsMatter would assume she no longer wished to access the service and her referral would be closed. This was in line with the MindsMatter service operating procedure.

1.6.39 On 15th December 2021, a GP telephone consultation was completed with Dave regarding an injury to his testicular area. He reported that he had been 'kneed' in the groin area by a 'girl' one week ago. From the triage assessment, it was established that this was bruising only and Dave was asked to monitor this for any changes and to seek medical intervention if necessary.

1.6.40 On 17th December 2021, Helen undertook the telephone assessment appointment with MindsMatter. Helen reported she was struggling to move on from an abusive relationship of three years. She said that in the past she suffered physical abuse but since ending the relationship it was mainly mental and emotional abuse. Helen noted that police had been involved with the situation, but she did not take this further as she was afraid social services would take her children away. Helen confirmed she was able to contact the police or safeguarding teams should she feel the need but advised she currently felt safe due to support from family and friends. Helen confirmed that Dave had received a suspended sentence and had to pay a fine for an assault against her, but that she had ended up paying the fine for him. She also suggested that a few weeks ago Dave had thrown her phone against the wall and her friend had been present. Helen confirmed she felt ready to talk about her feelings and thoughts. She confirmed she was aware of Hyndburn and Ribble Valley (HARV) domestic violence team and advised she would contact them later that day. Helen denied any plans or intentions of self-harm or any suicidal ideation at the time of the assessment. The practitioner noted that there were no safeguarding concerns for her children and that they were receiving therapy from school. Helen was advised that there was a long waiting list to access CBT, but she confirmed she wanted to be placed on the list. A CBT

review call was also discussed with Helen, which was to provide any other support she may require whilst she was waiting to commence CBT.

1.6.41 On 13th April 2022, Lancashire Police were called to Helen's home following a report of a violent domestic incident. When they arrived, officers found Helen and Dave were both present and intoxicated. Helen indicated that Dave was her ex-partner and had been at the address since the previous evening. They were drinking and Dave became aggressive but had stayed with Helen overnight. Helen asked Dave to leave the following morning, but he refused to do so. Helen and Dave began to argue during which Dave punched Helen to the right side of her face. Helen responded by punching Dave to the face in self-defence. Helen said she has been in an 'on and off' relationship with Dave for around 5 years and had recently been staying away from Dave due to his behaviour. However, she had let him back on Tuesday night as he wanted to collect his belongings. Helen let Dave stay and drink with her, but he became nasty towards her, calling her names.

1.6.42 Dave was arrested at the scene for an offence of Section 39 Common Assault (assault by beating). Helen provided a witness statement, and her injuries were photographed. Safeguarding matters were addressed, Helen confirmed Dave did not have a key to her address and did not live with her. She was told to keep her windows and doors locked and contact police if an approach was made from Dave's family. Helen told officers she had been suffering with depression and anxiety, due to which she was off work sick and was awaiting CBT. Helen confirmed she would like support for domestic violence to help her end the relationship and not let Dave back in her life. Helen stated she was not scared or afraid of Dave and that it is a mental problem that she will always give in to him. There is evidence of physical and emotional abuse towards Helen by Dave.

1.6.43 Officers spoke to the children present and recorded that they were unaware of Dave's presence in the house overnight. The children reported they had heard shouting and Helen's eldest daughter received a text from her mum asking that she call the police. A Police Safeguarding Report Form (PSRF) was submitted at Medium Risk.

1.6.44 On 22nd April 2022, Helen contacted the police and said she wanted to retract her victim statement. A retraction statement was obtained, in which Helen stated she had lied in her original statement and that Dave had accidentally elbowed her in the face whilst they were both intoxicated. Helen stated she no longer wanted to support a prosecution or attend court. Helen denied that she had been influenced by anyone to change her account of the incident. A sergeant reviewed the evidence gathered and found that the threshold to submit to CPS was not met and the case was closed as no further action. Dave's bail conditions were cancelled.

1.6.45 On 22nd April 2022, the police MASH referral was reviewed and passed to Early Help. Early Help called and spoke to Helen who said she was not in the relationship anymore and it was over. She didn't want support around domestic abuse and didn't want support for the children as they were in receipt of support from their schools. Helen was signposted to appropriate services but declined further Early Help support. The manager made the decision not to override consent at that time.

1.6.46 In early May 2022, Mindsmatter sent Helen a letter and text message explaining that she needed to arrange a telephone consultation or notify them if she wished to remain on the waiting list for CBT. It went on to explain that if Helen did not respond by 18th May 2022, the service would assume that she no longer wanted to access treatment and would close her referral.

1.6.47 On 5th May 2022, Helen completed a threat of homelessness referral via the local housing online portal. This was due to her being served with an eviction notice by her landlord. Her case was allocated to an advisor who required documentation that confirmed her situation. A telephone appointment was arranged for 17th May 2022.

1.6.48 On 13th May 2022, Helen attended hospital with an injury to her right middle and ring finger. She explained this had been sustained fighting with Dave some six weeks earlier. Helen had not sought medical attention at the time but was now concerned about a lump on the ring finger. The working diagnosis was that the right middle ring figure was fractured and had also sustained soft tissue damage. Helen was discharged home with a suggested GP follow up. The hospital doctor documented that a safety discussion had taken place, although there was little information recorded as to the content of this within the records.

1.6.49 On 17th May 2022, Helen had a telephone consultation with her GP. Helen stated she had low mood and thought she was better off not being here, although stated no active intent to take her own life. Helen said she was still waiting for CBT through Mindsmatter. Citalopram medication was restarted, Helen was advised that she should not stop/start this medication.

1.6.50 On 14th June 2022, MindsMatter sent a letter to Helen's GP stating that due to Helen not responding to previous correspondence, her referral had been closed and they had referred her back to her GP. Three days later, MindsMatters closed Helen's referral on their system.

1.6.51 The following day, 15th June 2022, Helen had a telephone consultation with her GP during which she stated she felt weak and could barely stand, was dizzy and had no energy. Helen requested Gabapentin, explaining she was already on this medication, although her GP could not find any records that she had been prescribed this. The GP refused to prescribe the Gabapentin and stated Helen needed further blood tests.

1.6.52 On 20th June 2022, health records note that Helen had failed to attend two scheduled appointments for a head and neck CT scan.

1.6.53 In early July 2022, the local council housing officer contacted Helen's landlord, who confirmed that her arrears stood at £4227.59. At that time, no possession order had been granted to the landlord. A Citizen's Advice Bureau (CAB) worker also contacted the local council housing officer. CAB believed Helen had been served with a section 21 notice and requested a copy of Helen's 'personal housing plan'.

1.6.54 On 8th August 2022, the local council housing officer contacted Helen requesting a copy of the possession order. Helen replied with the following email.

> *"Hi Karen, it's Helen from **** street I'm still having no luck finding a house as they all want guarantors and I've got my court date for possession of my house on 5th sept so looks like I'm going to be out on streets before Xmas I'm struggling and really worrying now as I have 3 kids as well."*

1.6.55 The following week, the housing officer contacted Helen and advised that the section 8 notice is not a possession order but a claim for possession, and she does not have to vacate the house on 5th September 2022. Helen was advised to keep bidding on 'B-with-us' and if she finds another property the local council can assist with the rent deposit. Helen confirmed she was actively bidding on the 'B-with-us' housing register.

1.6.56 On 22nd August 2022, Helen had a telephone consultation with her GP. Helen complained of being tired all the time, aching all over, having no energy, struggling to sleep; and feeling depressed with a constant headache. She stated she was now

unemployed, smoking 20 cigarettes a day, that she had 3 children and was a single mum. She also reported constant abdominal pain and diarrhoea. The GP stated further blood tests were required.

1.6.57 At 11.21am on 30th August 2022, Lancashire Police were informed by the North West Ambulance Service (NWAS) of a hanging at Helen's home address. Helen had been discovered hanging from a light fitting in the living room of the house. Dave, her mother and Helen's daughters were also present. Helen's son was not at home at this time.

1.6.58 On 13th January 2023, an Inquest was held to establish the circumstances surrounding the death of Helen. The inquest considered the specific detail of who the deceased was, where, when and how Helen died and the medical cause of death. This is the primary purpose of a coronial inquest. The Coroner cannot, in law, deal with any other matters.

1.6.59 The inquest concluded that Helen's cause of death was suicide by hanging.

1.7 Overarching Learning and Recommendations

1.7.1 Embed a culture of professional curiosity and equip practitioners with skills to establish the full facts.

1.7.2 Emphasise the ability to override criteria and use professional judgement to refer cases to dedicated joint working forums.

1.7.3 Devise strategies to engage with victims that are flexible and designed to meet the needs of the individual.

1.8 Single Agency Learning and Recommendations

1.8.1 The following agencies identified learning within their own organisation. Details of that learning can be found in section 7 of the full report.

- East Lancashire Healthcare Trust
- Children's Social Care - Lancashire County Council
- Lancashire & South Cumbria NHS Foundation Trust
- The Probation Service
- High School – Secondary school for Tom and Lisa
- Citizens Advice Rossendale & Hyndburn
- HCRG Care Group
- Lancashire and South Cumbria Integrated Care Board (ICB) GP practices
- Hyndburn Borough Council - Housing Standards in the Private Rented Sector
- Lancashire Constabulary

1.9 Conclusions and Key Issues

1.9.1 The panel have considered the significant amount of information obtained as part of this review and believe there are 4 significant contributors to Helen taking her own life.

1.9.2 **Domestic Abuse** - It is clear that Helen suffered significant physical and psychological abuse during her 5-year relationship with Dave. The compelling accounts from Tom and Debbie along with data provided by the Lancashire Constabulary, offer a good insight into this. Information from other agencies, Health in particular, offers a

further insight into Helen's spiralling mental health during her abusive relationship with Dave. There can be little doubt this ultimately contributed to Helen taking her own life.

1.9.3 **Mental Health** - It is clear from the analysis conducted that Helen sought help for her deteriorating mental health on several occasions. Unfortunately, her chaotic lifestyle often led to her struggling to maintain this engagement, thereby preventing her from getting the support she desperately needed. The significant delay in obtaining CBT also contributed; therefore Helen was not supported or protected effectively. There were several opportunities to intervene and protect Helen, but sadly these were missed.

1.9.4 **Substance Misuse** - Helen's use of alcohol clearly escalated during her relationship with Dave. Information provided to the review also suggests that Dave 'introduced' Helen to cocaine and that she and Dave were possibly using this drug on an almost daily basis. It is reasonable to suggest that the significant use of both in the final stages of her life contributed to the deterioration in Helen's physical and mental health. It is also likely that Dave's use of alcohol and cocaine resulted in lowered inhibitions and the possibility of increased aggression, further contributing to his predilection for domestic abuse. This potentially contributed to Helen taking her own life.

1.9.5 **Significant Financial Debt** - There is clear and substantial evidence to indicate that Helen was having serious financial problems for some time prior to her death. This had a significant impact on her psychological well-being and her sense of desperation is evident in several interactions with professionals. It is also worthy of note that Helen's last known text communication was with a relative, from who she was seeking financial support. It is reasonable to assume that the impending court proceedings for eviction, and the potential of becoming homeless were the catalyst that led to Helen taking her life when she did.

1.9.6 **Other Factors** – Throughout the period of this review, there is an absence of a single agency lead or a trusted professional in Helen's life. Given the multiple contact points with services and combined knowledge available through MASH and MARAC, this is difficult to understand.

Whilst there is evidence of extensive information sharing via established mechanisms, no significant interventions occur as a result. Did Helen and her family fall just short of the "threshold bar"? There was a sense that information sharing was process-driven, with emphasis on compliance rather than cutting through the process to identify true risk and the vulnerabilities of Helen and her family.

A lack of professional curiosity was evident across all agencies.

Appendix B: Multi-Agency Action Plans

Title of DHR	DHRHB2	To be actioned	
Plan	Multi-agency Action Plan	Ongoing	
Independent authors	Paul Withers & Neil Ashton	Complete	
Governance arrangements	The Pennine Community Safety Partnership provides the governance arrangements for Domestic Homicide Reviews across the Pennine area. The board will oversee the recommendations to ensure effective implementation and within an appropriate timeframe.		

Recommendations	Lead Agency	Responsible Lead	Key Action/s	Evidence	Key outcomes	RAG	Progress/Outcome achieved	Target date/ completion date
Identify and address 'poor' performance in the investigation of Domestic Abuse Incidents and the preparation of prosecution files.	Lancashire Constabulary	Det. Supt. Neil Drummond	Supervisors to provide clear oversight regarding investigations and file preparation and address any 'poor' performance. Supervisors to record their observations and actions.	To be reviewed as part of any planned Domestic Abuse Audits. To be included as part of any Domestic Abuse Training 'package'	Improve the quality of Domestic abuse Investigations and prosecution files.		*Completed*	29/02/2024
Review Lancashire Constabulary Domestic Abuse Retraction Protocol/Policy once written by Targeted Operating Model (TOM) Implementation Team.	Lancashire Constabulary	Det. Supt. Neil Drummond	Once TOM Retraction Policy introduced review same to view if quality retraction statements are being obtained, which include a. Appropriate safeguarding arrangements have been provided to victim b. Review if rationale for retracting	To be reviewed as part of any planned Domestic Abuse Audits. To be included as part of any Domestic Abuse Training 'package'	Develop understanding as to rationale for victims retracting Domestic Abuse statements. Reduce the Domestic Abuse attrition rate for Lancashire.		*Completed*	29/02/2024

			statements have been explored fully with the victim. Obtaining rationale as to why retracting. c. Establish if the timeliness of taking witness statements, after the incident, affects attrition rates.					
Provide update as to the progression of delivering Domestic Abuse Matters (DA Matters)Training across the Constabulary.	Lancashire Constabulary	Det. Supt. Neil Drummond	Check on-going progress re introduction of DA Matters Training.	Dates of delivery	Improve understanding of DA and effect on victims.		*Completed*	29/02/2024
Victims of DA are often prevented from engaging with services, In view of disclosed domestic abuse, consideration to be given before discharging service users for failed contacts.	Lancashire & South Cumbria Foundation Trust (LSCFT)	Katri Kuusniemi	Cases where risk has been identified to be discussed with team leader prior to discharge.	Clear guidance written into SOP which is currently under review	Staff will respond to domestic abuse appropriately and consider this as a potential barrier to accessing services.		The now approved new Talking Therapies service SOP includes the service's attendance policy. This outlines that where clinicians are aware of risks, they need to make an additional call and seek further guidance from managers/supervisors before discharging where contact not made.	January 2023

Ongoing DA risk was not fully recognised and acted upon. Proactive help was not offered, lack of consideration of the impact of DA and mental health on the ability for victims to be proactive in seeking support. No professional curiosity and consideration of the wider family.	Lancashire & South Cumbria Foundation Trust (LSCFT)	Katri Kuusniemi	Recommendation that all Mindsmatter staff access in house training re: Routine Enquiry and domestic abuse.	Internal data collection through line management	Staff will respond to domestic abuse appropriately and offer proactive support.		The Talking Therapies assessment document includes questions to ask about domestic abuse, and the link to the DASH risk assessment is embedded. Bitesize training has been recommended to all staff. Further progress required to ensure this has been discussed in all teams' safeguarding supervision sessions.	January 2023
Safeguarding and identified risks Information to be shared with GPs	Lancashire & South Cumbria Foundation Trust (LSCFT)	Katri Kuusniemi	Recommended practitioners share risks and safeguarding concerns with the service users GP	Written into SOP Internal audit	Information will be shared across health agencies to strengthen safeguarding practice.		The now-agreed Talking Therapies service SOP includes the attendance policy, which outlines the need to share risk information with GPs and other relevant referrers. A recent (December 2024) casenote audit found 85% compliance with regard to completion of discharge letters to referrers which outlined outstanding issues and made signposting suggestions.	January 2023
Routine enquiry needs to be embedded into practice and recorded with an auditable trail.	Lancashire & South Cumbria Foundation Trust (LSCFT)	Katri Kuusniemi	Service to look at integrating routine enquiry mandatory field into patient records as part of the system remodel.	Internal audit	Routine enquiry will be embedded into practice		As outlined above, the Talking Therapies standard assessment structure includes questions to ask about domestic abuse, and the link to the DASH risk assessment is embedded. Bitesize training has been recommended to all staff. Further ongoing work required to ensure this has been discussed in all teams' safeguarding supervision sessions.	March 2024

To establish whether there are any lessons to be learned from the case about the way in which professionals and organisations worked together and carried out their duties and responsibilities.	Lancashire & South Cumbria Integrated Care Board (ICB)	Robert Nicholson-Kershaw	Routine enquiry about domestic abuse should be included in consultations for patients presenting with mental health issues, substance misuse, stress and anxiety	Dissemination of relevant guidance by e-mail or newsletter by the place-based partnership Recirculate the Sample DA policy to all practices. Domestic Abuse Toolkit circulated to all practices.  DA Booklet (005) final.pdf Domestic Abuse/MARAC process reminder circulated to Practices.  220517%20Domestic %20Abuse%20reminc  DA Recording & Coding EMIS & IG E Evidenced documents distributed across practices	Domestic abuse enquiry, use of professional curiosity in place across the practice Easier identification of patients at risk Prompts added onto EMIS (GP record keeping system) in regard to routine enquiry and DA All information sent and shared with both GP practices involved in this DHR Both GP practices have also been involved in the IRIS programme		Completed	Action completed Jan 2025

To identify clearly what those lessons are, how they will be acted upon and what is expected to change as a result. Agencies will also identify good practice and how that enabled partners to work together in this case.	Lancashire & South Cumbria Integrated Care Board (ICB)	Robert Nicholson-Kershaw	Link and promote the ICS 'Let's keep talking campaign'.	Learning Brief to be circulated across relevant L&SC Safeguarding networks. Safeguarding Practice lead identified, discuss, and confirm coding, risk assessments and action completed at individual practice. Summary of feedback and attendance lists – attendees to feedback actions taken in practice following conference Support services directory disseminated across Primary Care to help support patients and their emotional / mental health.  DBO797 HLSC Lets Keep Talking 4pp A5 l	Improved documentation of assessment of suicide risk in cases of anxiety and depression etc. To ensure suicide risks are considered, assessed, and escalated in a timely manner and safeguarding concerns followed up and acted on Domestic abuse enquiry, use of professional curiosity in place This document was embedded in the practice action plan. One GP practice has responded thanking us for this document		Completed	Action completed Jan 2025

To establish whether the concerns and responses by professionals and their organisations were appropriate both historically and in the time leading up to the apparent suicide. Consider cycle of behaviour escalation when a patient is ceasing anti-depression medications and not engaging with mental health referrals and pathways	Lancashire & South Cumbria Integrated Care Board (ICB)	Robert Nicholson-Kershaw	Action Plan to be presented and worked through with both practices involved in this case, with a focus on DA toolkit and support as per action point 1 & 2 above Wider case learning to be taken across Primary Care Networks in champions sessions	Action Plan review with practices	Action plan reviewed and monitored by Practice. Professional curiosity is embedded across the practice.		Completed	Jan 2025
To consider the impact that the Covid-19 Pandemic had on the victim accessing support to Domestic Abuse Services, and how the pandemic may have led to increasing episodes of Domestic Abuse, and the deterioration of the victim's mental health. *Review policies and consider whether these adequately outline appropriate support actions/next steps that are required when GP*	Lancashire & South Cumbria Integrated Care Board (ICB)	Robert Nicholson-Kershaw	Discuss and gain assurance on current GP practice around face to face or telephone appointments	Establish whether there is a risk matrix for appointments dependent on circumstances, DA risks or other factors for face to face or telephone appointments	Professional curiosity is embedded across the practice. Risk matrix on face to face or telephone appointments was discussed as part of the embedded learning action plan with both practices involved in this DHR		Completed	Jan 2025

surgeries receive letters from other services (particularly mental health, domestic abuse, and substance misuse services) regarding patient's being discharged due to non-attendance or non-engagement								
Specific DV Perpetrator Programmes being considered as part of the sentencing process.	Probation Service	Daniela Chiappi	The EPF (Effective Practice Framework) tool has now been implemented, which generates recommendations for Pre-Sentence Report writers, in respect of appropriate interventions for those convicted of criminal offences. This is in addition to the assessment and professional judgement skills of the Probation Officer preparing the report for Court.	EPF records and Performance Reports.	To ensure that effective and appropriate interventions are targeted towards those that pose the most risk of harm, in order to reduce the risk of re-offending.		Completion of EPF is now mandated at the point of sentence and pre-release. There has been some difficulty embedding this practice, however staff have recently been reminded of the directive and any failures to complete are identified in Performance Reports and any failures to complete will be escalated to the Head of the Probation Delivery Unit.	31/03/2025

Home Visits being undertaken upon receipt of information of concern.	Probation Service	Daniela Chiappi	It is standard practice that at least one home visit is undertaken in all cases under the supervision of the Probation Service. Those with DV-related convictions or higher risk levels can expect to receive a higher number of home visits during their supervision period. In addition, Probation staff have also been offered training in respect of what to look for during home visits, with an emphasis on not taking things at face value.	Home Visits policy, Home Visit Risk Assessment Forms and Touchpoint discussions in supervision meetings.	To ensure that Home Visits are undertaken as per procedure and that staff use professional curiosity, as opposed to taking things on face value. Also that visits are repeated as required and that any change in circumstance or behaviour is thoroughly investigated.		The use of Home Visits is improving, although it is not fully embedded across the organisation. However, the Regional Quality Improvement Plan includes encouraging and supporting staff to undertake training around risk management, including learning around the importance of regular Home Visits and what to look for during this activity.	31/03/2025
Prompt submission of Domestic Abuse and Children's Social Care checks.	Probation Service	Daniela Chiappi	New guidance has been issued in respect of completing both DV and CSC checks on all cases, regardless of risk level or the type of offence committed. Probation Officers are also expected to request updated checks throughout the period of supervision, particularly for those individuals convicted of domestic violence-related offences. There is also a greater emphasis on	Safeguarding guidance, Delius records and associated Performance Reports. Touchpoint discussions as part of management oversight.	To ensure close monitoring of home circumstances and that any information of concern is shared between agencies as required, as part of the wraparound risk management process; and that appropriate action is taken in the event of any		The service is part way there on this. The expectation to submit requests for information is fairly well embedded, however there are still improvements to be made in terms of submitting repeat requests in the event of a change in circumstance or behaviour. Also, we need to embed the practice of ensuring that swift action is undertaken in the event of any concerns being raised.	31/03/2025

			information-sharing with Police and Children's Social Care. In addition, if there are concerns, Probation staff then submit a referral for further assessment.		information of concern.			
Increased level of professional curiosity when working with people on probation.	Probation Service	Daniela Chiappi	All Probation staff are required to attend training around professional curiosity and these events are offered on a regular basis, to ensure all staff have the opportunity to attend. This is monitored via electronic training records.	Training records and management oversight.	To ensure staff have the skills required to deliver an enhanced level of monitoring; asking the right questions, even those that are uncomfortable, and then taking appropriate action as required to ensure individuals are safeguarded.		Discussion in supervision enables reflection in terms of actions undertaken and allows staff to develop their skills and learning. Also, staff have the opportunity to attend regular quality development sessions with the Quality Development Officer. In addition, staff are held to account if performance is repeatedly below the required standard; this can include Performance Management measures.	31/03/2025
Review of risk levels in the event of further incidents or any significant change in circumstances.	Probation Service	Daniela Chiappi	Probation guidance states that OASys risk assessments must be reviewed in the event of any further incidents or a significant change in circumstances. A tiering system is in place to ensure that cases are allocated to officers who have the required qualifications and skills to manage that	OASys guidance and management oversight. Allocation procedures.	To ensure that individuals are supervised by staff with the relevant training and qualifications where necessary and that risk assessments are thorough and accurate.		In the event of any change in risk, there isn't enough evidence to demonstrate that cases are being reviewed in the event of significant change. However the recent Quality Improvement Plan includes training and development opportunities to address this aspect of our work and cases are randomly audited on a monthly basis, with feedback provided to the practitioner and their manager.	31/03/2025

			particular case and all High Risk cases are managed by qualified Probation Officers.					
Ensuring appropriate management oversight of all cases.	Probation Service	Daniela Chiappi	All Probation cases are allocated by the Senior Probation Officer and a 'touchpoint' system is in place which prompts managers to discuss cases with officers on a regular basis, regardless of any concerns. There is a 'Pre-release discussion' in the case of those in custody, an 'Initial discussion' when a case is first sentenced and 'Review' discussions, which can be undertaken at any point during the sentence.	Touchpoint guidance, Management Oversight entries and Performance Reports.	To ensure that appropriate levels of management oversight are applied in all cases, to allow for additional monitoring and guidance where required.		Progress has been made in this area; all managers have now attended Management Oversight training and all are required to complete the SPO development programme. Managers are also provided with reports on a regular basis, which detail cases that require management oversight.	31/03/2025

To be more aware of signs of domestic abuse.	East Lancashire Hospital Trust	Bridget Costello-Brown	Safeguarding Level three Training mandated. Bespoke domestic abuse training offered to all staff. The trust now has two full time appointed IDVAs based at both acute sites. Admin hours protected and dedicated to MARAC research. ED violence reduction navigator nurses employed.	Safeguarding Adults Level three training data. Domestic abuse Training figures. Domestic abuse quarterly data. Eighteen hours of Admin time per week is to support the IDVA's with MARAC research, flagging and tagging. ED Navigator nurses' data.	Staff to have more understanding of the care act. Staff to have a greater understanding of domestic abuse and how this may present. Staff to be competent in routine enquiry and utilise professional curiosity. Staff to have more visual awareness's around flagging and tagging. ED Navigator nurses are auditing the attendance to ED and sharing any victims of potential domestic abuse.		Completed	27/09/2023

Safeguarding adults' level three training mandated.	East Lancashire Hospital Trust	Bridget Costello-Brown	Safeguarding Adults Level Three training has been mandated and there is more understanding around making safeguarding personal and the think family approach. Bespoke training for domestic abuse Routine inquiry being rolled out to all divisions	Safeguarding Adults Level three training data. More personal training tailored to the provision. Staff to be competent in routine enquiry and utilise professional curiosity.	Level Three training to empower staff with up-to-date safeguarding information. Staff more aware of the signs of domestic abuse and actions they need to follow. Ongoing work but for staff to be confident and competent in routine enquiry		Completed	27/09/2023
System failures during attendances.	East Lancashire Hospital Trust	Bridget Costello-Brown	Have since moved onto electronic patient records (EPR) which gives an accurate up to date data of attendances, interactions and any implementations from staff.	If disclosures are made around domestic abuse, IDVA is made aware and the safeguarding team to offer support.	Access to notes is more accessible in a timelier manner. Staff from various divisions are able to see any safeguarding concerns, eg re-occurring injuries.		Completed	27/09/2023

Disclosure of depression	East Lancashire Hospital Trust	Bridget Costello-Brown	CB disclosed depression, no further exploration into this – referral made to LSCFT Mental health Liaison Team, however discharged herself before being seen.	All attendances are shared with GP now, with any outstanding actions to look at following up.	Trust is moving over to being registered with mental health – to look at incorporating depression screening tools / pathways / referral pathways. Depression Checklist to look to be embedded into EPR.		Completed	27/09/2023
Impact of COVID-19 Pandemic	East Lancashire Hospital Trust	Bridget Costello-Brown	ELHT recognises the impact COVID-19 and the impact this has on individuals accessing provisions. ELHT also recognises that missed opportunities were had when CB attended alone due to the restrictions for visitors.	Bespoke training around routine enquiry is being embedded across divisions.	For all potential victims of domestic abuse who access provisions, to be given the opportunity to disclose any domestic abuse.		Completed	27/09/2023
Staff are trauma informed and have child centred domestic abuse training.	Joint Partnership Business Unit	Danielle Winkley	Toms story to be delivered to the workforce	Practice development managers to report numbers to JPBU JPBU to collate evidence of learning from other partnerships.	Workforce are practicing in a trauma informed manner.		Completed- Toms story has been delivered to PDMs and will be delivered across the workforce, further numbers and outcomes to be collated	Dec 2024

MASH to continue to seek the child's voice, through direct and indirect participation	Multi-Agency Safeguarding Hub	Rachel Pickup	MASH to continue to be part of the participation board and employing a participation officer (returning to work in March 2024)	CSC Annual participation report	MASH to evidence seeking the voice of the child – Voice of the child workshops taking place throughout Feb and March 2024.		(New Participation now in post from October 2024. Voice of the child workshops completed, Templates revised August 24 to ensure child's voice obtained, Participation report due April 24, Monthly Multi Agency Audit meetings reviewing Child's voice as part of Audit screening.	Completed Oct 2024
MASH to consider overriding consent	Multi-Agency Safeguarding Hub	Rachel Pickup	MASH staff to attend training on overriding consent?	Consent workshops in MASH and CASSH October 2023 CSC information sharing and consent guidance updated in April 2023 and shared with staff. Short guide for parents and carers on consent completed and shared out Top tip and 7 min briefing shared across CSC	Staff feel confident in overriding consent.		Short guide for parents and carers on consent completed and shared out Top tip and 7 min briefing shared across CSC Parents/Carers provided with leaflet in regards to consent. Professionals provided with guidance in referral responses on consent and thresholds. Clear rationale to be provided if overriding consent during Mash screening. Consent review report completed Sept 24  Consent%203%20month%20review%20J	Completed

The Care Review sets out family led decision making as a golden thread throughout social work practice. Lancashire to consider how we can embed this in practice.	Lancashire County Council – Children Social Care	Danielle Winkley	Lancashire to consider how it can embed family led decision making	Family Group conference to share findings of research project with Senior Management team.	Family led decision making will become a golden thread throughout practice.		Lancashire have embedded family led decision making, FGC project finding shared and continue to be developed	Completed September 2024
Appropriate response from School Nurses and Health Visitors to information received from police around Domestic Abuse incidences	HCRG Care Group	Lisa Farrell	Over the previous 9 months as an organisation we have provided bite size training on completing SMART action plan / updated internal SOP on Responding to Domestic Violence and Abuse and provided bite size training, and an audit is ongoing to assess appropriate PSRF follow up is taking place including completion of SMART action plan.	Internal Audits Internal Bitesize training Internal SOP	Improved response to Domestic Abuse		Completed	18/07/2023
Development of impact of Domestic Abuse on children Multi-Agency training package	LCC – CSC / HCRG	Danielle Winkley/ Lisa Farrell	HCRG Care Group/ Children Social Care are developing a training package using the child's voice – which highlights the impact and areas of abuse, neglect, emotional, mental health & substance misuse.	Multi-Agency Training Package	Improved response to Domestic Abuse		Training package developed and delivered to over 60 professionals (train the trainer) further training event planned.	16/10/2023

Appendix C: Multi-Agency Recommendations

Title of DHR	DHRHB2	To be actioned	
Plan	Multi-agency Recommendations	Ongoing	
Independent authors	Paul Withers & Neil Ashton	Complete	
Governance arrangements	The Pennine Community Safety Partnership provides the governance arrangements for Domestic Homicide Reviews across the Pennine area. The board will oversee the recommendations to ensure effective implementation and within an appropriate timeframe.		

Recommendation	Lead Agency	Responsible Lead	Key Action/s	Evidence	Key outcomes	RAG	Progress/ Outcome achieved	Target date/ completion date
ELHT is taking steps to ensure routine enquiry is embedded in services, in particular gynaecology. However, this should be embedded across all directorates.	East Lancashire Hospital Trust (ELHT)	Rebecca Woods	Mandatory training to include routine enquiry. Bespoke training for ELHT tailored for specific needs. Safeguarding screening tool in electronic patient record (EPR).	Safeguarding Adult Level 3 training includes RE and is mandatory for all L3 staff (in accordance with intercollegiate document. Bespoke training has been provided to numerous ELHT services and is well embedded in maternity, gynaecology, community services and emergency pathways. A safeguarding screening tool has been introduced to the EPR and is mandatory with every new admission. One of the questions is about routine enquiry and prompts appropriate safeguarding action.	Improved compliance across the Trust with mandatory training. Routine enquiry embedded in ELHT services. Ongoing training to support this from Safeguarding Team. Safeguarding screening tool used appropriately and routine enquiry undertaken at all new admissions. Ongoing audits for assurance.		*Complete*	*Feb 25*
ELHT to ensure up to date adult and child safeguarding information is available on intranet pages and more accessible to all staff.	East Lancashire Hospital Trust (ELHT)	Rebecca Woods	Safeguarding information available on ELHT SharePoint system, accessible by all staff.	Pages have been designed on the SharePoint site for all categories of abuse defined by The Care Act 2014. One of those categories is domestic abuse and this page contains information on recognition and response to concerns of domestic abuse as well as guidance on required safeguarding actions.	Staff able to easily access information on the SharePoint site as required.		Complete	Jan 25

ELHT is transferring over to electronic patient records in June 2023, currently the trust uses primarily paper records with only some systems are online. The system change aims to improve accuracy in patient records and collaborate multiple systems into one. Safeguarding concerns will be more easily identified, and patients classed as high-risk domestic abuse and on the special register will be alerted to practitioners accessing their records.	East Lancashire Hospital Trust (ELHT)	Rebecca Woods	Implementation of electronic patient record (EPR).	EPR was implemented in June 2023 and combines a number of systems utilised previously, including paper and electronic systems, into one holistic patient record. Safeguarding 'flags' are available to use on patient records to highlight a wide range of safeguarding issues, one of which is an alert around the patient being a victim of high risk domestic abuse. This prompt the clinician to consider the presentation in the context of domestic abuse and escalate an concerns accordingly.	EPR embedded and safeguarding concerns accurately captured. Safeguarding 'flags' utilised to alert clinician to the domestic abuse risk.		Complete	June 23

The special register is a positive tool that can be used to flag multiple factors, ranging from MARAC to learning disability patients. However, MARAC patients are removed after twelve months, and it is not possible to identify why the patient was on the special register in the first instance once removed. ELHT should review this process, so professionals are able to access full history and risks.	East Lancashire Hospital Trust (ELHT)	Rebecca Woods	Implementation of electronic patient record (EPR) which has the functionality to apply safeguarding 'flags' to the patient record, including where there have been patients heard at MARRAC due to being a victim of high-risk domestic abuse.	Safeguarding 'flags' are available to use on patient records to highlight a wide range of safeguarding issues, one of which is an alert around the patient being a victim of high-risk domestic abuse. This prompt the clinician to consider the presentation in the context of domestic abuse and escalate any concerns accordingly. The 'active' flag is deactivated after 12 months if there have been no MARRAC repeats. However, unlike the previous system the history remains on the patient record.	Safeguarding 'flags' utilised to alert clinician to the domestic abuse risk.		Complete	June 2023

The innovation of 'Safeguarding Champions' has been established within the trust and they meet every two months. The 'Safeguarding Champions' meetings explore key themes such as domestic abuse, sexual violence, MCA and DoLS, and use expert speakers to provide up to date information to staff. This information is then cascaded to departments via the 'Safeguarding Champions'. This initiative should continue and focus on DA related matters as a standing item.	East Lancashire Hospital Trust (ELHT)	Rebecca Woods	Safeguarding Champions to be embedded in practice at ELHT on a rolling programme. Champions meetings to includes themes around domestic abuse as a standing item.	Safeguarding Champions meetings are now held as a full day event once a quarter and available to all ELHT practitioners. This is a think-family model and whilst the speakers differ one quarter to the next, themes around domestic abuse, coercion and control feature in every session.	Safeguarding Champions meeting include themes around domestic abuse, coercion and control feature in every session. Safeguarding Champions benefit from this education and cascade their knowledge with their colleagues within their own service areas. Information shared at Champions days is available on the SharePoint pages for all staff to access.		Complete	Jan 25

Depression and anxiety screening tools should be implemented to support patients disclosing depression and anxiety issues.	East Lancashire Hospital Trust (ELHT)	Rebecca Woods	Patients are screened for issues relating to mental health on presentation and throughout their patient journey at ELHT. Appropriate referral and escalation takes place where mental health issues are highlighted. Appointment of a Mental Health Specialist Nurse.	Patients are referred to Mental Health Liaison Team whereby mental health concerns are observed or disclosed. Mental Health Specialist Nurse appointed – supports with complex cases and with escalation where referrals have been met with an unsatisfactory response from mental health services.	Patients experiencing mental health issues are referred in a timely manner to appropriate mental health services.		Complete	June 2025
Consider using Tom's Story during induction training for all new staff and it could also be included as part of regular safeguarding training for all staff.	East Lancashire Hospital Trust (ELHT)	Rebecca Woods	Include reference to Tom's story in mandatory and bespoke safeguarding training.	Tom's story reference in training- links shared and also available on SharePoint safeguarding training.			Complete	June 2025

As part of any referral, MASH practitioners should be required to consider previous referrals to ensure they have the 'full picture' and can offer a more informed professional assessment the domestic abuse taking place within the home. This would hopefully help support the identification of patterns of abuse and remove the risk of parents dismissing individual reports as 'one-off incidents' when there is evidence to show they are not.	Children's Social Care	Danielle Winkley	Chronology's to be used on MASH referrals	Audits of case files to evidence that chronologies are used.	Use of history to inform decision making		Audits evidence more robust use of history to inform decision making.	18/03/2026

Safeguarding checks should be undertaken by MASH practitioners with ALL agencies involved with the children and the agency working most closely with them should be required to undertake enquiries and offer pastoral support even without parental consent. (Continued on S7 full report)	Children's Social Care	Danielle Winkley	Information shared through operation encompass	Information is shared to schools and nurseries through operation encompass. DSL are supported through school safeguarding service to explore this information.	Operation Encompass in place for schools and nursery's.		Operation Encompass in place and information shared routinely with schools. 98% of schools are supported by Lancashrie Safeguarding in education service.	18/03/2026
All CSC, CFSW and Early Help staff to undertake mandatory safeguarding and domestic abuse training that incorporates Tom's Story. Such training should also form part of induction training for all new staff for CSC, CFSW and Early Help.	Children's Social Care	Danielle Winkley	HCRG Care Group/ Children Social Care are developing a training package using the child's voice – which highlights the impact and areas of abuse, neglect, emotional, mental health & substance misuse.	Multi-Agency Training Package	Improved response to Domestic Abuse		Training package developed and delivered to over 60 professionals (train the trainer) further training event planned. Rolled out across Lancashire in 2024.	16/10/2023
MindsMatter staff to be trained in 'Think Family' approach	Lancashire & South Cumbria NHS Foundation Trust (LSCFT)	Kelly McNally	Practitioners will receive training appropriate to their role and responsibilities.	Staff will be equipped to recognise and address safeguarding issues. Training figures.	All training will be reviewed to ensure it is line with the new intercollegiate document for children and adults.		Completed- Talking Therapies staff now have access to Think Family training and are	December 2024

							required by the service to complete it	
Develop an alternative approach to "opt-in" final warning letters where risk or safeguarding concerns are evident. There may be many reasons why service users do not respond to correspondence, other than not wanting to continue with treatment	Lancashire & South Cumbria NHS Foundation Trust (LSCFT)	Kelly McNally	Cases where risk or safeguarding has been identified to be discussed with team leader prior to discharge and an alternative approach to the opt-in letter agreed.	Staff will respond to domestic abuse appropriately and consider this as a potential barrier to accessing services.	Standard Operating Procedure has been amended.		Completed- The now approved new Talking Therapies service SOP includes the service's attendance policy. This outlines that where clinicians are aware of risks, they need to make an additional call and seek further guidance from managers/supervisors before discharging where contact not made	December 2024
Continue to emphasise the importance of completing DASH when consulting with service users disclosing domestic abuse	Lancashire & South Cumbria NHS Foundation Trust (LSCFT)	Kelly McNally	Use of the DASH risk assessment tool to be embedded into practice.	DASH is embedded into the system for recording and is included in the prompt sheet. DASH is included in LSCFT domestic abuse training. DASH bitesize training to be offered.	DASH will be completed for all victims of domestic abuse where safe to do so.		The Talking Therapies assessment document includes questions to ask about domestic abuse, and the link to the DASH risk assessment is embedded. Bitesize training has been	Completed – March 2026

							recommended to all staff. Further progress required to ensure this has been discussed in all teams' safeguarding supervision sessions. 03/26- DASH and DA is featured in most supervision sessions, this action can be closed as complete	
Carry out periodic sampling of discharge letters to ensure GPs are being fully informed of risk information, especially domestic abuse, safeguarding and mental health issues	Lancashire & South Cumbria NHS Foundation Trust (LSCFT)	Kelly McNally	Clinical risk discharge audit Annual case note audit		Consistent information sharing of risk across the health economy.		A recent (December 2024) casenote audit found 85% compliance with regard to completion of discharge letters to referrers which outlined outstanding issues and made signposting suggestions. A further specific audit about risk information needs to be completed by	April 2025

							end of April 2025. Tom's story training has been shared in November 2024 with all team leaders for sharing with all clinical staff. The safeguarding champions' group is due to agree attendance for this training in February 2025.	
Consider using Tom's Story during induction training for all new staff and it could also be included as part of regular safeguarding training for all staff.	Lancashire & South Cumbria NHS Foundation Trust (LSCFT)	Kelly McNally	Toms Story to be shared with the safeguarding champions for dissemination across the teams. Multi agency delivery across the wider partnership.	Training numbers	Toms story to be available to staff. Staff to consider the lived experience of children subjected to domestic abuse.		We have a 20 minute section for induction. DA / DASH features in our bitesize and mandatory training. All our SG training is in line with the intercollegiate documents. There is no capacity for all staff to attend Toms Story. Some of the SG team have attended and the training offer was shared	Completed

							with the network. There is no mechanism to monitor uptake of this. We have promoted the training across the trust and continue to promote all training in weekly safeguarding bulletins. As of 20/03/26 there are no training spaces available for this training on LSAB.	
All the lessons identified are covered within existing policy in the unified Probation Service. Supervisors and managers must ensure they are adhered to	Probation Service	Daniela Chiappi	Mandatory use of EPF to determine appropriate licence conditions and interventions.	Performance Reports. Discussion around eligibility for Domestic Abuse programmes in supervision with Line Managers. Intervention eligibility criteria.	For all eligible individuals to complete appropriate offence-focused work via specific Toolkits and Programmes.		Policy is firmly embedded in service delivery.	18/12/2024
There is a home visit framework which directs home visits in every case – supervisory oversight required	Probation Service	Daniela Chiappi	Ensure that Home Visits are undertaken in every case supervised by the Probation Service.	Performance Reports.	Having this policy has ensured that all staff understand that Home Visits must be undertaken in all cases, however further monitoring and improvement is required in this area.		Home Visits are mandatory; random RCAT audits identify when HV's haven't been undertaken and all cases are also subject to	18/12/2024

							management oversight via the Touchpoint process.	
Dedicated probation staff have been embedded within the Lancashire MASH to undertake domestic abuse enquiries and ensure police intelligence is available and acted upon when appropriate	Probation Service	Daniela Chiappi	Ensure that all cases supervised have a Domestic Abuse check completed, in order to inform our assessment of risk and ensure safeguarding of any vulnerable individuals.	Performance Reports. Quality conversations with staff members via Management Oversight and Reflective Supervision.	Having this in place has ensured that checks have been completed on most cases and that the relevant safeguarding actions have been undertaken.		Significant focus has been given to DA checks and appropriate action; these are a mandatory element of Probation supervision.	18/12/2024
Embedded MASH staff also ensure CSC enquiries are processed in a timely manner	Probation Service	Daniela Chiappi	Ensure that all cases supervised have a CSC check completed, in order to inform our assessment of risk and ensure safeguarding of children.	Performance Reports. Quality conversations with staff members via Management Oversight and Reflective Supervision.	Having this in place has ensured that checks have been completed on most cases and that the relevant safeguarding actions have been undertaken.		CSC enquiries are now usually returned within 24 hours.	18/12/2024
The Senior Probation Officer (SPO) to ensure that all staff are aware of and utilising the above policy/processes	Probation Service	Daniela Chiappi	To safeguard vulnerable adults and children and protect them from risk of serious harm.	Attendance at relevant training and development sessions, case audit feedback, and Management Oversight in supervision meetings.	All staff compliant with the agency's safeguarding policies and procedures.		SPO's are all required to attend mandatory Management Oversight training, to ensure	18/12/2024

							policy/preprocess are being fully adhered to.	
Probation should incorporate Tom's story into their required induction training for all new staff and it should be included as part of regular safeguarding training for all	Probation Service	Daniela Chiappi	To ensure that all Probation staff have access to Tom's story to enable them to gain an improved understanding of the impact of domestic abuse on both children and adults.	Staff engagement and learning via Tom's story	Improved understanding of the impact of domestic abuse on families.		Tom's Story has been offered to all staff within the Probation Service and this will continue.	18/12/2024
It was clear that Dave did not attend his final scheduled appointment with CLCRC. As a result it appears there was no 'final sign off' and no assessment of his personal circumstances at this specific time. This is not satisfactory and should be a requirement in all cases where an individual is directed to fulfil a court imposed sanction.	Probation Service	Daniela Chiappi	Ensure that any missed appointments are recorded and appropriately enforced, in line with policy and procedure. Also, to signpost and provide advice and guidance when supervision comes to an end.	Appropriate enforcement action taken for all missed appointments, which is managed via performance reports.	All cases are appropriately enforced, in the event of failure to attend without a reasonable explanation.		National Standards provides strict guidance in terms of levels of contact and any deviation from this is identified in performance reports and shared with both Probation Practitioners and Managers.	18/12/2024

Positive interventions adopted by the school should be shared wider and adopted accordingly	High School	Leanne Williamson	Sharing best practice		Support students to express themselves, in this case, by writing their account, thoughts and feelings Supportive and sensitive to the needs of the family Following guidance and the schools safeguarding policy TAF when required Effective record keeping Sensitively monitor wellbeing and progress Encompass alert – impact on childrens assessed Counselling and pastoral support as needed		Shared with the school and LCC education team	Completed Dec 2024
All Lancashire schools should consider incorporating Tom's Story into their required induction training for all new staff and it should be included as part of regular safeguarding training for all staff	Lancashire County Council	Aby Hardy	Using Tom's Story for school training	Tom's Story has been delivered in schools training. It can be recommended for schools to include within their training but cannot be mandated	Raising awareness on the importance of capturing the voice of children and young people present during domestic abuse incidents		Completed – shared with schools and training has been rolled out across Lancashire	February 2025

Citizens Advice has a 'Supporting Vulnerable Clients' Policy and staff have regular safeguarding training. Ensure all staff are aware of and fully utilising the above policy and procedures. Consider strategies to secure consistent engagement with service users	Citizens Advice	Moham med Khan	Induction for all volunteers and staff.	Safeguarding training provided by national Citizens Advice	Volunteers and staff identify safeguarding of adults and children. Reporting to relevant authorities.		Complete – included in training	November 2024
Consider using Tom's Story during induction training for all new staff and it could also be included as part of regular safeguarding training for all staff.	Citizens Advice	Moham med	Not needed as safeguarding policy has domestic abuse training.	Reviewed regular safeguarding training	- Raising awareness of domestic abuse to staff across the organisation		Reviewed and completed	November 2024
Continue annual audit programme in relation to response to PSRFs and SMART action planning	HCRG Care Group	Lisa Farrell	This is part of internal annual audit calendar	Outcome of audit	Clear SMART action plans in response to appropriate PSRF's			End of quarter 1 25/26
We have produced bitesize domestic abuse training including NFS, in line what has been produced via the PLDASG.	HCRG Care Group	Lisa Farrell	Bite size training developed and rolled out	Training numbers	Understanding the wider impact of areas of Domestic Abuse including NFS for practitioners across the organisation		Completed	September 2024

Tom's Story should be considered as part of regular safeguarding training for all staff.	HCRG Care Group	Lisa Farrell	Practitioners have attended CSAP train the trainer and have rolled this out across HCRG Care Group	Training numbers	Understanding the impact of Domestic Abuse on Children to practitioners across the organisation		Completed	September 2024
Ensure Primary Care can recognise and respond appropriately to safeguarding concerns and incidents, including referral to the local authority	Lancashire & South Cumbria Integrated Care Board	Rob Kershaw	Dissemination of relevant guidance by e-mail or newsletter by the place-based partnership.	Practices have incorporated recommendations provided Routine enquiry template use/audit	Routine enquiry about domestic abuse should be included in consultations for patients presenting with mental health issues, substance misuse, stress and anxiety and professional curiosity is strengthened. Any safeguarding concerns are appropriately communicated and referred as appropriate. Prompts added onto EMIS (GP record keeping system) in regard to routine enquiry and DA All information sent and shared with both GP practices involved in this DHR		Completed	January 2025

Make sure GPs practice training around safeguarding and domestic abuse is effective and up to date and incorporates Tom's Story	Lancashire & South Cumbria Integrated Care Board	Rob Kershaw	Ensure multiagency training opportunities – including Tom's Story are distributed to Primary Care Support and sharing of upcoming Lunch and Learn Safeguarding Training opportunities are promoted through Primary Care.	Training numbers Staff feedback/evaluation	Both GP practices have also been involved in the IRIS programme. Practice staff are appropriately trained to the required level of Safeguarding necessary and key Safeguarding staff within the practice are nominated and identified. The impact of Domestic Abuse on children is understood and children are recognised as victims as domestic abuse and appropriate safeguarding measures taken.		Completed	January 2025
Review of all safeguarding policies and procedures including domestic abuse	Lancashire & South Cumbria Integrated Care Board	Rob Kershaw	Recirculate the Sample DA policy to all practices. Domestic Abuse Toolkit circulated to all practices. Domestic Abuse/MARAC process reminder circulated to Practices.	Practices have sight of updated DA Policy in order to provide a template for individual Practices Policy.	Domestic abuse enquiry, use of professional curiosity in place This document was embedded in the practice action plan. One GP practice has responded thanking us for this document		Completed	January 2025

Explore further learning opportunities for 'professional curiosity' and 'Think Family' approach for GP practices	Lancashire & South Cumbria Integrated Care Board	Rob Kershaw	Support and sharing of upcoming Lunch and Learn Multiagency Safeguarding Training opportunities are promoted through Primary Care	Training numbers	Practice staff are appropriately trained to the required level of Safeguarding necessary and key Safeguarding staff within the practice are nominated and identified.		Completed	January 2025
Consider cycle of behaviour escalation when a patient is ceasing anti-depression medications and not engaging with mental health referrals and pathways	Lancashire & South Cumbria Integrated Care Board	Rob Kershaw	Action Plan to be presented and worked through with both practices involved in this case. Wider case learning to be taken across Primary Care Networks in champions sessions	Action Plan review with Practices.	Action plan reviewed and monitored by Practice. Professional curiosity is embedded across the practice.		Completed	January 2025
Review policies and consider whether these adequately outline appropriate support actions/next steps that are required when GP surgeries receive letters from other services (particularly mental health, domestic abuse, and substance misuse services) regarding patient's being discharged due to	Lancashire & South Cumbria Integrated Care Board	Rob Kershaw	Recirculate the Sample DA policy to all practices. Discuss and gain assurance on current GP practice around face to face or telephone appointments as well as Safeguarding procedures aligned to specific patient vulnerability.	Establish whether there is a risk matrix for appointments dependent on circumstances, DA risks or other factors for face to face or telephone appointments	Risk matrix on face to face or telephone appointments was discussed as part of the embedded learning action plan with both practices involved in this DHR Correspondence regarding individual patient vulnerabilities is appropriately coded, reviewed and followed up by GP prior to filing.		Completed	January 2025

non-attendance or non-engagement								
If resources allow re-visits should be carried out, photographic evidence as a minimum prior to closing requests for service. Tenants should also be required to confirm the work has been completed rather than sole reliance on the word of the landlord and/or letting agency.	Hyndburn Borough Council – Environmental Health	Helen Dodds	Update procedures relating to investigations and re-visits and evidence required to close a complaint	Updated work procedures Updated case notes Training of Officers Audits/ monitoring of investigations/complaints	Re-visits are completed where resources allow and evidence obtained where required		Improved housing standards and investigation of complaints procedures	Completed Sept 2025
Consider using Tom's Story during induction training for all new staff and it could also be included as part of regular safeguarding training for all staff.	Hyndburn Borough Council – Environmental Health	Helen Dodds	Use Toms story as a training aid	Training records and minutes of team meeting	Improved knowledge and staff awareness		This will be used at a departmental meeting planned for Spring 2025 – Completed	September 2025

Tom's Story should be considered and incorporated into safeguarding and domestic abuse training for new recruits and as part of all staff's regular training	Lancashire Constabulary	Garry Fishwick / Donna Brown	Consider using Tom's story as a training aid.	While Tom's story is not used as a specific training product within Lancashire Constabulary, the intended learning outcomes of lived experience-based training are comprehensively embedded within both initial and ongoing safeguarding and domestic abuse education for all staff. New recruits receive a full day of Domestic Abuse, Safeguarding and Vulnerability training which is supplemented by Nationally recognised programmes such as DA Matters, ensuring exposure to victim and survivor perspectives.	This training is ongoing and delivered to all new recruits.		Completed 2025	Reviewed April 2026
Training for officers attending domestic abuse incidents should be reviewed to ensure it includes a focus on the importance of collecting relevant evidence with a view to the need for building evidence-led prosecutions, given research demonstrating the higher likelihood of victims and witnesses possibly retracting their statements in domestically abusive situations	Lancashire Constabulary	Garry Fishwick/ Donna Brown	Training for officers on Evidence Led Prosecutions.	Training for officers attending domestic abuse incidents includes a dedicated input on Evidence-Led prosecutions (ELP), delivered to new recruits within their first year of service, which provides a strong foundation in evidential requirements and investigative opportunities in domestic abuse cases. This training highlights the importance of robust early evidence gathering, particularly in recognition of the increased risk of victim and witness retraction in domestic abuse contexts.	Training is monitored through established Governance structures.		Completed 2025	Reviewed April 2026

Training for staff/officers responsible for receiving and processing victim/witness statement retractions should be reviewed to ensure that it leaves them equipped to recognise the impact of domestic abuse, psychological abuse and manipulation and coercive control. Professional curiosity and reassurance should be integral parts of interactions with victims/witnesses who express that they want to retract their statement	Lancashire Constabulary	Garry Fishwick / Donna Brown	Consider training for officers in relation to DA retraction statements for victim/witnesses to incorporate professional curiosity.	Lancashire Constabulary has clear processes in place to manage victim and witness retractions in DA cases, with a strong focus on safeguarding, risk assessment, and evidential decision making. Guidance dictates that officers are required to explore pressure, intimidation or coercion when a victim seeks to retract rather than accepting the retraction on face value. Officers are expected to provide professional judgment on reliability, vulnerability, and risk, including suspicions of witness intimidation. Guidance explicitly references controlling or coercive behaviour, including non-physical indicators. An MG6 retraction is completed by the OIC in all retraction cases, the guidance recognises anger, defensiveness, or disengagement as potential indicators of fear and coercive control, rather than lack of credibility.	Professional curiosity is a key element of domestic abuse training and is actively embedded through Continuing Professional Development (CPD). The Force will continue to reinforce this learning through ongoing CPD and supervisory oversight to ensure consistent, high-quality practice.		Completed 2025	Reviewed April 2026

Information provided to victims/witnesses about statement retraction should include information about support services available to them	Lancashire Constabulary	Garry Fishwick / Donna Brown	Include information about support services if victim/witnesses of DA retract their statements.	Victims who express a wish to retract a statement are actively provided with information about available support services. Victim Care Lancashire offers free and confidential emotional and practical support, including explaining what a retraction statement is, supporting victims to communicate their reasons clearly, and liaising with the police or Witness Care Unit where appropriate. In line with the Victims' Code, referrals to Victim Care Lancashire are made automatically, with an opt-out option should the victim wish to decline support. Once a suspect is charged, the Witness Care Unit maintains contact with the victim and can facilitate onward referrals, including where a victim later chooses to retract. Victims can also be referred directly by police or self-refer. Victims are reassured that a request to retract does not automatically end proceedings and that the police and CPS may continue with an evidence-led prosecution where it is assessed as appropriate and in the public interest.			Completed 2025	Reviewed April 2026

Appendix D: Home Office Quality Assurance Feedback

Home Office

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Marsham Street London
SW1P 4DF

Tel: 020 7035 4848

www.homeoffice.gov.uk

Lindsay Frew
Pennine Partnerships Manager Community Safety Team
Blackburn with Darwen Borough Council Old Town Hall, King William Street Blackburn
BB1 7DY

2nd July 2025
Dear Lindsay,

Thank you for submitting the Domestic Homicide Review (DHR) report (Helen) for Pennine Lancashire Community Safety Partnership (CSP) to the Home Office Quality Assurance (QA) Panel. The report was considered at the QA Panel meeting on 4th June 2025. I apologise for the delay in responding to you.

The QA Panel found this review thorough and easy to read, noting the author's commendable efforts to gain a full picture by engaging with friends and family rather than relying solely on agency records.

The insights from Tom were noted to be especially impactful in capturing the child's perspective, and the Panel welcomed the recommendation to use his account in future training. Although there was no formal tribute to Helen, the review conveys a strong sense of her as a beloved daughter, mother and friend, and highlights the profound impact of domestic abuse on her life.

The QA Panel felt that there are some aspects of the report which may benefit from further revision, but the Home Office is content that on completion of these changes, the DHR may be published.

Areas for final development:

- **The executive summary currently lacks a front page and table of contents, which should be added.**
- **The equality and diversity section is currently underdeveloped, consisting of only a single line. More information should therefore be added prior to publication, particularly relating to the protected characteristics of relevance to this review.**
- **The analysis section repeats some content from earlier parts of the report and could be made more succinct.**
- **Acronyms should be spelled out at first mention.**
- **It would be helpful to add ages for Helen and her children to aid understanding.**

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