DOMESTIC HOMICIDE REVIEW

'Helena'

Date of death: April 2020

OVERVIEW REPORT

October 2024

Chair and Author: Carol Ellwood-Clarke QPM
Support to Chair and Author: Ged McManus

CONTENTS

1. INTRODUCTION

1.1 Safer Lincolnshire Partnership and the Domestic Homicide Review Panel offer their sincere condolences to Helena's family.

1.2 This report of a Domestic Homicide Review (DHR)[1] examines how agencies responded to, and supported Helena, a resident of Lincolnshire, prior to her death in April 2020. The review has been completed following Home Office Domestic Homicide Review statutory guidance (2016)[2].

1.3 Helena had been in a relationship with Rodrigo for about four years: they had recently separated at the time of Helena's death. Helena and Rodrigo had two children together. Helena suffered with a heart condition, for which she was under specialist cardiology care and on medication.

1.4 In April 2020, Helena was found deceased at her home address. A Home Office Post-mortem determined that Helena had died as a result of an acute deterioration in her heart disease. The pathologist also concluded that 'although the presence of such disease could have resulted in her death at any time, I understand that (redacted) may have been involved in a number of altercations with her partner on the day of her death. It is recognised that being involved in stressful events can have an adverse effect on cardiac function and increase the risk of a dysrhythmic event occurring'.

1.5 Rodrigo was arrested and charged with Helena's murder: the charge of murder was later changed to manslaughter[3]. In March 2021, Rodrigo appeared at Crown Court, on three indictments: manslaughter of Helena, and two charges of Assault Occasioning Actual Bodily Harm[4] on Helena.

---

[1] Section 4 of this report sets out in more detail the purpose of a DHR and the terms of reference the review panel adopted.

[2] www.gov.uk/government/uploads/system/uploads/attachment_data/file/575273/DHR-Statutory-Guidance-161206.pdf

[3] https://www.cps.gov.uk/legal-guidance/homicide-murder-and-manslaughter

Manslaughter can be committed in one of three ways:

1. Killing with the intent for murder but where a partial defence applies, namely loss of control, diminished responsibility or killing pursuant to a suicide pact.
2. Conduct that was grossly negligent given the risk of death, and did kill ("gross negligence manslaughter"); and
3. Conduct taking the form of an unlawful act involving a danger of some harm that resulted in death ("unlawful and dangerous act manslaughter").

[4] https://www.legislation.gov.uk/ukpga/Vict/24-25/100/section/47

The charge of manslaughter was not progressed. Rodrigo pleaded guilty to both charges of assault.

1.6 In addition to agency involvement, the review will also: examine the past to identify any relevant background or trail of abuse; whether support was accessed within the community; and whether there were any barriers to accessing support. By taking a holistic approach, the review seeks to identify appropriate solutions to make the future safer.

1.7 The intention of the review is to ensure agencies are responding appropriately to victims of domestic violence and abuse by offering and putting in place appropriate support mechanisms, procedures, resources, and interventions, with the aim of avoiding future incidents of domestic homicide, violence, and abuse. Reviews should assess whether agencies have sufficient and robust procedures and protocols in place, and that they are understood and adhered to by their employees.

1.8 It is not the purpose of this DHR to enquire into how Helena died: this is determined through other processes.

2. TIMESCALES

2.1 Following Helena's death, formal notification was sent to Safer Lincolnshire Partnership by Lincolnshire Police. A meeting was held on 22 May 2020 where it was agreed to conduct a Domestic Homicide Review. The Home Office was notified of the decision.

2.2 The first meeting of the Review Panel took place on 8 July 2020. Further details regarding the methodology and timescale for the DHR are covered in Section 5.

2.3 The DHR covers the period from 1 January 2016 to April 2020. The start date was chosen as it was identified that this was shortly prior to the start of the relationship between Helena and Rodrigo. All agencies were asked to consider and analyse any significant contacts prior to these dates, and this has been included within the review, where relevant.

2.4 The Domestic Homicide Review was presented to Safer Lincolnshire Partnership on 3rd March 2023 and concluded on 25th May 2023, when it was sent to the Home Office.

3. CONFIDENTIALITY

3.1 Until the report is published, it is marked: Official Sensitive Government Security Classifications May 2018.

3.2 The names of any key professionals involved in the review are disguised using an agreed pseudonym. The report uses pseudonyms for the victim and perpetrator: these were agreed with Helena's family.

3.3 This table shows the age and ethnicity of the subjects of the review. No other key individuals were identified as being relevant for the review.

Name	Relationship	Age	Ethnicity
Helena	Victim	23	South European
Rodrigo	Ex-partner	30	South European
Iria	Child of victim	Pre-school age	South European
Davi	Child of victim	Pre-school age	South European

4. TERMS OF REFERENCE

4.1 The panel settled on the following Terms of Reference at its first meeting on 28 July 2020.

4.2 The DHR panel set the period of review from 1 January 2016 (shortly prior to start of the relationship) to 9 April 2020.

4.3 **The purpose of a DHR is to**:

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

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

- apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate;

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

- contribute to a better understanding of the nature of domestic violence and abuse; and

- highlight good practice.

(Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews [2016] Section 2 Paragraph 7)

4.4 **Specific Terms**

1. What indicators of domestic abuse, including coercive and controlling behaviour,[5] did your agency identify for Helena?

2. What knowledge did your agency have that indicated Rodrigo might be a perpetrator of domestic abuse, and what was the response? Did that knowledge identify any controlling or coercive behaviour?

3. How did your agency assess the level of risk faced by Helena and her children? In determining the risk, which risk assessment model did you use, and what was your agency's response to the identified risk?

4. What services did your agency provide for the subjects of this review; were they timely, proportionate and of an acceptable level, in relation to the identified levels of risk?

5. What did your agency do to safeguard any children exposed to domestic abuse?

6. What was your agency's response to the lived experiences of the children? Did that include an understanding of how their lived experiences impacted on their emotional and physical development?

7. How did your agency take account of Helena's vulnerabilities, including her health conditions, when responding to incidents and providing services?

8. Were the subjects informed of options/choices to make informed decisions? Were they signposted to other agencies, and how accessible were these services to the subjects?

9. Were single and multi-agency policies and procedures, including the MARAC, followed? Are the procedures embedded in practice, and were gaps identified?

10. Were there any issues in relation to capacity or resources in your agency that affected its ability to provide services to the subjects of this review, or on your agency's ability to work effectively with other agencies? N.B. Please also consider any additional capacity/resource issues with agency contact during the Covid-19 pandemic.

[5] The Serious Crime Act 2015 (the 2015 Act) received royal assent on 3 March 2015. The Act creates a new offence of controlling or coercive behaviour in intimate or familial relationships (section 76).

11. How did your agency take account of any racial, cultural, linguistic, faith or other diversity issues, when completing assessments and providing services to the subjects of this review?

12. Were there any examples of outstanding or innovative practice?

13. What learning did your agency identify?

14. Do the lessons arising from this review appear in other reviews held by this Safer Lincolnshire Partnership?

15. Has any relevant practice changed since the events under review?

5. METHOD

5.1 On 26 June 2020, Carol Ellwood-Clarke was appointed as the Independent Chair and Author. The Chair was supported in the role by Ged McManus.

5.2 The first meeting of the DHR panel determined the period the review would cover. The Review Panel determined which agencies were required to submit written information and in what format. Those agencies with substantial contact were asked to produce Individual Management Reviews (IMR)[6], and the others, short reports.

5.3 Some agencies interviewed staff involved in the case to gain a better understanding of how and why decisions were made. The written material produced was distributed to panel members and used to inform their deliberations. During these deliberations, additional queries were identified, and auxiliary information was sought.

5.4 The DHR Chair liaised with the panel members to identify family members or friends to help inform the DHR process. This is covered in Section 6.

5.5 In July 2020, the DHR was suspended due to the ongoing criminal investigation.

5.6 Following the court case, in March 2021, Safer Lincolnshire Partnership (SLP) reviewed the case against the criteria as detailed within the Home Office Statutory Guidance. Lincolnshire Police provided the following information gathered during the criminal investigation to assist SLP in reviewing the case against the DHR criteria:

1. The victim had significant underlying heart disease, and death could have happened at any time.
2. Medication for the heart disease was stopped during pregnancy, and there is evidence of poor compliance of medication post pregnancy.
3. Sustained stressful episodes increased the risk of sudden arrhythmic death, making it more likely (based on balance of probabilities) that emotional distress led to the fatal episode.

The circumstances are that it is a reasonable assumption that the victim had heightened stress as a result of the domestic situation. Therefore, it is

[6] Individual Management Review: a templated document setting out the agency's involvement with the subjects of the review.

reasonable to assume, on the balance of probabilities, that death appears to have resulted from abuse, thus meeting the requirements of a DHR.

5.7 The additional information was reviewed by Safer Lincolnshire Partnership, and a decision was made to continue with a DHR. Further information regarding events leading up to the death of Helena are covered within Section 13.

5.8 Following access to the overview report the family told the Chair that they did not agree with the information provided by Lincolnshire Police at paragraph 5.6. The family stated –

'We recognise that Helena had a heart condition, but we don't accept that she could have died at any time without serious additional stress or anxiety. She suffered from heart symptoms usually after an incident of domestic violence and died shortly afterwards following a further violent assault.

Helena had been on optimal medication for her condition and did not require/qualify for anything further aside from lifelong surveillance and medical reviews'.

The family also agreed with paragraph 11.2 in the report that details that Helena's heart condition was not classed as a disability.

5.9 The family disagreed with the second bullet point at 5.6 and stated – 'Prior to her pregnancy Helena had taken medication, which was stopped by a GP in December 2019. There are no records showing the GP restarting the prescription therefore this was not a case of poor compliance (as stated by Lincolnshire Police) as it had not been made available to Helena post pregnancy. Helena had been to the doctors at least twice post pregnancy, in January 2020 and March 2020 and at no point during these visits was the medication for her heart re-prescribed'.

5.10 The Review Panel have acknowledged the comments provided by the family following access to the report. The following information has been provided to the family in response to their views.

'The post mortem examination found that Helena had died 'as a result of an acute deterioration in her heart disease.' The Home Office Pathologist stated 'although the presence of such disease could have resulted in her death at any time'. The Home Office Pathologist provided further comment to state that domestic abuse may have been a precipitating factor to death, which formed part of the decision making for the initial charge against Rodrigo'.

'Medical information provided to the review records incidents of Helena missing appointments/self-discharge and not attending hospital when advised'.

5.11 Following the report being shared with the family the ICB provided further information to the review that had not been shared during the completion of the DHR. The information related to four entries in Helena's GP records from April – December 2019 in relation to Helena's prescribed medication. The first of these in April 2019, documented that Helena had stopped her medication when she found out that she was pregnant and that Helena had been advised by a Consultant to restart Aspirin and Bisoprolol that same month. A further entry documented that Helena was taking Aspirin and Bisoprolol but in October 2019 at a medication review compliance was reported as an issue and it was discussed setting reminders on her phone to assist.

5.12 The DHR recommenced in July 2021. The Review Panel met eight times. The meetings were held using online video facility and through a hybrid approach of face to face, with online video functionality.

5.13 The Review Panel was cognisant of the ongoing coronial processes that were taking place throughout the undertaking of the DHR. The Review Panel agreed to reserve the right to amend the review after the inquest, if necessary.

5.14 The Review Panel agreed the need to ensure that expertise and advice was available in relation to Portuguese culture. The Chair approached Maria Joao Melo Nogueira (Operations, Partnerships and Client Support Director of Respeito[7]), who agreed to support the DHR process and be a panel member. Respeito is a charity and a company limited by guaranty and was founded in November 2016. It is based in the borough of Lambeth in London, where an estimated 50,000 Portuguese speakers live. Respeito is dedicated to reducing domestic abuse in the Portuguese speaking community by raising awareness of its negative impact and by providing training, support, and information to empower people to become agents for change. Respeito is based on the principles of equality, human rights, and social integration. The panel was satisfied that Maria was appropriately qualified and experienced to provide expert advice on Portuguese culture and attitudes.

5.15 The Chair wrote to Rodrigo to invite him to contribute to the review. The letter was delivered by Rodrigo's probation officer, who explained the DHR

[7] https://respeito.org.uk/

process. Rodrigo declined to be involved in the DHR. During the completion of the DHR, the Chair was informed by the Victim Service Homicide Worker that Rodrigo had returned to live in Portugal.

5.16 The Chair of Safer Lincolnshire Partnership agreed for an extension of the timeframe for the DHR to be completed, as a result of delays due to the criminal investigation and the Covid-19 pandemic. The Home Office was notified of the extension.

5.17 Following Helena's death, Lincolnshire Police referred themselves to the Independent Office of Police Conduct (IOPC)[8]. [See Section 10]. Due to the criminal investigation and ongoing coronial processes, the IMR author from the police was unable to speak to police officers and police staff who had been involved in contacts with the subjects of the DHR. The Review Panel considered the most appropriate method as to how information from these contacts could be shared and analysed for the purposes of the DHR. The Chair liaised with the investigating officer from the IOPC, who agreed for relevant extracts from the IOPC investigation report to be included within the DHR overview report. A copy of the draft overview report was shared with the investigating officer.

5.18 Thereafter, a draft overview report was produced that was discussed and refined at panel meetings before being agreed. The draft report was shared with Helena's family, who were invited to make any additional contributions or corrections.

[8] https://www.Policeconduct.gov.uk/

6. INVOLVEMENT OF FAMILY, FRIENDS, WORK COLLEAGUES, NEIGHBOURS AND THE WIDER COMMUNITY

6.1 The Chair wrote to Helena's family to inform them of the review and included the Home Office Domestic Homicide Review leaflet for families and the Advocacy After Fatal Domestic Abuse leaflet (AAFDA)[9].

6.2 The Chair contacted the Victim Service Homicide Worker for the family, to ensure that the family had support throughout the DHR process.

6.3 Due to the suspension of the DHR, the Chair maintained contact with the Victim Service Homicide Worker – to provide updates regarding the progression of the DHR, and for them to inform the family.

6.4 In November 2021, the Chair met with Helena's mother and stepfather, who provided valuable information for the review: this has been included in the report, where relevant. The family were supported by their Victim Service Homicide Worker during this meeting.

6.5 Due to the age of the children, and that they were both pre-verbal, it was not appropriate for them to be spoken to as part of the DHR.

6.6 The Chair spoke to Helena's best friend, who had been friends with Helena since primary school. The friend provided valuable information for this review: this has been included in the report, where relevant.

6.7 The police provided the Chair with statements obtained from a work colleague and neighbour during the homicide investigation. Relevant information from these statements has been included in the report, where relevant. The Chair did not make contact with these individuals due to the outstanding coronial case.

6.8 Helena was on maternity leave at the time of her death. The family told the Chair that Helena had recently been to the Doctors shortly before her death, where it was confirmed that she was fit and well enough to return to work. Helena was due to return to her place of work, the week after her death.

6.9 Helena lived in a council owned property. Information from South Kesteven District Council was provided to the DHR. Contact between

[9] https://aafda.org.uk/

Helena and South Kesteven District Council related to routine tenancy matters.

7. CONTRIBUTORS TO THE REVIEW

7.1 This table show the agencies who provided information to the review.

Agency	IMR	Chronology	Report
Department for Works and Pensions			X
East Midlands Ambulance Service	X	X	
Glenfield Hospital		X	
GP Surgery[10]	X	X	
Lincolnshire Community Health Services	X	X	
Lincolnshire County Council Adult Services			X
Lincolnshire County Council Children's Services	X	X	
Lincolnshire Police	X	X	
Nottingham University Hospital	X	X	
South Kesteven District Council			X
United Lincolnshire Hospitals NHS Trust	X	X	

7.2 The IMRs contained a declaration of independence by their authors and the style and content of the material indicated an open and self-analytical approach, together with a willingness to learn. All the authors explained they had no management of the case or direct managerial responsibility for the staff involved with this case.

7.3 As well as the IMRs, each agency provided a chronology of interaction with the subjects of the review, including what decisions were made and what actions were taken. The IMRs considered the Terms of Reference (TOR) and whether internal procedures had been followed and whether, on reflection, they had been adequate. The IMR authors were asked to arrive at a conclusion on their own agency's involvement and to make recommendations, where appropriate.

[10] GP Surgery for all subjects of the DHR.

7.4 The IMR should include a comprehensive chronology that charts the involvement of the agency with the victim and perpetrator over the period of time set out in the 'Terms of Reference' for the review. It should summarise: the events that occurred; intelligence and information known to the agency; the decisions reached; the services offered and provided to the subjects of the review; and any other action taken.

7.5 It should also provide: an analysis of events that occurred; the decisions made; and the actions taken or not taken. Where judgements were made or actions taken that indicate that practice or management could be improved, the review should consider not only what happened, but why.

7.6 The IMRs in this case were of good quality and focussed on the issues facing the subjects of the review. They were quality assured by the author, the respective agency, and by the Panel Chair. In addition, the panel's legal advisor carried out a quality audit of all IMRs. Where challenges were made, they were responded to promptly and in a spirit of openness and co-operation.

7.7 The following agency was contacted during the scoping period but held no information:

- Lincolnshire Partnership NHS Foundation Trust

7.8 Below is a summary of contributors to the review.

7.8.1 **Department for Works and Pensions**

The Department for Work and Pensions (DWP) is responsible for welfare, pensions, and child maintenance policy. As the UK's biggest public service department, it administers the State Pension and a range of working age, disability, and ill health benefits to around 20 million claimants and customers.

7.8.2 **East Midlands Ambulance Service**

East Midlands Ambulance Service NHS Trust (EMAS) employs over 3983 staff, over 70 sites, and responded to 994,144 emergency calls during 2020/2021. EMAS covers an area of approximately 6,425 square miles, across 6 counties: Nottinghamshire, Derbyshire, Leicestershire and Rutland, Lincolnshire, and Northamptonshire.

7.8.3 **Glenfield Hospital**

Glenfield Hospital is about three miles northwest of Leicester city centre. The hospital has approximately 415 beds and provides a range of services for patients, including nationally recognised medical care for heart disease, lung cancer and breast care.

7.8.4 **GP Surgery**

The surgery is a rural practice with approximately 8,700 registered patients. The surgery has three general practitioners, three nurse practitioners, two practice nurses, two health care support workers, and a full complement of administrative staff. The practice has a CQC rating as good.

7.8.5 **Lincolnshire Community Health Services**

Lincolnshire Community Health Services NHS Trust (LCHS) is the primary community healthcare provider in Lincolnshire, delivering community-based services aimed at supporting people to manage their own health at home and reducing the need for people to go into hospital. LCHS care for thousands of patients every day, in partnership with other health and social care services, to deliver joined-up care in community settings. The Trust works closely with other health and social care services to support a shift from care in acute hospitals, into more joined-up care in the community, close to home.

7.8.6 **Lincolnshire County Council Adult Services**

Adult Services carry out its statutory duties under the Care Act 2014, in relation to assessment and provision of support to meet identified needs for adults living in Lincolnshire who have been assessed as eligible for support, to meet their social care needs. Where possible, we do this through a strength-based approach, reablement, and building community connections.

7.8.7 **Lincolnshire County Council Children's Services**

Lincolnshire County Council Children's Services Department provides both universal and targeted services to 142,000 children and their families across the county. The services provided to children are governed by a raft of legislation and regulatory requirements. The statutory framework is wide-ranging and includes services to protect children from harm, and to identify and respond to children who are in need.

The authority also provides health visiting and Children and Young Peoples Nurse (CYPN) services, following transition from LCHS to Children's Services on 1 October 2017.

7.8.8 **Lincolnshire Police**

In terms of geographic area, Lincolnshire Police is one of the largest forces in the United Kingdom. It covers 2,284 square miles and the current population of the force area is approximately 757,000.

The Force consists of three operational commands, each led by a chief superintendent. Two of the commands are territorial – East and West – and are made up of four districts, each led by a chief inspector. Additionally, there are eleven neighbourhood policing areas, each led by an inspector. It is operational officers from within the neighbourhood policing areas who initially respond to, and investigate incidents, including incidents of domestic abuse.

The third command is the Crime Department. This has responsibility for central specialist services, including the Crime and Criminal Justice, the force's intelligence functions, and the Protecting Vulnerable Person's (PVP) unit. The PVP unit includes specialist investigative and safeguarding teams and the PVP Police Safeguarding Hub (PVP–PSH), which is the force's single point of contact for all child and adult protection referrals.

Under collaborative arrangements with other forces in the East Midlands, all homicide investigations are now undertaken by the East Midlands Special Operations Unit, Major Crime (EMSOU MC), and a SIO from that unit will be appointed to lead the enquiry; however, the early stages of such a crime are initially responded to and managed by local officers.

7.8.9 **Nottingham University Hospital**

Based in the heart of Nottingham, it provides services to over 2.5 million residents of Nottingham and its surrounding communities. NUH provides specialist services for a further 3 – 4 million people from across the region, and they are one of the largest employers in the region, employing around 16,700 people at Queens Medical Centre (QMC), Nottingham City Hospital, and Ropewalk House. The following services are based at QMC – Emergency Department (ED), Major Trauma Centre, Nottingham Treatment Centre, and the Nottingham Children's Hospital. QMC is also home to the University of Nottingham's School of Nursing and Medical School. Nottingham City Hospital's planned care site is where the cancer centre, heart centre, and stroke services are based. Ropewalk House provides a range of outpatient services, including hearing services.

7.8.10 **South Kesteven District Council**

South Kesteven is a local government district in Lincolnshire, England, forming part of the traditional Kesteven division of the county. It covers Grantham, Stamford, Bourne, and Market Deeping.

7.8.11 **United Lincolnshire Hospitals NHS Trust**

United Lincolnshire Hospitals NHS Trust is situated in the county of Lincolnshire and is one of the biggest acute hospital Trusts in England – serving a population of over 720,000 people.

8. THE REVIEW PANEL MEMBERS

8.1 This table shows the Review Panel members.

Review Panel Members		
Name	**Job Title**	**Organisation**
Carol Ellwood-Clarke	Independent Chair and Author	
Rachel Freeman	Head of Service, Children in Care and Residential Estates	Lincolnshire County Council Children's Services
Martin Holvey[11]	Reviewing Officer for Lincolnshire Police	East Midlands Regional Review Unit
Jane Keenlyside	MARAC Manager	EDAN Lincs[12]
Ged McManus	Support to Independent Chair and Author	
Maria Joao Melo Nogueira	Operations, Partnerships and Client Support Director	Respeito
Richard Myszczyszyn[13]	Head of Protecting Vulnerable People	Lincolnshire Police
Hazel Noble	Independent Management Review Co-ordinator	Lincolnshire County Council Adult Social Care
Sarah Norburn[14]	Domestic Abuse Co-ordinator	Lincolnshire Police
Jennifer Parker	Deputy Named Nurse for Safeguarding	Lincolnshire Community Health Services
Martyn Parker[15]	Head of Protecting Vulnerable People	Lincolnshire Police

[11] Attended meetings to present police IMR.

[12] https://edanlincs.org.uk/ldass/
EDAN Lincs Domestic Abuse Service is a registered charity covering the county of Lincolnshire, and provide support and assistance to men, women and children suffering, or fleeing from domestic abuse.

[13] Replaced Martyn Parker.

[14] Attended to deputise for Head of Protecting Vulnerable People for Lincolnshire Police.

[15] Martyn Parker attended initial panel meetings.

Rebecca Pinder[16]	Safeguarding and Mortality Review Nurse	NHS Lincolnshire Clinical Commissioning Group
Karen Ratcliff	Service Manager	We Are With You[17]
Claire Saggiorato	Lead Nurse – Safeguarding	Lincolnshire County Council Children's Health
Elaine Todd	Named Nurse for Safeguarding Children and Young People	United Lincolnshire Hospitals NHS Trust
Maggie Westbury	Adult Safeguarding Lead	Nottingham University Hospital NHS Trust
Emma Wilson	Adult Safeguarding Lead	East Midlands Ambulance Service
Safer Lincolnshire Partnership		
Jade Thursby	Domestic Abuse Lead	Lincolnshire County Council
Toni Geraghty	Legal Advisor	Legal Services – Lincolnshire
Teresa Tennant	Business Support	Lincolnshire County Council

8.2 The Chair of Safer Lincolnshire Partnership was satisfied that the Panel Chair and Author were independent. In turn, the Panel Chair believed that there was sufficient independence and expertise on the panel to safely, and impartially, examine the events and prepare an unbiased report.

8.3 The panel met eight times and the circumstances of Helena's death were considered in detail, with matters freely and robustly considered, to ensure all possible learning could be obtained. Due to the Covid-19 pandemic, some of the panel meetings were held virtually. Other meetings were held using a hybrid method, i.e., a mixture of in person and use of online

[16] Representing GP Surgery.

[17] https://www.wearewithyou.org.uk/services/lincolnshire-lincoln/
Help people change their behaviour to become the very best that they can be, in relation to drug or alcohol use or worries about their mental health.

facilities. Outside of the meetings, the Chair's queries were answered promptly, via email or telephone call, and in full.

9. CHAIR AND AUTHOR OF THE OVERVIEW REPORT

9.1 Sections 36 to 39 of the Home Office Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews December 2016, sets out the requirements for review Chairs and Authors.

9.2 Carol Ellwood-Clarke was appointed as the DHR Independent Chair and Author. She is an independent practitioner who has chaired and written previous DHRs and other safeguarding reviews. Carol retired from public service (British policing – not Lincolnshire) in 2017, after 30 years, during which she gained experience of writing Independent Management Reviews, as well as being a panel member for Domestic Homicide Reviews, Child Serious Case Reviews, and Safeguarding Adults Reviews. In January 2017, she was awarded the Queens Police Medal (QPM) for her policing services to Safeguarding and Family Liaison. In addition, she is an Associate Trainer for SafeLives[18].

9.3 Carol was supported in her role by Ged McManus. Ged is an independent practitioner who has chaired and written previous DHRs and Safeguarding Adults Reviews. He has experience as an Independent Chair of a Safeguarding Adult Board (not Lincolnshire). He served for over 30 years in different police services in England (not in Lincolnshire). Prior to leaving the police service in 2016, he was a Superintendent with particular responsibility for partnerships, including Community Safety Partnership and Safeguarding Boards.

9.4 Between them, they have undertaken the following types of reviews: child serious case reviews; Safeguarding Adults Reviews; multi-agency public protection arrangements (MAPPA) serious case reviews; Domestic Homicide Reviews; and have completed the Home Office online training for undertaking DHRs. In addition, they have undertaken accredited training for DHR Chairs, provided by AAFDA.

9.5 Neither of them has previously worked for any agency involved in this review. Carol Ellwood-Clarke was the Author of a previous Lincolnshire DHR[19]. Both have recently concluded a DHR[20] in Lincolnshire.

[18] https://safelives.org.uk/
[19] DHR2018L
[20] DHR2020G

10. PARALLEL REVIEWS

10.1 HM Coroner for Lincoln opened and adjourned an inquest. Notification was sent to HM Coroner that a DHR was being undertaken. In October 2024, an inquest hearing was held. The conclusion of the jury as to the cause of death was – 'unlawful killing'. The following verbatim account was provided by the jury –

'(Redacted) had been subjected to domestic abuse, assault, and coercive controlling behaviour in the period leading up to the 08/04/2020. She had an underlying heart condition known to her then partner.

She was assaulted twice on the 08/04/2020 and she died as a result of severe emotional stress caused by the second assault leading to cardiac arrhythmia and sudden cardiac death.

As a jury we believe that the evidence presented has shown significant missed opportunities to safeguarding (redacted) and her children. Those are identified with our responses to the attached questionnaire.

We as a jury feel that within the incidents of the 29/12/19 & 08/04/2020 Officers did not carry out their duties in accordance with the A.P.P. on the (illegible). There was a failure to carry out a full investigation of all he available evidence. If these actions had been carried out then the former partner on balance would have remained in custody'.

10.2 Lincolnshire Police completed a criminal investigation following Helena's death. Rodrigo was charged with Helena's murder. Following a court case in March 2021, the criminal trial, into Helena's death, was not progressed. [See 1.5 & 5.6].

10.3 Following the death of Helena, Lincolnshire Police referred themselves to the IOPC. The Chair maintained contact with the investigating officer from the IOPC, and in November 2021, the Chair received a redacted copy of the final IOPC report. The IOPC report was not a public document at this time, due to the ongoing coronial processes. The IOPC report identified the following learning: 'The decision maker may wish to consider whether a Learning Recommendation should be made to Lincolnshire Police for them to consider that they should implement the process into written policy to explain when calls should be directed to 101 and the actions the 999 call handler should be taking when advising callers to call back on 101'.

Lincolnshire Police have updated the relevant force policy to reflect this recommendation.

10.4 The review was not aware of any other investigations that have taken place since Helena's death.

11. EQUALITY AND DIVERSITY

11.1 Section 4 of the Equality Act 2010 defines protected characteristics as:

- **age** [for example an age group would include "over fifties" or twenty-one-year-olds. A person aged twenty-one does not share the same characteristic of age with "people in their forties". However, a person aged twenty-one and people in their forties can share the characteristic of being in the "under fifty" age range].
- **disability** [for example a man works in a warehouse, loading and unloading heavy stock. He develops a long-term heart condition and no longer has the ability to lift or move heavy items of stock at work. Lifting and moving such heavy items is not a normal day-to-day activity. However, he is also unable to lift, carry or move moderately heavy everyday objects such as chairs, at work or around the home. This is an adverse effect on a normal day-to-day activity. He is likely to be considered a disabled person for the purposes of the Act].
- **gender reassignment** [for example a person who was born physically female decides to spend the rest of her life as a man. He starts and continues to live as a man. He decides not to seek medical advice as he successfully 'passes' as a man without the need for any medical intervention. He would have the protected characteristic of gender reassignment for the purposes of the Act].
- **marriage and civil partnership** [for example a person who is engaged to be married is not married and therefore does not have this protected characteristic. A divorcee or a person whose civil partnership has been dissolved is not married or in a civil partnership and therefore does not have this protected characteristic].
- **pregnancy and maternity**
- **race** [for example colour includes being black or white. Nationality includes being a British, Australian or Swiss citizen. Ethnic or national origins include being from a Roma background or of Chinese heritage. A racial group could be "black Britons" which would encompass those people who are both black and who are British citizens].
- **religion or belief** [for example the Baha'i faith, Buddhism, Christianity, Hinduism, Islam, Jainism, Judaism, Rastafarianism, Sikhism and Zoroastrianism are all religions for the purposes of this provision. Beliefs such as humanism and atheism would be beliefs for the purposes of this provision but adherence to a particular football team would not be].
- **sex**
- **sexual orientation** [for example a man who experiences sexual attraction towards both men and women is "bisexual" in terms of

sexual orientation even if he has only had relationships with women. A man and a woman who are both attracted only to people of the opposite sex from them share a sexual orientation. A man who is attracted only to other men is a gay man. A woman who is attracted only to other women is a lesbian. So, a gay man and a lesbian share a sexual orientation].

11.2 Section 6 of the Act defines 'disability' as:

[1] A person [P] has a disability if —

[a] P has a physical or mental impairment, and

[b] The impairment has a substantial and long-term adverse effect on P's ability to carry out normal day-to-day activities[21]

None of the subjects of the review is known to have had any diagnosed physical or mental impairment that would have defined them as disabled.

11.3 Helena had been diagnosed with chronic myocarditis[22] and was under the care of cardiology specialists in Leicester and Nottingham. Helena was prescribed medication due to her heart condition. During both pregnancies, Helena attended Nottingham University Hospital for regular consultant-led maternity care.

11.4 During the time frame for the review, Helena was seen on four separate occasions by a nurse practitioner and a GP. Helena had 20 notable contacts with Accident and Emergency Departments or 111 services. In the main, Helena's presentation was for chest pain.

11.5 Helena's heart condition did not have an adverse impact on her ability to carry out daily tasks. Helena had been in employment prior to her maternity leave.

11.6 Rodrigo had limited contact with his GP practice during the review period. These contacts were for unrelated conditions and not relevant to the DHR. Rodrigo was not in receipt of any secondary care services.

11.7 The Review Panel was provided with information from family and friends that Rodrigo used illicit drugs, such as cocaine. In May 2019, Helena told the police that Rodrigo was using cocaine and cannabis. In November 2019, Helena told the police that Rodrigo was taking 'speed[23] and smoking

[21] Addiction/Dependency to alcohol or illegal drugs are excluded from the definition of disability.

[22] https://www.myocarditisfoundation.org/research-and-grants/faqs/chronic-myocarditis/

[23] Speed is the street name for amphetamine sulphate, although it's sometimes used to refer to other amphetamines.

weed[24]'. The Review Panel found no evidence that other agencies were aware of Rodrigo's drug use. Rodrigo was not known to drug and alcohol services. Following the arrest of Rodrigo after the death of Helena, toxicology samples found evidence that Rodrigo had taken cannabis, amphetamine, and paracetamol prior to the sample being taken. The police investigation also found trace evidence of amphetamine on paperwork found in Rodrigo's vehicle.

11.8 The Equality Act 2010 (Disability) Regulations 2010 (SI 2010/2128) states that addiction to alcohol, nicotine or any other substance (except where the addiction originally resulted from the administration of medically prescribed drugs) is to be treated as not amounting to an impairment for the purposes of the Equality Act 2010. It should be noted that although addiction to alcohol, nicotine and drugs is excluded from The Equality Act 2010, addiction to alcohol and drugs should be taken into account when a Care Act 2014 (care and support) assessment is completed.

11.9 Neither Helena or Rodrigo came to the attention of Adult Social Care during the review period; therefore, there was no opportunity for Adult Social Care to consider whether a care and support assessment was appropriate. There has been no indication in the review that either Helena or Rodrigo had care and support needs.

11.10 Helena was Portuguese and had lived in the UK since the age of five. Helena's mother informed the Chair that Helena spoke fluent English and had no communication difficulties. Helena attended local schools and completed her GCSEs in English Language. Whilst agency records acknowledged that Helena's primary language was Portuguese, it was also documented that Helena spoke and understood English.

11.11 During the completion of a Child and Family Assessment in 2020, Helena's and her children's needs were reflected upon in the assessment. Helena discussed how she was very close to her family – seeing her mother and grandmother daily. Helena spoke of other family members in the local area, including an uncle who was a priest at the Portuguese Church, which she attended with her mother and family. Helena was a Pentecostal Christian. Helena told professionals that her culture was very important to her, and she had the support of the local Portuguese community.

11.12 The Review Panel was provided with detailed information on Portuguese culture and attitudes by their panel expert: this has been captured, where

[24] Weed is the street name for cannabis, a plant-based drug.

relevant, within Section 14 of the report. Therefore, this will not be repeated under this Section.

11.13 Rodrigo was Portuguese. English was his second language. The Chair was informed by Rodrigo's probation officer that during contacts with Rodrigo, there was a need for regular checks to be made to verify his understanding of discussions. Rodrigo also needed assistance in understanding and writing in the English language. The Chair was advised that in formal settings, such as during the criminal trial, an interpreter was required to facilitate communication. During the completion of assessments – as part of the care proceedings for the children, following the death of Helena – Rodrigo declined the use of an interpreter, citing that he had sufficient understanding of English. Helena's mother told the Chair that whilst Rodrigo spoke English, he was not fluent in the language and needed help from Helena to fill in forms and deal with official correspondence. Rodrigo's understanding of the English language is analysed further, under Section 14.

11.14 Domestic homicide and domestic abuse in particular is predominantly a crime affecting women, with women by far making up the majority of victims, and by far the vast majority of perpetrators being male. The latest available domestic abuse data, from the Crime Survey for England and Wales (CSEW)[25], are for the year ending March 2020. These showed that an estimated 2.3 million adults, aged 16 to 74 years, experienced domestic abuse in the year ending March 2020: a prevalence rate of approximately 5 in 100 adults.

11.15 There were 362 domestic homicides recorded by the police in the three-year period between year ending March 2018 and year ending March 2020. This represents 19% of all homicides where the victim was aged 16 years and over, during this period. Of the 362 homicides, 214 (59%) were female victims who were killed by a partner or ex-partner. In contrast, 33 (9%) were male victims who were killed by a partner or ex-partner. The remaining 115 (32%) were victims killed by a suspect in a family category.

11.16 In 2016, Safelives published a report – 'A Cry for Health: Why we must invest in domestic abuse services in hospital'[26]. The report documented

25 https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/domesticabuseprevalenceandtrendsenglandandwales/yearendingmarch2021

26 https://safelives.org.uk/sites/default/files/resources/SAFJ4993_Themis_report_WEBcorrect.pdf

that around 30% of domestic abuse begins during pregnancy, with 40–60% of women who are experiencing domestic abuse are abused during pregnancy.

11.17 In 2015, the British Journal of Midwifery published an article – 'Intimate partner violence and pregnancy: How midwives can listen to silenced women'[27]. The article referenced that during pregnancy, domestic abuse can result in physical, psychological and gynaecological health conditions; and is associated with causing serious complications during pregnancy and adverse outcomes for the baby. The report further documents that there is increasing evidence to suggest that women are at increased vulnerability of domestic abuse during pregnancy and 1 year post-birth, and that midwives have an important role in the screening, detection and the management of women experiencing domestic abuse during pregnancy.

[27] https://www.britishjournalofmidwifery.com/content/clinical-practice/intimate-partner-violence-and-pregnancy-how-midwives-can-listen-to-silenced-women/

12. DISSEMMINATION

12.1 The following organisations/people will receive a copy of the report after any amendment following the Home Office's quality assurance process.

- The Family
- Safer Lincolnshire Partnership
- All agencies that contributed to the review
- Lincolnshire Police and Crime Commissioner
- Domestic Abuse Commissioner

13. BACKGROUND, CHRONOLOGY AND OVERVIEW

This part of the report combines the Background, Overview and Chronology sections of the Home Office DHR Guidance overview report template. This was done to avoid duplication of information and to recognise that the review was looking at events over an extended period of time. The narrative is told chronologically, and details key events. This section builds on the lives of Helena and Rodrigo and is punctuated by subheadings to aid understanding. The information is drawn from documents provided by agencies, information provided by family, and material gathered by the police during their investigations. These events are factual. Analysis appears in Section 14.

13.1 Helena

13.1.1 Helena came to live in England when she was five years old. Helena integrated to school life, in England, quickly and seemingly easily. Helena was happy and within a few weeks she could speak good English. Helena made many friends, and her mum described her as 'more English than Portuguese'.

13.1.2 On leaving school, Helena went to college where she did a course to qualify to work as airline cabin staff. Towards the end of the course, Helena was diagnosed with a heart condition: this meant that she was unable to pursue that line of work. Instead, she worked as a carer.

13.2 Rodrigo

13.2.1 The Review Panel was only able to gather limited information on Rodrigo's background – from agencies and Helena's family and friends.

13.2.2 During the completion of assessments – as part of the care proceedings for the children, following the death of Helena – Rodrigo provided the following information. Rodrigo stated that he had been brought up in Portugal with his parents and two sisters. His parents separated and his mother remarried. Rodrigo moved to the United Kingdom around eight years ago. The Review Panel has been unable to ascertain any contact details for Rodrigo's family members. Rodrigo advised that his main employment, since moving to live in the United Kingdom, had been as a welder.

13.2.3 The Review Panel established that Rodrigo's employment ended in 2019. Following this, Rodrigo had worked in a recycling factory for a short period of time, before ceasing work due to the Covid-19 pandemic.

13.3 Helena and Rodrigo's relationship

13.3.1 Helena and Rodrigo's relationship started around 2016, when they met in a local Portuguese coffee shop where many members of the Portuguese community meet. This meeting was not long after Rodrigo had come to England. Helena's mother stated that Rodrigo did not speak to his family in Portugal. Helena's mother told the Chair that when Helena told her about Rodrigo, she was happy. Rodrigo was from a good family and was a working man, who Helena's mother thought would be a good partner for her daughter. Helena's mother told the Chair that she was aware of some domestic abuse in their relationship, and that she encouraged Helena to leave Rodrigo and promised to support her. However, the Chair was informed that family was very important to Helena, and she had told her mother that she wanted to stay and work on the relationship with Rodrigo. Helena's mother told the Chair that Rodrigo told Helena: "If I can't have you no other man will."

13.3.2 Helena and Rodrigo had two children together. After the couple's second child was born, Helena's mother stated that she, and her partner, noticed a change in Rodrigo, and they alleged that Rodrigo had begun to use cocaine and was spending money from the family budget to do so. Rodrigo lost his employment twice. They received regular calls to provide help and were giving Helena money, every week, for food and clothes for the children.

13.4 Events prior to 2016 (pre-Terms of Reference)

13.4.1 There was no relevant information held by agencies prior to the commencement of the review period.

13.5 Events in 2016

13.5.1 Throughout 2016, Helena had contact with health professionals in relation to her heart condition. Around April 2016, Helena and Rodrigo are understood to have started their relationship.

13.6 Events in 2017

13.6.1 On 3 March, Helena and Rodrigo were registered as living together in a property in Grantham. They remained in this property until 22 June 2018.

13.6.2 Throughout 2017, Helena had contact with health professionals in relation to her heart condition. Towards the end of 2017, Helena's engagement also focused on maternity care.

13.7 Events in 2018

13.7.1 Around the end of 2017 and early 2018, Helena was assaulted by Rodrigo. Helena told the police that when she was around five months pregnant with her eldest child, Rodrigo started to strangle her. This is believed to have been around the end of 2017 and early 2018. Helena stated that this was 'out of the blue'. Helena reported this incident to the police in April 2020, and she provided the police with photographs of her injuries from the strangulation.

13.7.2 Throughout 2018, Helena had contact with health professionals in relation to her heart condition.

13.7.3 On 21 September, Helena attended at hospital with a fracture to her finger. Helena informed medical staff, at that time, that she had sustained the injury when she had punched her car door in anger. In April 2020, Helena told the police that Rodrigo had caused the injury.

13.7.4 On 22 September, Rodrigo moved out of the property he shared with Helena. It was not known when Rodrigo returned to live at the property.

13.7.5 On 29 September, Helena informed the DWP that her relationship had ended with Rodrigo. From this date onwards, Helena was paid Universal Credit as a single person. The DWP held no information that Helena's relationship with Rodrigo had resumed.

13.8 Events in 2019

13.8.1 Throughout 2019, Helena had contact with health professionals in relation to her heart condition. At the beginning of 2019, Helena's engagement with health also focused on maternity care.

13.8.2 On 19 May, Helena contacted the police, via 999, to report a domestic abuse incident involving Rodrigo. Helena reported that they had been arguing, and Rodrigo was refusing to leave the address. Their young child

was present, and Helena was five months pregnant with their second child. Police attended and spoke to Helena, and she told them about a previous assault by Rodrigo, which had occurred two to three years earlier, when Rodrigo had 'choked' and slapped her. Helena stated that Rodrigo was using cocaine and cannabis, which made them argue more, and he was becoming more controlling of her. Helena stated that they were also in debt due to Rodrigo's drug use, that Rodrigo had threatened suicide, and that their relationship had now come to an end. The police recorded a crime for common assault, for the assault two to three years earlier. Helena provided a statement. A DASH was recorded and graded as standard. The crime report was finalised. The incident was not shared with other agencies. Rodrigo was not seen by the police.

13.8.3 On 31 August, Iria was taken to hospital, by Helena and Rodrigo, with an arm injury. Helena told health professionals that Iria had nearly fallen from the sofa, and she had grabbed her right arm to avoid the fall. Iria was diagnosed with a pulled elbow. During contact with the Chair, after Helena's death, Helena's mother alleged that Rodrigo had caused the injury by roughly pulling Iria's arm, and that Rodrigo had told Helena that she must lie about the injury or the children would be taken away by Social Services.

13.8.4 On 7 September, Helena contacted the police to report Rodrigo missing. Rodrigo had left the house saying: 'it didn't matter if I am no longer here'. Helena was eight months pregnant at the time. The police initially risk assessed the incident as high. Rodrigo was quickly located and returned home. Rodrigo told the police that he needed sometime to himself, and he never had any intention of harming himself.

13.8.5 Helena's friend told the Chair that Rodrigo would often go missing, that this was a frequent occurrence, and that not all incidents were reported to the police. Helena's friend described how Rodrigo would take the children's car seats, pushchairs, and bank cards when he went missing – leaving Helena at home with the two young children. Rodrigo would then ring Helena and play mind games, leaving messages such as 'Find me', and indicating that if he was not found within a certain time, he would harm himself. Rodrigo would give Helena a number of clues as to where he was 'hiding'. The friend described how Helena would call her and ask her to drive her and the children to 'find' Rodrigo. The friend described how, on these incidents, Helena was isolated (as she lived in an upstairs flat). As Rodrigo had removed the car seats and pushchairs, Helena had no means of being

able to get out of the flat with two young children. Furthermore, without her bank cards, she had no access to money.

13.8.6 On 5 November, Helena called the police to report Rodrigo as missing. Helena reported that Rodrigo had left the house following an argument and had been missing for over 12 hours. Helena had recently given birth to her second child. Helena stated that Rodrigo was suffering from depression, although he was not on any medication. Rodrigo's car was located moving around Grantham, and the risk assessment for the incident was graded as low. Rodrigo returned home and stated that he needed sometime to himself.

13.8.7 The following day, Helena called the police, via 999, to report a domestic abuse incident. Police attended at the house. They found Helena with her two children and her mother. Rodrigo had left the property. Helena reported that there had been an argument over finances, and that she suspected Rodrigo of spending money on drugs. Helena stated that the argument developed into Rodrigo trying to leave the house, and when she tried to stop him, he pushed past her. Helena told the police that Rodrigo was taking 'speed and smoking weed', and that he was controlling and was not accepting Helena's wish to separate from him (at various points during their relationship). It was recorded that neither Helena or Rodrigo were in employment, or in receipt of benefits. Information provided to the DHR process by DWP, confirm that Helena and Rodrigo were in receipt of financial support from DWP during the timeframe of the review.

13.8.8 Helena also told the police of a similar incident that had happened on 4 November: prior to her reporting him missing. Helena stated that during that incident, Rodrigo had grabbed her jaw, whilst restraining her arm. This resulted in her biting his cheek.

13.8.9 The police contacted Rodrigo, and he agreed to stay away from the house until things had calmed down. During that contact, Rodrigo stated that he had been assaulted by Helena; however, he stated that he may have been excessive when he held Helena's arm behind her back. A DASH was completed, and the incident risk assessed as medium. A crime report was created for an offence of common assault on Helena. It was recorded that Helena acknowledged that she had assaulted Rodrigo. Helena stated that she did not want to progress a complaint of assault on herself by Rodrigo. The incident was finalised, with both parties being given words of advice. Helena declined any further assistance from Social Services or partner agencies. The incident was shared with Children's Social Care.

13.8.10 On 29 December, Helena called the police via 999. Helena was described as hysterical throughout the telephone call, and during the call, she reported that she had been assaulted by Rodrigo on 25 December, when he had grabbed her face so hard, she could hardly breathe. Helena also described an assault on 26 December, when Rodrigo had pushed her into a kitchen pillar: this had caused her to hit her head and resulted in her having blurred vision and a headache. Helena described to the police that over the last two and a half years, she had been sleeping on the sofa, even whilst she had been pregnant.

13.8.11 The police attended at Helena's house, and she described to them that an argument had started over money, and Rodrigo's drug use. It was recorded that Helena stated that she did not know what to do, and that she was unsure if she wanted to separate from Rodrigo. A crime report was created for an offence of common assault. Helena was provided with safety advice. The crime report was finalised as: 'the victim declines/withdraws the support although there was a named suspect'. A DASH report was created, and was risk assessed as standard. Rodrigo was not seen about this incident until after Helena's death. The incident was shared with Children's Social Care on 6 January 2020.

13.8.12 Helena's friend told the Chair that Helena knew the police officer who dealt with this incident, as they had been at school together. Helena stated that she felt let down and not believed, and that she felt that she had nowhere to go, in terms of the domestic abuse. The friend stated that Helena had told her that the police had said that the incident was 'communication errors' and 'that it happened in all relationships', and that she [Helena] could be prosecuted for assaulting Rodrigo. This information was shared with the police who dealt with the comments outside of the DHR process, in line with the Home Office Statutory Guidance, section 2, paragraph 11. The guidance states that: '*DHRs are not specifically part of any disciplinary inquiry or process. Where information emerges in the course of a DHR indicating that disciplinary action should be initiated, the established agency disciplinary procedures should be undertaken separately to the DHR process. Alternatively, some DHRs may be conducted concurrently with (but separate to) disciplinary action.*'

13.9 Events in 2020

13.9.1 On 6 January, Children's Social Care screened the notification from the police and requested additional information. This was the first notification

that Children's Social Care had of domestic abuse. The case was allocated to a social worker to undertake a Child and Family Assessment.

13.9.2 On 10 January, the social worker visited Helena: both children were present. Helena stated that she had separated from Rodrigo, and her family had financially and practically supported Rodrigo in finding alternative accommodation. Helena told the social worker that if Rodrigo made changes, i.e., stopped using cannabis, then she would resume their relationship. Helena told the social worker that there had never been any physical violence between her and Rodrigo, and she stated that she had exaggerated incidents during contact with the police.

13.9.3 On 20 January, during a meeting between the social worker and their supervisor, it was agreed for the Child and Family Assessment to continue – with consideration of case closure by the end of January. The social worker made several attempts to contact Rodrigo. However, all contact were unsuccessful.

13.9.4 On 24 January, the social worker informed the health visitor of the domestic abuse incidents.

13.9.5 Helena's friend told the Chair that at the beginning of February, she had seen Helena with bruising around her neck and a black eye. Helena had also shown her photographs of the injuries that Helena alleged had been caused by Rodrigo – he had assaulted her and pushed her into the baby's crib, causing the crib to break. The friend told the Chair that Helena had told her that she had found a board with cocaine remnants, wedged inside one of the children's car seats, that Rodrigo had placed there. When she spoke to him about this, he had assaulted her.

13.9.6 The friend told the Chair that Helena had made the decision to leave Rodrigo, and that she was determined not to resume their relationship. The friend described how they provided Helena with car seats for the children and paid for meals for her if they went out with friends, as Helena did not have any money.

13.9.7 On 6 February, Children's Social Care received the results of police intelligence and PNC (Police National Computer) checks on Helena and Rodrigo. Within the information shared, was the domestic abuse incident from May 2019. This was the first time that Children's Social Care was aware of this incident. This incident was added to the Child and Family Assessment. It was recorded that Helena had told the social worker that

she was unable to recall this incident. On 13 February, the Child and Family Assessment was closed.

13.9.8 On 28 March, Helena was assaulted by Rodrigo. The incident was not reported to the police until 8 April. Helena told the police that Rodrigo had 'lost the plot' and grabbed and twisted her arm behind her back, causing bruising. Rodrigo had then pushed her into a wardrobe, before pushing her onto the bed, where he climbed on top of her. Rodrigo put his arm across her neck to stop her breathing. He was pushing so hard, and for so long, that an imprint from the jumper that he was wearing, was left on her skin. Helena told the police that, on this occasion, she thought he may kill her.

13.9.9 Helena's friend told the Chair that she had seen the bruising to Helena's neck and the imprint mark from the jumper. The friend told the Chair that Helena was worried about leaving her house, due to the visible injuries, and therefore stayed in her property.

13.9.10 The family told the Chair that, on 7 April, Helena had asked them for money to help with an advance payment for a childminder, as she was due to start a new job. Helena's mother and father visited her and saw that there were bruises on her neck.

13.9.11 On the morning of 8 April, Helena telephoned the police and reported that, during an argument with Rodrigo, he had thrown a hard plastic toy at her, which had hit her. Helena had thrown the toy back at Rodrigo, and Rodrigo had then thrown her onto the bed and climbed on top of her. During the assault, Helena had asked Rodrigo if he was going to kill her this time, and he placed his arm across her throat, restricting her breathing. This left a bruise on her neck. As he was leaving the property, he pushed the door back, trapping her between the door and the wall. He said: 'I don't care about the door; I'll kill you with the door'.

13.9.12 Rodrigo was arrested at lunchtime. Helena gave a statement to the police, where she provided details of previous incidents of domestic abuse that had not been reported to the police. A DASH risk assessment was completed, which was graded as medium. Later that day, the risk assessment was reviewed by a supervisor and increased to high. A referral to MARAC was to be made.

13.9.13 The IOPC report documented that whilst Rodrigo was in custody, a police officer went to see Helena and gave her Rodrigo's key to the property.

13.9.14 Late afternoon, Helena telephoned the Children's Health Single Point of Access[28] (SPA). Helena told them that she had previously experienced domestic abuse, and that Rodrigo had tried to strangle her today and had been arrested. Helena stated that she did not want Rodrigo to have access to the children. Both children had been present during the incident. Immediate safeguarding advice was given, and Helena was informed that a referral would be made to Children's Social Care. The referral was screened and allocated for a Child and Family Assessment.

13.9.15 Rodrigo was released from custody, in the early evening. Rodrigo was released on conditional bail, with conditions that he should not contact Helena by any means, except via a third party to arrange access to their children. The bail was authorised by the custody sergeant and for the case to be sent to CPS for a decision as to whether Rodrigo should be charged.

13.9.16 The IOPC report highlighted that Helena was informed of the details of Rodrigo's bail conditions by the custody sergeant (during a telephone call), and from the police officer responsible for investigating the case (during a separate telephone call, made after Rodrigo had been released from custody).

13.9.17 After Helena's death, Helena's friend told the Chair that Helena had telephoned her after the arrest of Rodrigo. During their conversation, Helena had told her that the assaults from Rodrigo were happening more often. Helena later telephoned the friend and told her that Rodrigo had been released from custody and that she had been told by the police that she had to allow Rodrigo into the property to collect his belongings. The friend told the Chair that Helena was crying during this telephone call, saying that she was scared. Helena's friend stated that she would have gone to the property to be with Helena but because of the restrictions in place due to Covid-19 pandemic, she was frightened of the repercussions if she was found to have breached those restrictions. The friend sent a text message to Helena later that evening but did not receive any reply.

13.9.18 Statements provided by the police for the purposes of the IOPC investigation, do not support the information provided by Helena's friend: that Helena had been told to allow Rodrigo into the property to collect his belongings.

[28] This is a centralised response service which takes children's health enquiries from parents and professionals.

13.9.19 After the death of Helena, a work colleague of Helena's told the police that Helena had contacted them, via Facebook messenger, during the early evening of 8 April. In the message, Helena stated: 'I called them…. Rodrigo was knocking me about so I got him done. Please don't say anything though xx'. Helena's work colleague stated that she was shocked when they received the message, as they thought they got on so well and he didn't seem to be that kind of person. When asked if Helena was OK, and if they had split up, Helena replied: 'Yeah, I've said it depends on what happens from now on but because if the children there will always be contact one way or another xxx'.

13.9.20 Prior to midnight, Helena telephoned the police via a 999 call. During that call, Helena stated that Rodrigo had returned to the property, assaulted her, and had left the premises. Helena was advised by the police to call 101, which she then did. Police attended at Helena's address a short time later and forced entry into the property. Helena was found inside the property. Both children were also at the address. Helena was later pronounced deceased.

13.9.21 During the investigation into Helena's death, a neighbour stated that that they had heard an argument between a male and female from within Helena's flat. This incident occurred on the evening (late) that Rodrigo had been released from custody. The neighbour reported hearing a male and female shouting from the address. The neighbour stated that they regularly heard shouting from the address, about twice a week, and that this would last for 10 minutes to an hour. The neighbour reported hearing a really loud scream, followed by a really loud squeal, about 10 seconds later. The neighbour stated that this sounded like Helena, as they had heard her scream before. The neighbour reported hearing the stomping of feet and Helena shout: 'Get out, get out'. This was followed by the neighbour hearing Helena say: 'Don't touch her, that's my baby, that's my baby'. This was followed by a male voice saying: 'Shall I drop it?' and 'I'll drop it. Do you want me to drop it?' The neighbour did not know what this was in reference to. Helena could be heard sobbing. The neighbour then heard a communal door close and assumed that a person had left the address.

14. ANALYSIS USING THE TERMS OF REFERENCE

14.1 Term 1

What indicators of domestic abuse, including coercive and controlling behaviour, did your agency identify for Helena?

14.1.1 During contact with midwifery services in Lincolnshire, Helena was asked 'routine questions'[29] about domestic abuse. Helena did not disclose that she was, or had been, a victim of domestic abuse.

14.1.2 Helena's maternity care was consultant-led by Nottingham University Hospital (a different health authority), and at the commencement of this DHR, learning was identified in relation to the lack of use of routine domestic abuse enquiry by the obstetricians who were caring for Helena. This area of learning has been addressed. [See 14.15.11].

14.1.3 The health visitor was not aware of domestic abuse in Helena and Rodrigo's relationship until 24 January 2020, when the health visitor was told by a social worker that Rodrigo had moved out of the house and that his cannabis use caused tension within the family home. This is the first occasion that the health visitor was aware of domestic abuse or substance misuse within the family.

14.1.4 On 3 April 2020, the health visitor contacted Helena via telephone. Helena was asked about domestic abuse during the call and made no disclosures. This call was made in line with Children's Health Covid Guidelines in place, due to the Covid-19 pandemic. [See 14.9.7].

14.1.5 Five days later, on 8 April, Helena telephoned the Children's Health Single Point of Access (SPA). Helena requested to speak to a health visitor and told the call handler that she had previously experienced domestic abuse and that there had been a further incident that morning, and that her partner (Rodrigo) had been arrested. The call was transferred to the central duty health visitor, who continued the call with Helena. The central duty health visitor informed the locality health visiting team of the call and requested a DASH be completed and follow-up support be offered to Helena and the children. A DASH risk assessment was not completed during the call, as it was felt that the immediate priority was to complete a safeguarding referral to Children's Social Care, due to the time of day (approximately 16:00hrs).

[29] https://www.nice.org.uk/guidance/qs116/chapter/Quality-statement-1-Asking-about-domestic-violence-and-abuse

Lincolnshire Police

14.1.6 The police received reports from Helena that she had been a victim of domestic abuse. The below table details those reports and action taken:

Incident date	Date reported	Details	Outcome	Risk Assessment
2016/2017	19.05.19	Helena disclosed Rodrigo had 'choked' and slapped her.	Crime for common assault. No action taken as offence statute barred.	Standard
Dec 17 - Jan18	08.04.20	Helena was five months pregnant and reported that Rodrigo had strangled her.	No action taken as recorded as a common assault and incident statute barred.	Medium, upgraded to High
19.07.18	08.04.20	Helena received a fractured finger during an assault by Rodrigo.	No action taken as recorded as common assault and incident statute barred[30].	Medium, upgraded to High
19.05.19	19.05.19	Helena disclosed an argument with Rodrigo over debt due to Rodrigo's use of cocaine and cannabis. Rodrigo had threatened suicide. Helena	DASH recorded. Incident not shared.	Standard

[30] The general rule for time limits on summary-only offences is that prosecutions will be time barred if information is laid more than six months after the date of the offence.

		disclosed that Rodrigo was becoming more controlling. Helena stated that the relationship had ended. Helena was five months pregnant. Young child in house.		
04.11.19	06.11.19	Helena disclosed that during argument, Rodrigo had grabbed her jaw whilst restraining her arm. This resulted in Helena biting his cheek.	Crime report created for an offence of common assault. Words of advice given to Helena and Rodrigo.	Medium
06.11.19	06.11.19	Helena disclosed that she had been assaulted by Rodrigo, as he had pushed past her.	Words of advice given.	Medium
25.12.19	29.12.19	Rodrigo assaulted Helena and grabbed hold of her face so hard she could barely breathe.		Standard
26.12.19	29.12.19	Rodrigo pushed Helena into a kitchen pillar, causing blurred vision and headache.		Standard
28.03.20	08.04.20	Helena reported that Rodrigo had assaulted her and grabbed and twisted her	Rodrigo was arrested on 8 April and later released on	Medium, upgraded to High

		arm behind her back, causing bruising. Rodrigo had pushed her into a wardrobe, before pushing her onto the bed and then climbing on top of her. Rodrigo had put his arm across her neck to stop her breathing and was pushing so hard, and for so long, that an imprint from the jumper that he was wearing, was left on her skin.	conditional bail.	
08.04.20	08.04.20	Rodrigo assaulted Helena by throwing a hard plastic toy at her. Rodrigo threw her onto the bed, climbed on top of her and put his arm across her neck – restricting her breathing, causing a bruise to her neck.	Rodrigo was arrested on 8 April and later released on conditional bail.	Medium, upgraded to high.
08.04.20	08.04.20	Helena contacted the Police and reported that Rodrigo had been to her address and assaulted her. Rodrigo had left the property.	Helena was found deceased upon Police arrival.	

14.1.7 The Review Panel acknowledged that the incidents were not reported in chronological order. The Review Panel was unanimous in their view that the incidents showed an escalation in the level of violence and risk towards Helena.

14.1.8 In May 2019, Helena told the police that Rodrigo was becoming more controlling. During this contact, Helena disclosed an assault that had occurred two to three years earlier. The police recorded a crime for a common assault[31], in relation to the earlier assault. As the assault had occurred over six months prior to the matter being reported to the police, it prevented the police undertaking an investigation into the circumstances of the assault – as the offence was classed as 'statute barred'[32]. The police did not complete a separate DASH for the assault but did include the details within the DASH submitted for the May incident. This was in line with expected practice. There was no further information recorded regarding the controlling behaviour of Rodrigo, as disclosed by Helena. The DASH did record that there was a young child living in the house and that Helena was pregnant. The incident and details within the DASH were not shared with Children's Social Care.

14.1.9 The Review Panel sought clarification from Lincolnshire Police Force Crime Registrar, in relation to the recording of the crimes identified during this contact: they were informed that a second crime should have been recorded for the offence of coercive and controlling behaviour, as defined by Section 76 Serious Crime Act 2015. [See Appendix B].

14.1.10 When Helena contacted the police in December 2019, she reported that she had been assaulted on two separate occasions by Rodrigo, (25 and 26 December 2019). The police provided Helena with advice and recorded a crime for one offence of assault. The Review Panel was informed by Lincolnshire Police Force Crime Registrar that as Helena had reported, at the same time, that she had been assaulted on two occasions, then it was correct practice to record a crime for one offence to cover the two assaults, in line with National Crime Recording Standards. The Review Panel was also informed that two separate assaults within a relationship, within that period of time, would have required a crime to have been recorded in

[31] Common assault is a criminal offence under the Criminal Justice Act 1988 and the Offences Against the Person Act 1861 and is committed when someone assaults another person or commits a battery.

[32] An offence of common assault can only be prosecuted within six months of the incident occurring.

relation to the offence of coercive and controlling behaviour, as defined by Section 76 Serious Crime Act 2015.

14.1.11 Lincolnshire Police have informed the Review Panel that incidents of domestic abuse are now subject of a secondary screening process, which ensures that the correct crime has been recorded for the case, and where necessary additional crime reports are recorded. In addition, Lincolnshire Police commenced roll out, in February 2022 to all first responders, the latest accredited training in relation to domestic abuse, with emphasis on coercive control. This training package, known as Domestic Abuse Matters, has been designed in conjunction with the College of Policing and is being jointly delivered by police and Women's Aid. Domestic Abuse training is also featured in other core police training – for specific roles such as student officers, force control room call handlers, sergeants, and inspectors.

14.1.12 Helena told the police, during contact in December, that she did not know what to do, as she was not sure if she wanted to separate from Rodrigo. The police recorded that Helena had no visible injuries and that she did not wish to support a prosecution. Rodrigo was not spoken to by the police regarding either assault. Further analysis regarding this incident, including the risk assessment, is covered in Term 3.

14.1.13 It was not until the last reported incident, in April 2020, that Rodrigo was arrested by the police. Helena provided the police with a statement detailing the abuse that had occurred that day, and details of previous incidents of domestic abuse. Further analysis to this incident is covered in Term 3.

14.1.14 The Review Panel was informed that in accordance with Lincolnshire Police Force Policy, any body worn video footage from the incidents in May, November, and December 2019, were retained for 31 days, and thereafter destroyed (in accordance with General Data Protection Legislation), and that footage is only retained if it is required as evidence in a specific case. As no action was taken against Rodrigo in May, November, and December, the footage was not retained, which meant that any evidence captured on these incidents, via body worn video, was not available to the police during investigations in April 2020.

14.1.15 The IMR author from the police has been unable to speak to any police officers involved in the incidents being analysed by the DHR, due to legal advice that they had received: this took into account the outstanding coronial processes, and the possibility that those police officers may be required to give evidence during the inquest. The Review Panel has

therefore relied on the information recorded on police's systems, as part of their analysis and information contained with the IOPC report.

Lincolnshire County Council Children's Services

14.1.16 The following details the process within Lincolnshire for Children's Social Care, to receive information in relation to domestic abuse incidents:

Public Protection Notifications (PPNs) are sent to Children's Social Care, from the police, via two routes. The Protecting Vulnerable People/Police Safeguarding Hub (PVP/PSH) within the police, review incidents and decide whether these are sent to Children's Social Care, either as a Safeguarding Child Referral or Domestic Abuse Notification.

Domestic Abuse Notifications – Domestic abuse notifications graded by the police as standard/medium, are shared with the Children's Services via a PPN. On receipt of a PPN, the information is added to the child(ren) children's services electronic record and if an allocated social worker or early help worker is involved, the notification is shared directly with the caseworker. If the child(ren) is not an open case with Children's Social Care, as was the circumstances of this case, the information is logged, and where there are three PPN notifications received within a 12-month period, the case is directed to Children's Services Screening Team. This process enables a review of cases that are considered to be lower risk of domestic abuse, to ensure that frequency is monitored, and assessment facilitated with the aim of preventing significant harm. Children's Services also take cognizance as to whether there has been a DASH completed, if a female is pregnant, and whether a child, under 18 months, is involved.

Safeguarding Children Referrals – are screened by Advanced Practitioners within the Children's Services Screening Team, who decide whether a Social Care Child and Family Assessment is required, and/or whether consent has been sought and given, and if it is appropriate for an Early Help contact to the Early Help Front Door. Where the domestic abuse risk is graded as high, the notifications are shared with Children's Services Screening Team for an initial assessment.

14.1.17 Children's Social Care first became aware of Helena and her children following a PPN being received on the 6 November 2019. The PPN detailed that Helena had been assaulted by Rodrigo when she prevented him leaving the house and that Helena had received a mark to her arm. The notification detailed that Helena had disclosed that, two days earlier, Rodrigo had grabbed her throat in order to move her out of the way, causing scratches, marks, and bruises. Helena had declined consent for information to be shared with partner agencies and it was recorded that

she stated that she did not want "social" getting involved. It was also recorded that Rodrigo was reported to not be accepting of Helena's wishes to separate with him (at various times throughout their three-year relationship). The notification documented reports of financial difficulties and allegations that Rodrigo used drugs (amphetamine and cannabis), and that he was controlling. The children and maternal grandmother were reported to have been a witness to the latest incident. The police had graded the incident as medium.

14.1.18 The information was not sent to Children's Services Screening Team, as it was believed to have been the first incident of domestic abuse between Helena and Rodrigo. This decision was in line with policy. Within the timescales of this review, the police did not routinely share domestic abuse notifications with health visiting services and midwifery unless it was high risk and the case had been referred to MARAC. The Review Panel has been informed that a pilot has commenced to share all domestic abuse notifications with health visiting services, 0-6 years, and education establishments.

14.1.19 On 6 January 2020, Children's Social Care received a domestic abuse notification (PPN) from the police, in relation to their contact with Helena on 29 December. The PPN detailed that Helena had reported a domestic abuse incident, and that she was experiencing dizziness and had bruising. Helena alleged that Rodrigo's use of amphetamine and cannabis had caused an argument. The incident had been graded as standard. Helena had refused consent for information to be shared with partner agencies.

14.1.20 The PPN was screened by Children's Services Screening Team and as it was recorded that this was the second incident within a twelve-month period – known to Children's Social Care – further information was sought via the Police Safeguarding Hub (PSH). The Advanced Practitioner was advised that the incident reported, had related to two incidents (25 and 26 December 2019). Details of both incidents were included in the PPN. It was also reported that Helena's mother had advised her to return to Rodrigo, as he was a good father, and that they were seen as a perfect couple in the community. This information contrasted with information provided to the Chair. [See 13.3.1]. Following receipt of this further information, the case was allocated to a social worker for assessment.

14.1.21 On 10 January, the social worker completed an announced visit to the family home. Helena and the children were present. It was noted that Helena's family had financially supported Rodrigo to source alternative accommodation. Helena confirmed her intention to resume the relationship with Rodrigo if he made changes, including stopping his cannabis use.

Helena told the social worker that she felt that Rodrigo suffered with depression. Helena said that there had never been any physical abuse between them, and that when they had an argument, Rodrigo would cry and try to hug her and then she would get annoyed as he was in her personal space. Helena described calling the police in anger and that they had pushed each other, and she had fallen and banged her head. Helena denied that Rodrigo was emotionally or verbally abusive, or that she was scared of him. The children and maternal grandmother were present during the visit. The children were noted to appear happy and well cared for, and the home was clean and well presented.

14.1.22 The panel's cultural expert told the Review Panel that the information from Helena's mother about helping Rodrigo and referring to him as a good father, was part of the Portuguese culture, in that 'mothers' protect the male members of the family and see them as always doing the 'right thing', with less focus on any domestic abuse. The panel expert provided further clarity on the view that Rodrigo 'came from a good family', which would have been said because he would have been seen as being equal to her family – i.e., that they worked and were law abiding, and that this was not about class, but in response to an individual's behaviour.

14.1.23 The social worker attempted to contact Rodrigo on the 24 and 31 January; however, the contact was unsuccessful. This is analysed further in the report.

14.1.24 As part of the assessment process, the social worker requested further information from the police in the form of a Police National Computer (PNC) disclosure. On 24 January 2020, additional information was provided by the police, which included details of the incident from 19 May 2019. This was the first time that Children's Social Care was aware of this incident. The social worker made a further attempt to contact Rodrigo on 6 February. This was unsuccessful.

14.1.25 The receipt of this information, provided the social worker with additional information regarding the domestic abuse that Helena had suffered from Rodrigo. The information also contradicted the information that Helena had told the social worker on 10 January: that Rodrigo had never been physically abusive towards her. The social worker discussed the additional information (that the police had provided) with Helena. Helena told the social worker that she could not remember the incident from May 2019.

14.1.26 During a meeting between the social worker and their supervisor, on 7 February, it was identified that the children were well cared for, Helena had separated from Rodrigo, and maintained that she had exaggerated

incidents of domestic abuse to the police. Helena refused consent to work with Children's Social Care, under Child in Need (CIN)[33]. It was agreed for the case to be closed as there was a lack of evidence to support escalation to child protection. Rodrigo had not been seen at the point of case closure. [See 14.3.16].

14.1.27 The next notification to Children's Social Care was on 8 April 2020, when contact with Children's Services Screening Team was received via a referral from a health visitor. The screening was completed at 21:59 hours, and the case was passed to the locality team for allocation to a social worker.

14.1.28 The Review Panel discussed the indicators of domestic abuse that Helena had disclosed to professionals, including information provided by family and friends. These included:

- Physical assaults (including strangulation)
- Financial abuse
- Emotional abuse
- Vulnerability due to pregnancy
- Evidence of coercion and control
- Isolation
- Helena sleeping on the sofa
- Impact of Rodrigo's drug use
- Psychological abuse.

14.1.29 In 2021, the Government introduced new legislation in the form of the Domestic Abuse Act 2021. Section 70 of the Domestic Abuse Act 2021, introduced the offences of non-fatal strangulation and non-fatal suffocation. The offences came into force on 7 June 2022 and are not retrospective.

14.1.30 The Review Panel was clear in their analysis that Helena had been the victim of domestic abuse prior to her death, and that this abuse was perpetrated by Rodrigo.

14.2 Term 2

What knowledge did your agency have that indicated Rodrigo might be a perpetrator of domestic abuse, and what was the

[33] Under Section 17 Children Act 1989, a child will be considered in need if: they are unlikely to achieve or maintain or to have the opportunity to achieve or maintain a reasonable standard of health or development without provision of services from the local authority.

response? Did that knowledge identify any controlling or coercive behaviour?

14.2.1 The police were the first agency to be aware that Rodrigo was a perpetrator of domestic abuse. Term 1 provides some details of how the police addressed Rodrigo's offending behaviour: the details of which, will not be repeated under this Term of Reference. The Review Panel's analysis on the response to Rodrigo's offending behaviour is captured within Term 3.

14.2.2 Helena told the police in May 2019, that Rodrigo was becoming more controlling. This was the first incident when Helena disclosed domestic abuse to a professional. Helena told the police that there had been an argument with Rodrigo over debt, due to Rodrigo's use of cocaine and cannabis. Rodrigo had also threatened suicide. Helena disclosed that Rodrigo had previously assaulted her in 2016/2017. The police recognised that the assault amounted to a crime, and they recorded a crime for an offence of common assault. The crime was reviewed by a supervisor. The police had no power of arrest, as the crime was over its statutory time limit, so no further positive action was taken. Rodrigo was not spoken to by the police. The police did not record any further details around Helena's disclosure of 'controlling'. The Review Panel agreed that this was an opportunity for the police to have gathered further information, including whether there was evidence of a crime of coercive and controlling behaviour, as detailed within Section 76 Serious Crime Act 2015.

14.2.3 On 5 November 2019, Helena contacted the police to report Rodrigo missing. This was the second time that Helena had reported Rodrigo missing (previous incident – September 2019). Helena reported that Rodrigo had left, following an argument. Rodrigo returned home later that day and told the police that he needed sometime to be alone. There was no further police involvement. A DASH was not completed.

14.2.4 On 6 November 2019, Helena reported that she had been assaulted by Rodrigo. Rodrigo was not at the property when the police attended. Helena stated that that there had been an argument over finances, which was linked to his drug use. During this contact, Helena disclosed to the police that Rodrigo had assaulted her on 4 November 2019, which had led to Rodrigo leaving the property and subsequently being reported missing. The police recorded a crime for common assault, in relation to the incident of 4 November. The incident was risk assessed as medium. The police spoke to Helena and Rodrigo separately. Helena told the police that she did not support a prosecution and did not fear any immediate violence from Rodrigo. No further action was taken by the police. The outcome of the

crime was reviewed and agreed by a supervisor. There was clear evidence in these contacts that Rodrigo was a perpetrator of domestic abuse.

14.2.5 The Review Panel reflected on the incidents in November 2019 and were clear in their view that there was an escalation in the incidents of domestic abuse. The Review Panel acknowledged that this was a vulnerable time for Helena, as she had recently given birth to their youngest child, and that their other child was also of a young age (pre-school age).

14.2.6 On 29 December 2019, Helena disclosed two further incidents where she had been assaulted by Rodrigo. These assaults were domestic abuse. The police recorded a crime for one assault. [See 14.1.10]. Rodrigo was not seen or spoken to by the police. This is further analysed under Term 3.

14.2.7 Children's Social Care received notifications from the police that Rodrigo was a perpetrator of domestic abuse. The first notification was received on 7 November 2019. Subsequent notifications identified that Rodrigo had been identified as a perpetrator of domestic abuse in six incidents between 19 May 2019 and 8 April 2020. There was no evidence that the information relating to the first incident, on the 19 May 2019, was shared with Children's Social Care at that time.

14.2.8 The notification from the police on 6 January, identified physical and emotional abuse by Rodrigo. The case was allocated to a social worker for a Child and Family Assessment. Despite attempts to contact Rodrigo, he was not seen as part of the assessment process. The assessment concluded that there was a lack of evidence to escalate the case to child protection. [See 14.1.26].

14.2.9 The health visitor was made aware that Rodrigo was a perpetrator of domestic abuse, following information received from the social worker on 24 January 2020. However, not all the incidents of domestic abuse in which Rodrigo had been involved, were shared with the health visitor – due to no process being in place to do so at that time. [See 14.5.7].

14.2.10 EMAS was not aware of any information that indicated that Rodrigo was a perpetrator of domestic abuse. During attendances for Helena, Iria and Davi, it was documented that a male, who was described as 'partner' or the father of the children, was present. Details of this male were not recorded. There was no evidence that during EMAS contacts, Rodrigo was exhibiting signs of coercive or controlling behaviours.

14.2.11 EMAS identified a missed opportunity to record details of all persons present and to consider any potential risk in the home, as these details were not obtained during contact with Helena. The Review Panel was

informed that it is expected practice by ambulance crews to document the names of people present during attendances. The expected practice is included in all face-to-face, e-learning, and workbook safeguarding training at EMAS. The Review Panel was informed that in response to address the learning identified, a newsletter was issued in 2021 that included the importance of documenting who is present during attendances. Since April 2022, EMAS have commenced auditing records, and any learning identified from these audits is then used to inform practice. The Review Panel was satisfied that this learning has been addressed; therefore, a recommendation has not been made.

14.2.12 The Review Panel reflected on the information provided to the Chair by Helena's mother and Helena's friend, which is detailed within Section 13. It includes the following:

- Rodrigo telling Helena to lie about an injury sustained to their child [13.8.3].
- Rodrigo going missing [13.8.5 & 13.8.6].
- Helena left without access to car seats and pushchairs to transport children [13.8.5].
- Helena having no access to money [13.8.5].
- Helena having to sleep on a settee [13.8.10].

The Review Panel agreed that these incidents were examples of coercive and controlling behaviour, perpetrated by Rodrigo, and that these incidents were evidence of criminal acts, as defined by Section 76 Serious Crime Act 2015.

14.2.13 The Review Panel also reflected on the information that Helena had provided to professionals, and the information provided to the Chair by Helena's mother and friend, in relation to financial abuse. The Review Panel took cognizance of the following definitions, as detailed by the UK charity, Surviving Economic Abuse[34]:

Economic abuse is a legally recognised form of domestic abuse and is defined in the Domestic Abuse Act. It often occurs in the context of intimate partner violence and involves the control of a partner or ex-partner's money and finances, as well as the things that money can buy. Economic abuse can include exerting control over income, spending, bank accounts, bills, and borrowing. It can also include controlling access to, and use of, things like transport and technology, to allow an individual to

[34] https://survivingeconomicabuse.org/about-us/what-we-do/
Surviving Economic Abuse (SEA) is the only UK charity dedicated to raising awareness of economic abuse and transforming responses to it.

work and stay connected, as well as property and daily essentials like food and clothing. It can include destroying items and refusing to contribute to household costs.

Financial abuse is controlling finances, stealing money, or coercing someone into debt.

Economic abuse and financial abuse involve similar behaviours, but it is helpful to think of financial abuse as a subcategory of economic abuse.

14.2.14 The Review Panel was clear in their conclusion that Helena had been subjected to economic abuse by Rodrigo.

14.3 Term 3

How did your agency assess the level of risk faced by Helena, and her children? In determining the risk, which risk assessment model did you use, and what was your agency's response to the identified risk?

14.3.1 The police completed a DASH PPN to assess the level of risk faced by Helena and her children during contact on the reported incidents of domestic abuse.

14.3.2 In response to the disclosures made by Helena in May 2019, the police recorded the risk assessment as standard. Helena had disclosed that they had been arguing and that Rodrigo refused to leave the house. Helena also disclosed that two to three years earlier, Rodrigo had 'choked' and slapped her. Helena was five months pregnant at this time. Iria had been present during the incident in May. This incident was not shared with Children's Social Care until January 2020, as per policy in place at that time. [See 14.1.24].

14.3.3 At the time of the incident, the risk assessment grading fell into three headings – standard, medium, and high:

Standard – Current evidence does not indicate likelihood of causing serious harm.

Medium – There are identifiable indicators of risk of serious harm. The offender has the potential to cause serious harm but is unlikely to do so unless there is a change in circumstances, for example, failure to take medication, loss of accommodation, relationship breakdown, drug or alcohol misuse.

High – There are identifiable indicators of risk of serious harm. The potential event could happen at any time and the impact would be serious.

14.3.4 The Review Panel agreed that the risk assessment grading on the incident in May 2019, was appropriate, given the presenting information. However, the Review Panel determined that the incident should have been shared with midwifery and health visiting services – given the age of Iria and that Helena was pregnant – despite there being no process in place to do so at that time. This is addressed further in Term 9.

14.3.5 On 7 September and 5 November 2019, Helena had contacted the police to report Rodrigo as a missing person. At the time of the incident in September, Helena was eight months pregnant. During contact with the police on 5 November, Helena told the police that Rodrigo had left the house following an argument, he had been missing for over 12 hours, and that he was suffering with depression, although he was not on any medication. There was no DASH risk assessment completed for either missing person's episode, neither was there any referrals made or evidence of signposting Helena and/or Rodrigo to support services. The Review Panel considered the circumstances around the missing episode. They agreed that the information provided by Helena should have been explored further with her, to identify the extent of the concerns she had raised and, if relevant, provide an opportunity to refer and/or to have signposted Helena and Rodrigo to services.

14.3.6 The Review Panel acknowledged that when Helena contacted the police in May, September, and November 2019, these were at a time when she was vulnerable, which included pregnancy (May and September), recent birth of their youngest child (November), and in all of them, the presence of their eldest child who was of pre-school age. The Review Panel has already determined that, given these vulnerabilities, these incidents should have been shared with midwifery, health visiting, and 0-6 years. This area of learning is covered in Term 1.

14.3.7 On 6 November, Helena reported two further incidents of domestic abuse involving Rodrigo (4 and 6 November 2019). The police completed a DASH PPN, and risk assessed the incidents as medium. The PPN was shared with Children's Social Care. As this was the first incident reported to Children's Social Care, no further action was taken, and there was no contact made with Helena or other agencies. [See Term 1].

14.3.8 On 29 December 2019, Helena reported a further two incidents of domestic abuse involving Rodrigo, that had occurred on 25 and 26 December. The police completed a DASH, and risk assessed the incidents as standard. The

risk assessment was reviewed by a supervisory officer who agreed with this assessment. The IMR author from the police has informed the Review Panel that the incidents should have been risk assessed as medium. The Review Panel agreed with this analysis, as it was clear that the incidents of domestic abuse were increasing, including the level of violence that was being used. The incidents were shared with Children's Social Care on 6 January 2020.

14.3.9 Lincolnshire Police Domestic Abuse Supervisor Reviews Guidance[35] is aimed at supervisors and inspectors who are tasked with reviewing completed PPNs. The guidance states:

'A review of a domestic incident or crime is critical. As supervisors you must ensure that a full review is cognizant of safeguarding requirements as well as investigation and accurate crime recording processes'.

The document further states that the supervisor is responsible for:

- 'Monitoring domestic abuse incidents and crimes.
- Deciding what domestic abuse briefings consist of.
- Ensuring that their staff have understanding of safeguarding issues.
- Completing risk assessment reviews of domestic abuse cases.
- Being strong and visible leaders.
- Monitoring outcomes of cases and risk to victims.'

'The reviewing supervisor must consider various points in their review:

- What were circumstances of the initial report?
- Has the DASH form been completed fully?
- Is a MARAC referral necessary?
- Has all evidence been gathered and all enquiries complete?
- Have rationales for all actions (or non-actions) been provided?
- Has a review been conducted of previous incidents?
- Have crimes been recorded?
- Have safeguarding actions been recorded?
- Are there any further actions?
- Is a Domestic Violence Disclosure Scheme (DVDS) application appropriate?
- Is a Domestic Violence Protection Notice (DVPN) appropriate?'

14.3.10 The Police Initial Crime Attendance Policy (May 2019) includes an area in relation to repeat victims, which would mean a mandatory attendance. A repeat victim is described as a 'person who has suffered from the similar

[35] Dated – 21 December 2018.

classification of crime within the previous twelve months'. Whilst it was shown on the police incident, in December 2019, that Helena was a repeat victim, on the review undertaken by the supervisor, this was marked as 'no'. During the completion of the IOPC investigation, the supervisor stated that they could not recall if they completed any intelligence checks or reviewed previous incidents of domestic abuse.

14.3.11 The incident in December was the third reported incident in six months. The level of violence was increasing. In the latest incident, Helena stated that Rodrigo had grabbed her face, making it difficult to breathe, and banged her head. The review of the DASH did not identify that Helena was a repeat victim. The Review Panel was informed that there is no 'repeat victim' flag within Lincolnshire's IT system, and the fact that Helena was a repeat victim, should have been established when the officer reviewed police records. Lincolnshire Police have identified learning in relation to the response to repeat victims. This is covered in Terms 13 & 15.

14.3.12 The Safelives 'MARAC Referral Criteria' document[36] states:

'**Potential Escalation**

Why does SafeLives recommend a threshold of three incidents in 12 months?

We know from DHRs and SCRs that in some cases there were numerous 'lower level' incidents preceding the homicide that were not 'linked' together. When incidents are only viewed in isolation from each other, the true picture of risk can be missed. Where there are repeated incidents within a period of time, we recommend this as a catalyst for a MARAC referral so that information can be shared and a clearer picture of risk be established.

This criterion can be used to identify cases where there is not a positive identification of a majority of the risk factors on the list, but where abuse appears to be escalating, or has the potential to escalate. It is common practice to start with three domestic abuse occurrences in a 12-month period, but this may need to be reviewed depending on your local volume'.

14.3.13 The Review Panel discussed the above extract and the Lincolnshire MARAC policy. The Review Panel acknowledged that, within this review, there had been three incidents of domestic abuse within a six-month period, and with an escalation in risk and violence towards Helena. The Review Panel

[36] https://safelives.org.uk/node/1265

agreed that based on these facts, the case could have been referred to MARAC, based on professional judgement. This did not occur.

14.3.14 The Review Panel was informed that a new process has been approved by the Domestic Abuse Partnership Board and is in the early stages of implementation. The process takes account of the Safelives guidance, and details how standard and/or medium DASH risk assessments can be centrally monitored to flag where there have been three or more instances of domestic abuse reported within a 12-month period – with the overarching principle to maximise safeguarding opportunities and prevent further risk of harm. The Review Panel agreed that whilst this area of learning had been addressed at a strategic level, the review had identified learning for individual agencies responding to cases where there had been further incidents of abuse. The Review Panel has made a relevant recommendation.

14.3.15 The Review Panel sought clarification on the timescales for information sharing between the police and Children's Social Care. The panel was informed that there are no set timescales for sharing PPNs (including DASHs), as they are shared as soon as possible – acknowledging capacity within the Police Safeguarding Safety Hub and the level of risk of the incident.

14.3.16 The Review Panel reflected as to whether there were opportunities for the police to have issued Rodrigo with a Domestic Violence Prevention Notice[37] (DVPN): this would then have allowed the police to have applied to a magistrate court for a Domestic Violence Protection Order (DVPO). A DVPN is an emergency non-molestation and eviction notice that is issued by the police to a perpetrator of domestic abuse. A DVPO can prevent a perpetrator from returning to a residence and from having contact with the victim for up to 28 days, which allows a victim a degree of breathing space to consider their options, with the help of a support agency.

14.3.17 A perpetrator does not have to be in police custody for a DVPN to be issued. The victim does not have to give their consent for a DVPN, but their views should be taken into consideration when an application is being considered. A DVPN is issued by a police superintendent if they have reasonable grounds for believing that:

[37] https://www.gov.uk/government/publications/domestic-violence-protection-orders/domestic-violence-protection-notices-dvpns-and-domestic-violence-protection-orders-dvpos-guidance-sections-24-33-crime-and-security-act-2010

'The perpetrator has been violent towards, or has threatened violence towards the victim

And

The issue of the DVPN is necessary to protect that person from violence or a threat of violence by the perpetrator.'

14.3.18 With regards to necessity to prevent further violence / threat of violence, consideration should be given to:

- 'What the DVPN will seek to achieve and why this cannot be obtained by any other or less disruptive means, e.g. bail conditions not applicable or the perpetrator has accepted a formal police caution;
- Whether the risk of harm is too great to allow the perpetrator to return to the address and therefore the sole use of a suitable risk management plan is not adequate;
- The only option to reduce risk of further violence or threat of violence is to remove P from the address and to continue to deny access to the perpetrator by issuing a DVPN.'

Officers should consider carefully whether the issue of a DVPN is necessary and proportionate to protect the victim.

14.3.19 The Review Panel reviewed the incidents that had been reported to the police and considered whether there had been opportunities for Rodrigo to have been issued with a DVPN. It was the view of the Review Panel that, with the exception of the last incident, in April 2020, they did not feel that the criteria had been met.

14.3.20 The Review Panel also considered whether there was an opportunity to initiate a disclosure under the Domestic Violence Disclosure Scheme[38] (DVDS) to Helena. As Rodrigo did not have any previous convictions, had not been identified as a perpetrator of domestic abuse in other relationships, and had not been a perpetrator of other offending behaviour, then a DVDS would not have been relevant in this case. The police have identified learning in relation to the use of DVPN/O and DVDS. This is covered in Term 13 and 15.

[38] https://www.gov.uk/government/publications/domestic-abuse-bill-2020-factsheets/domestic-violence-disclosure-scheme-factsheet

14.3.21 Children's Social Care assessed the police notifications and, in January 2020, allocated the case for a Child and Family Assessment, in line with expected policy. Appropriate information was sought, in line with policy from Lincolnshire Police and the health visitor, to aid the assessment. The assessment identified: no concerns regarding the care or welfare of the children; that Helena had separated from Rodrigo, and he had moved out of the property; and that he attended for contact with the children and there had been no subsequent arguments. There were no further notifications received from any agency until 8 April 2020.

14.3.22 The social worker made three attempts to contact Rodrigo to ascertain his views; however, there was no response. It is acknowledged that it is always best practice to include fathers in the assessment process. However, the Review Panel was informed that Rodrigo could not be compelled to do so, and at the time of the case being closed, Rodrigo and Helena had separated and were no longer living in the family home.

14.3.23 An article[39] published in February 2018, reflected on research undertaken by John Symonds, a Social Work Lecturer at Bristol University. The article documented:

'The position of fathers in children's lives has changed dramatically over the last 50 years. Although most children still live with both their parents, family structures are much more varied. For example, the number of families with dependent children headed by a couple fell from 92% in 1971 to 78% in 2011.

When couples separate, children are more likely to live with their mother. This has implications for children's relationships with their fathers. In 2011, 92% of lone parents were women, compared with 8% who were men'.

14.3.24 The article also considered the engagement of fathers in child protection services and found that:

'Studies repeatedly show that child protection work tends to focus on mothers, with fathers having a peripheral presence in case files, child protection conferences and home visits. This has given rise to a series of descriptions of fathers as 'invisible' (Strega et al, 2008)[40]; 'ghosts' (Brown

[39] https://www.communitycare.co.uk/2018/02/19/working-fathers-key-advice-research/
[40] Strega, S; Fleet, C; Brown, L; Dominelli, L; Callahan, M and Walmsley, C (2008) Connecting father absence and mother blame in child welfare policies and practice Children and Youth Services Review, Volume 30, pp705-716

et al, 2009)[41], or 'shadows' (Ewart-Boyle et al, 2015)[42]. When fathers have perpetrated domestic violence, they may ensure they are not present during home visits, or their involvement in the family might be hidden by mothers for fear of reprisals or of having the children placed in care (Dominelli et al, 2010)'[43].

14.3.25 The Review Panel was informed that the attempts at contact with Rodrigo were undertaken by telephone, voicemail, and text, but these were not answered or responded to by Rodrigo.

14.3.26 Helena told the social worker that there had been no domestic abuse in her relationship with Rodrigo. A DASH assessment was not completed as part of the assessment. The case was closed on 13 February, with the following rationale:

- Rodrigo has moved out and the couple are no longer in a relationship, and this has reduced the number of arguments.
- Helena has stated that she only calls police, as she wants Rodrigo to leave, and she knows that they will make him. Also, that she has exaggerated her stories to police at times so they would take her serious.
- Helena has stated that she is not scared of Rodrigo, and in fact, it is likely that he is scared of her, as she is the one more likely to be aggressive and that it is her that is the instigator of any altercations.

The Review Panel recognised that the above comments could be seen as 'victim blaming'; however, they have included them for contextual information that was documented as being provided by Helena at this time.

14.3.27 The social worker discussed the impact that domestic abuse had on children, as well as safety planning: this included Helena's mother being part of her safety and support network. The Review Panel also reflected as to whether there had been an opportunity for a DASH to have been

[41] Brown, L; Callahan, M; Strega, S; Walmsley, C and Dominelli, L (2009)
'Manufacturing ghost fathers: the paradox of father presence and absence in child welfare'
Child and Family Social Work, Volume 14, pp25-34
[42] Ewart-Boyle, S; Manktelow, R and McColgan, M (2015)
'Social work and the shadow father: lessons for engaging fathers in Northern Ireland'
Child and Family Social Work, Volume 20, pp470-479
[43] Dominelli, L; Strega, S; Walmsley, C; Callahan, M and Brown, L (2010)
'"Here's my Story": Fathers of 'Looked After' Children Recount their Experiences in the Canadian Child Welfare System'
British Journal of Social Work, Volume 41, pp351-367

completed as part of the assessment process: taking cognizance that a DASH provides an assessment of risk at that moment in time, and that as risk assessments are dynamic, the risk can change depending on presenting factors and information that is shared. The Review Panel has identified this an area of learning and made a relevant recommendation.

14.3.28 The cultural expert told the Review Panel that amongst the Portuguese community, there is a general mistrust of children's services. The cultural expert described how their charity, Respeito, was founded in 2016, as a result of a meeting at the Portuguese Consulate in response to children being placed into the care system: with miscommunication being amongst the reasons why.

14.3.29 The Review Panel was informed that, in 2016, a TV channel in Portugal showed a documentary about Portuguese children being placed for adoption in the United Kingdom. The cultural expert reported that the documentary was broadcasted by a main Portuguese TV channel and that the documentary was seen across the Portuguese communities in the United Kingdom, with similar documentaries and films also aired by Portuguese TV, i.e., 'Listen' (2020). The cultural expert explained how these portrayed a negative side of adoption and resulted in a fear amongst the Portuguese community about the removal of children by Children's Social Care.

14.3.30 Further explanation was provided around the cultural element of arguments in a family home, including shouting at children. The cultural expert explained that the Portuguese do shout and raise their voices during arguments, and that they will also shout at their children and physically chastise them, which is not acceptable behaviour within the UK.

14.3.31 During contact with the central duty health visitor on 8 April 2020, Helena provided consent for a referral to be made to Children's Social Care. The central duty health visitor allocated the case to a health visitor for contact to be made with Helena the following day – to complete a DASH and for onward signposting.

14.3.32 The notification received by Children's Social Care from the police on 8 April 2020, was allocated for assessment due to concern identified in the health visitor's referral and the case having recently been closed.

14.3.33 The Review Panel discussed the response to Rodrigo's offending behaviour. None of the incidents of domestic abuse, prior to the incident on 8 April 2020, progressed into a criminal investigation; therefore, Rodrigo was not charged or summonsed in relation to any offences. This meant that Rodrigo could not be considered for attendance at a perpetrator

programme such as Building Better Relationships[44], as this relies on a perpetrator having been convicted of intimate partner violence.

14.3.34 The Review Panel was informed that within Lincolnshire, there is a community-based programme for perpetrators of domestic abuse: 'Make a Change'[45]. This programme is available for perpetrators who have not been sanctioned through the criminal justice system, and it is available through self-referral. It offers the following services:

- Direct work with people who are concerned about their behaviour towards their partner and/or ex-partner, including a full 26-week programme.
- Proactive support to the partners and ex-partners of people referred to the service.
- Briefings and trainings for professionals who want to strengthen their response to domestic abuse.
- Community outreach, including to the friends and family of people using abusive behaviour and/or accessing our services.

14.3.35 The Review Panel was informed that within Lincolnshire, Make a Change had been available, but referrals were no longer being accepted, as the funding comes to an end in March 2023. The Review Panel was informed that a piece of work is currently underway to map and review the availability of perpetrator programmes, against a detailed-needs assessment, which includes sustainability.

14.3.36 The Review Panel agreed that there had been a lack of intervention and interaction with Rodrigo in response to his offending. The Review Panel agreed that the learning from this review should be used to inform the ongoing work by the Domestic Abuse Partnership Board in responding to perpetrators of domestic abuse, who are not being managed within the criminal justice system. The panel has made a relevant recommendation.

14.4 Term 4

[44] https://risemutual.org/building-better-relationships/
[45] https://www.makeachange.uk.net/lincolnshire

What services did your agency provide for the subjects of this review; were they timely, proportionate, and of an acceptable level in relation to the identified levels of risk?

14.4.1 Helena's health care provision predominantly related to cardiac care and midwifery services. In relation to her presentation at Accident and Emergency, these related to cardiac concerns. Any potential clinical risks were responded to via a decision to admit Helena for further investigations and/or liaison with Tertiary Centre cardiologists. At the same time, appropriate referrals were made, as necessary. When, on occasions, Helena chose to discharge herself, there was documentation to evidence that Helena had been informed of any potential risks, and that she had the capacity in making this decision. There was no evidence to suggest her decision-making was due to coercion and control.

14.4.2 In relation to Helena's maternity care provision, clinical risks were identified regarding the potential impact her pregnancy might present upon her pre-existing cardiac condition. Furthermore, appropriate referrals to Tertiary Centres were made in order to ensure an advanced level of oversight and management. Non-attendances were appropriately explored by the community midwifery team.

14.4.3 All EMAS attendances were triaged in accordance with National Policy, using the Advanced Medical Priority Dispatch System (AMPDS) to determine the most appropriate response, based on clinical need. EMAS attended each time an ambulance was requested and attended in an appropriate time frame. EMAS completed appropriate medical assessments for Helena, Iria, and Davi during their attendances. At all attendances, crews made the appropriate decision to see and treat or convey to hospital for further assessment. On the occasions that Helena refused to travel to hospital, physical assessments took place and appropriate information/advice was given, in relation to her condition worsening. It is documented that Helena had capacity to refuse onward conveyance and treatment at hospital.

<u>Lincolnshire Children's Services</u>

14.4.4 Children's Services provided universal health visiting in line with the Healthy Child Programme (DoH 2009). The majority of contacts were achieved in line with policy.

14.4.5 There was a delay in health visitor contact with Helena, following receipt of domestic abuse information from the social worker on 24 January 2020: this was not achieved until 3 April 2020, when Helena was contacted via telephone. The Review Panel has been informed that a more timely

contact should have been made to assess Helena and the children's health and wellbeing. In understanding why earlier contact had not been made with Helena, the Review Panel was informed that the health visitor had recently returned to work, following a period of prolonged sick leave, and at the time of their return, contact restrictions were in place due to the Covid-19 pandemic. In reviewing the records, it was clear that the health visitor had included in the contact on 3 April, the age-appropriate assessments of both children that were required around that time. The Review Panel agreed that contact should have been made earlier.

Lincolnshire Police

14.4.6 The police responded to incidents of domestic abuse and Rodrigo being reported as a missing person. On 8 April, officers took positive action at the scene, and arrested Rodrigo. Officers checked on the safety and welfare of Helena and the children. PPNs were completed, and with the exception of the incident on 19 May 2019, information was shared with Children's Social Care. Further analysis on the police responses is covered in Terms 1, 2 and 3.

Lincolnshire County Council Children's Services

14.4.7 Children's Social Care responded appropriately to notifications received from Lincolnshire Police. Allocation and clear case management direction was provided, following the police domestic abuse notification on the 6 January 2020. A social care assessment was completed in line with expected practice, and supervision and managerial oversight was provided. Efforts were made to include Rodrigo in the assessment; however, he chose not to respond. Further analysis on this is covered in Term 3.

14.4.8 The Review Panel has been informed by the IMR author for Children's Services, that the decision to close the case on the 13 February was appropriate. The decision was based on the findings of the assessment, the fact that the parents had separated, Helena's refusal to engage with a child in need process, and the lack of additional evidence to support ongoing intervention or escalation to child protection. The Review Panel has reflected on the case closure and identified learning. [See 14.3.24].

14.5 Term 5

What did your agency do to safeguard any children exposed to domestic abuse?

14.5.1 Health professionals responding to Helena's heart condition and maternity care, had no knowledge that Helena had been a victim of domestic abuse. At the commencement of this review, Nottingham University Hospital identified immediate learning about the use of routine enquiry questions in relation to domestic abuse: this has already been addressed. [See Term 1].

14.5.2 Helena was asked about domestic abuse by Lincolnshire midwifery services; however, Helena did not disclose any incidents or areas of concern. When questioned about her increased level of chest pain, which had resulted in acute attendances, Helena did not disclose any relationship-related stressors.

14.5.3 Helena's GP had no record that Helena had been a victim of domestic abuse. The Review Panel was informed that it is expected practice that GPs are written to as part of Child and Family Assessments undertaken by Children's Social Care. Requests are also made for attendance and written reports, as part of child protection processes.

14.5.4 Rodrigo was recorded in health records as being present with Helena during a number of health appointments. There was no record to suggest that there were any concerns, in relation to their presentation or interaction together, during these appointments.

14.5.5 The police first responded to a domestic abuse incident in May 2019. Helena was five months pregnant. Iria was also present. The police recorded Iria's details within the DASH PPN. Iria was of a non-verbal age and therefore was not spoken to by the police. Helena also disclosed a further incident of domestic abuse that had occurred two to three years earlier. There were no children present during this earlier incident. The police did not share the details of these incidents with other agencies at this time.

14.5.6 At the beginning of November 2019, Helena reported an incident of domestic abuse. Both children were present (Helena had recently given birth to her second child). During this contact with the police, Helena reported a further incident of domestic abuse that had occurred two days earlier. The police shared the information with Children's Social Care. [See Term 1].

14.5.7 The Review Panel reflected on the decision not to share details of the incidents wider – including health visiting and midwifery services – given that children were present, and Helena was pregnant. The Review Panel was told that information was not shared due to policies in place at that time. In addition, Helena had not consented for information to have been

shared. The Review Panel agreed that even though Helena did not provide her consent, information should have been shared with health visiting and midwifery, as this would have provided an opportunity for Helena to have been offered support and engagement with partner agencies. The Review Panel has been informed that information is now shared with midwifery services, and that work has commenced to share incidents of domestic abuse with Children's Health Services and 0-6 years services. This area of learning is covered in Term 1.

14.5.8 At the end of December, the police responded to an incident of domestic abuse. During this contact, Helena disclosed two separate incidents of domestic abuse, of which both children had been present. This was now the sixth incident of domestic abuse, five of which had occurred within the last seven months. The incidents from December were shared with Children's Social Care on 6 January.

14.5.9 At the beginning of January 2020, Children's Social Care allocated the case to a social worker, following notification from the police. During the completion of the Child and Family Assessment, discussions were held with Helena about the impact of domestic abuse on the children; however, it was not recorded that details of local domestic abuse services were provided to Helena. It would have been good practice to provide Helena with the details of where she could access support should she require it. Rodrigo was not seen as part of the assessment. The social worker did not share the domestic abuse incidents with the health visitor until 24 January.

14.5.10 It was not until 6 February 2020, when information was received from the police, that the social worker was aware of the domestic abuse incidents reported to the police in May 2019. The health visitor was not updated with this additional information and was informed that there were no safeguarding concerns, and that the case was to be closed. The case was closed on 13 February 2020, following management oversight. The additional information was discussed with Helena; however, she stated to the social worker that she had no knowledge of the incident from May 2019.

14.5.11 On 8 April 2020, the health visitor made a referral to Children's Social Care, following contact from Helena and in recognition of the risk and impact of domestic abuse on the children. The health visitor was informed by Helena that Rodrigo was in police custody. Immediate safety planning advice was also provided by the health visitor.

14.5.12 Rodrigo was arrested by the police on 8 April 2020, for an assault on Helena. Rodrigo was released from custody with bail conditions not to

contact Helena, except via a third party to arrange access to their children. The bail conditions did not restrict Rodrigo having contact or access with his children. Details of the incident were shared with Children's Social Care, and a decision was made to allocate the case to a social worker.

14.5.13 The Review Panel considered the details of the bail conditions and, in particular, the fact that these did not prevent Rodrigo's access to the children. The Review Panel acknowledged that both children were pre-verbal and therefore would not have been able to have expressed their wishes and feelings directly to professionals. The Review Panel held a detailed discussion around the subtle elements of coercion and control. These elements included the requesting or facilitating of access to children by perpetrators (as a means to seeking further engagement and control over a victim), whilst balancing the requirements of the Bail Act (which focusses on an individual's human rights). The Review Panel recognised that since the introduction of the Domestic Abuse Act 2021, that children are now victims within their own right, and that this should be reflected within bail conditions when acknowledging the impact of domestic abuse on children and considering an individual's access to children upon release from custody. The Review Panel also agreed that the elements of the Domestic Abuse Act 2021 will be reflected further within assessments and engagement of Children's Social Care. The Review Panel has identified this as an area of learning and made a relevant recommendation.

14.6 Term 6

What was your agency's response to the lived experiences of the children? Did that include an understanding of how their lived experiences impacted on their emotional and physical development?

14.6.1 The police submitted DASH PPN risk assessments during incidents of domestic abuse, and recorded details of the children who had been present. The sharing of these incidents has been addressed within Term 5.

14.6.2 During contact with the social worker, it is recorded that Helena told the social worker that she had exaggerated the domestic abuse to the police and stated that Rodrigo had never physically assaulted her. It was known that Rodrigo had left the home, with financial support from Helena's mother, and Helena reported that she was happy with the arrangements for him to come to the property to spend time with the children. Despite this, the social worker reiterated the impact of witnessing domestic abuse, could have on the children if this were to continue.

14.6.3 The social worker observed the children with Helena, and they were seen to have a close and loving relationship. The impact of witnessing domestic abuse was discussed with Helena during the assessment, as well as the further incident of domestic abuse received from the police. The social worker told Helena the following:

"If the children are witnessing regular arguing between Helena and Rodrigo it is likely to have an impact on their long-term emotional health and development. Iria and Davi may start to consider arguing as 'normal', effecting how they communicate with others. Research shows that children who are routinely exposed to arguing can show signs of disrupted early brain development, sleep disturbance, anxiety, depression and conduct disorder". It was recorded that Helena acknowledged what was being said but stated that she did not feel that the children had experienced any harm, and she did not recall the incident from May 2019.

14.6.4 The Review Panel considered that the response by Helena could be seen as Helena minimising the risks that there were present to her and her children, for fear that if she remained with Rodrigo, then the children may be removed by Children's Services. The cultural expert told the Review Panel that domestic abuse, within the Portuguese community, is defined as physical aggression, and that the behaviour is often excused within the community, as you can be seen as a 'lesser family' if you experience domestic abuse; therefore, domestic abuse is not openly spoken about. The cultural expert explained further that within the Portuguese culture, the role of the mother is to look after the children and the father.

14.6.5 There was no statutory intervention by agencies in relation to the children and the domestic abuse that they had witnessed. The Child and Family Assessment concluded that the relationship had ended, and that Rodrigo had left the family home. There were no reported further incidents of domestic abuse, or concerns raised by professionals, until April 2020. Helena declined further support. Whilst the Child and Family Assessment did not fully explore all incidents of domestic abuse, the Review Panel was informed that there was no evidential reason that the case would have reached the threshold for statutory intervention (at the time of case closure in February 2020).

14.6.6 The Review Panel recognised that domestic abuse has a devastating impact on children and young people, which can last into adulthood. Women's Aid[46] details the following research findings:

- One in seven (14.2%) children and young people under the age of 18 will have lived with domestic violence at some point in their childhood.

- 61.7% of women in refuge on the Day to Count 2017 had children (aged under 18) with them (Women's Aid, 2018 – data from Women's Aid Annual Survey 2017).

- Between January 2005 and August 2015 (inclusive), 19 children and two women were killed by perpetrators of domestic abuse in circumstances relating to child contact (formally or informally arranged) (Women's Aid, 2016). A Women's Aid review of SCRs published since August 2015, highlighted at least one more case falling into this category (Women's Aid, 2017).

- Research published by Cafcass in 2017, in partnership with Women's Aid, analysed a sample of 216 child contact cases that closed to Cafcass between April 2015 and March 2016. It found that more than two thirds of the cases in the sample, involved allegations of domestic abuse, yet in 23% of these cases, unsupervised contact was ordered at the first hearing.

- Research published by Women's Aid and Queen Mary University London in 2018, based on the experiences of 72 women survivors of domestic abuse whose family court case concluded the last five years, found evidence of gender discrimination and a culture of disbelief within the family courts system. The systemic nature of negative perceptions around survivors of domestic abuse and mothers who raise concerns about child contact arrangements, along with gaps and inconsistencies in understanding and awareness of domestic abuse and its impact on children, is blocking the effectiveness of policies and practices to ensure safe child contact and increase awareness of domestic abuse within child contact procedures. The ingrained nature of such perceptions also increases the likelihood of human rights protection gaps for survivors and their children (Birchall and Choudhry, 2018).

[46] https://www.womensaid.org.uk/information-support/what-is-domestic-abuse/impact-on-children-and-young-people/

- In the above research by Women's Aid and Queen Mary University London, 61% of survey respondents had not had any special measures in the family court, 48% said that a fact-finding hearing had not taken place as part of their case, and 24% had been cross-examined by their abusive ex-partner in the court.

14.6.7 In 2015, the Royal College of Psychiatrists published a leaflet[47]: 'Domestic violence and abuse – the impact on children and adolescents.' The leaflet is aimed towards parents and carers. It covers the effects that domestic violence and abuse can have on children, and how to try and avoid these problems. The leaflet states:

'Younger children may become anxious. They may complain of tummy-aches or start to wet their bed. They may find it difficult to sleep, have temper tantrums and start to behave as if they are much younger than they are. They may also find it difficult to separate from their abused parent when they start nursery or school.

Older children react differently. Boys seem to express their distress much more outwardly, for example, by becoming aggressive and disobedient. Sometimes, they start to use violence to try and solve problems, and may copy the behaviour they see within the family. Older boys may play truant and start to use alcohol or drugs (both of which are a common way of trying to block out disturbing experiences and memories).

Girls are more likely to keep their distress inside. They may become withdrawn from other people, and become anxious or depressed. They may think badly of themselves and complain of vague physical symptoms. They are more likely to have an eating disorder, or to harm themselves by taking overdoses or cutting themselves. They are also more likely to choose an abusive partner themselves.

Children of any age can develop symptoms of what is called 'Post-traumatic Stress Disorder'. They may get nightmares, flashbacks, become very jumpy, and have headaches and physical pains'.

14.6.8 In 2019, Cafcass Cymru published a report: 'Impact On Children Of Experiencing Domestic Abuse'[48]. The document states: 'Children's responses to living with domestic abuse may vary according to age and

[47] https://www.rcpsych.ac.uk/mental-health/parents-and-young-people/information-for-parents-and-carers/domestic-violence-and-abuse-effects-on-children
[48] https://gov.wales/sites/default/files/publications/2019-08/cafcass-cymru-impact-on%20children-experiencing-domestic-abuse.pdf

stage of development. The ways in which children are affected may differ. For example, babies living with domestic violence appear to be subject to higher levels of ill health, poorer sleeping habits and excessive crying, along with disrupted attachment patterns. Children of pre-school age tend to be the age group who show most behavioural disturbance such as bed wetting, sleep disturbances and eating difficulties and are particularly vulnerable to blaming themselves for the adult violence. Older children are more likely to show the effects of the disruption in their lives through under performance at school, poorly developed social networks, self-harm, running away and engagement in anti-social behaviour.' (Humphreys and Houghton, 2008)[49]

14.6.9 The report details further research by Enlow et al. (2012)[50], which found that exposure to domestic abuse, particularly in the first two years of life, appears to be especially harmful and that whilst children are pre-programmed to respond to stressful situations, such as hunger, meeting new people, or dealing with new experiences, it is clear that some stressors are more harmful than others. The strong and prolonged activation of the individual child's stress management system results in toxic stress.

14.6.10 The Review Panel acknowledged the findings within the research and agreed that the change in the definition of domestic abuse, as defined by the Domestic Abuse Act 2021, reflects the outcomes of the research: that children who witness domestic abuse, are victims within their own right.

14.7 Term 7

How did your agency take account of Helena's vulnerabilities, including her health conditions, when responding to incidents and providing services?

14.7.1 Helena was in receipt of specialist services due to her heart condition, which were clearly documented within her health records. During her pregnancies, Helena received consultant-led care. Non-attendances were followed up appropriately, and records suggest an increased level of engagement with cardiac services during Helena's pregnancies.

---

[49] https://dera.ioe.ac.uk/9525/1/0064117.pdf
Literature Review: Better Outcomes for Children and Young People Experiencing Domestic Abuse – Directions for Good Practice

[50] Interpersonal trauma exposure and cognitive development in children to age 8 years: a longitudinal study
https://pubmed.ncbi.nlm.nih.gov/22493459/

14.7.2 During episodes of acute onset of chest pain, potential triggers were explored with Helena. Helena reported some work-related stressors, but no relationship-related stressors. Due to the need to establish a cause for the acute episodes, a referral was made for Tertiary Centre (specialist) oversight and further investigations.

14.7.3 In October 2016, Helena reported that she was not always able to afford her medications, as she was not in receipt of any benefits and, at that point, was unsure what her condition meant for her. The attending clinician provided advice in relation to seeking support for benefits and medications. Leaflets were also provided and explained – to support her clinical condition. Helena was also advised to compose a list of questions for discussion at her forthcoming outpatient appointment. The Review Panel was informed that documentation relating to subsequent attendances, evidenced that Helena was in receipt of medication at that time.

14.7.4 Advice from ULHT cardiology teams was sought in relation to each acute attendance at Accident and Emergency. Also, there was evidence, within the records, of Helena having attended Tertiary Centre cardiology appointments – with appropriate information sharing between these centres and ULHT observed.

14.7.5 Whilst there was some evidence of Helena's inconsistent pattern of engagement, these were recorded before Helena and Rodrigo's relationship commenced. The family told the Chair that Rodrigo was fully aware of Helena's heart condition and would frequently accompany her at health appointments. The family told the Chair that Rodrigo was aware that issues related to stress, including within their relationship, could have an impact on Helena's health and heart condition.

14.7.6 As Helena was under the care of secondary care services for ongoing health conditions, information was shared between secondary and primary care (via written correspondence), following attended appointments. Helena's GP practice has a care co-ordinator in place, who liaises regularly with the neighbourhood team lead to identify patient's that may require additional support. The Review Panel was informed that patients who make out of hours or Accident and Emergency attendances are highlighted and discussed. Furthermore, the GP practice would try to investigate further, the possible cause for the patients' choice and look at alternative ways to support them.

14.7.7 Helena did not trigger a review by the GP surgery for high attendances to out of hours or Accident and Emergency; therefore, she was not identified

as at high risk. The GP surgery was not aware of the home situation. This was identified as a learning point for the GP surgery. The Review Panel was informed that the practice care co-ordinator now reviews and discusses all high attendances with the relevant neighbourhood team, in the context of admission avoidance. Upon notification of frequent attendances, the practice care co-ordinator will review the patient's records and decide if any immediate or ongoing course of action can be taken to avoid further admissions and to support the individual. In addition to this process, the practice care co-ordinator works within the remit of the Vanguard Project[51]. The aim of this is to identify at-risk patients and try to prevent issues escalating by identifying those that may have frequently used services in the past, or possibly inappropriately, and put pre-emptive measures in place.

14.7.8 The GP surgery also holds regular safeguarding meetings with both the health visitor and midwifery service: they, in turn, receive the domestic abuse notifications from the police. 'Professional curiosity' is promoted at all primary care training (encouraging practitioners to consult in this way), along with the use of the 'Think Family' approach (to develop a better picture of what life is like at home).

14.7.9 The Review Panel reflected on Helena's heart condition and the wider knowledge amongst agencies. Whilst the police had some knowledge that Helena had a heart condition, this was provided by Helena during contact with them, in response to domestic abuse incidents. The police did not have the level of detail or knowledge of any potential triggers that could affect her heart condition, and the Review Panel acknowledged that they would not have been expected to have had this level of detail.

14.7.10 Following access to the report the family told the Chair that –

'We acknowledge that the police wouldn't have been expected to have a wider knowledge on Helena's heart condition however surely common sense shows that if someone's health is deteriorating (for example as witnessed on 6 November) then an ambulance or medical advice should have been seeked. A person does not have to consent to an ambulance for Lincolnshire Police to seek an urgent medical review. As stated in this report, the Victim can often minimise their pain and suffering without necessarily realising the risk. In addition to this we believe that upon

[51] https://www.england.nhs.uk/wp-content/uploads/2015/11/new_care_models.pdf
In January 2015, the NHS invited individual organisations and partnerships to apply to become 'vanguards' for the new care models programme, one of the first steps towards delivering the NHS Five Year Forward View (published October 2014) and supporting improvement and integration of services.

witnessing these concerning symptoms and decline in Helena's health that Helena's risks should have been heightened and safeguarding measures should have been put into place. There is also no evidence of officers asking and recording more detailed information regarding Helena's heart condition and how this may impact her and make her more vulnerable. The College of Policing's guideline states that a victim with a long-term illness is particularly vulnerable to domestic abuse from partners'.

14.7.11 In response to the family's comment the Review Panel took account of that within the IOPC report it details that during the incident on 6 November, Helena's mother was present, Helena had stated that she had a heart condition and knew how to manage things. Helena had asked the police to leave several times and had declined an ambulance to be called.

14.7.12 The Review Panel have included the comments from the family and additional information in response to these but have been unable to analyse these comments further as detailed in paragraph 5.16.

14.8 Term 8

Were the subjects informed of options/choices to make informed decisions? Were they signposted to other agencies, and how accessible were these services to the subjects?

14.8.1 When Helena declined onward travel to hospital for further assessment of her cardiac condition, ambulance crews provided her with information about how to access support from her GP and midwife. On one attendance, crew made an appointment with her GP (the following day), for review. All EMAS attendances are routinely shared with the GP. Helena did not disclose domestic abuse to any member of EMAS.

14.8.2 Helena's GP practice was not aware that she was a victim of domestic abuse, and therefore she was not signposted to other agencies – as the practice was not aware of the risk she was exposed to.

14.8.3 Health professionals' involvement with Helena during her pregnancies, focused on her vulnerabilities and cardiac condition. The Review Panel has seen evidence that Helena was informed about the options available to her throughout her pregnancy and in relation to her care. When Helena self-discharged following the birth of Iria, health professionals arranged for follow-up arrangements with the community midwifery team. Helena was deemed to have capacity in her decision-making around her maternity care.

14.8.4 Referrals for Tertiary Centre care were initiated, in regards to the risks associated with Helena's cardiology and maternity requirements. Documentation evidenced that Helena was able to access these services, with no concerns relayed in relation to funding/transportation issues.

14.8.5 During engagement with the social worker in January 2020, there was no record that Helena had been given access to local domestic abuse services. Helena had declined ongoing support from Children's Social Care, either under Child in Need[52] or Team Around the Child[53], which would have offered multi-agency support. There was insufficient evidence for Children's Social Care to escalate the case any further at the time.

14.8.6 In February 2018, during Helena's pregnancy with her first child, Helena told the health visitor that she had experienced some anxiety the previous year, which she attributed to work. Helena stated that she had not sought support through GP/Steps to Change, as she did not feel it was warranted: she said that she had her partner (Rodrigo) and her family for support. Helena stated that she was not currently feeling anxious. Helena responded negatively to the mental health assessment (Whooley questions)[54] undertaken by the health visitor. Whooley questions were introduced by NICE 2007, and it is recommended that the questions are asked in the antenatal period, at the primary birth visit, the 6 – 8-week developmental assessment, and the 8 – 12 months postnatal. The health visitor signposted Helena to P3[55] and advised that if a further supportive letter was required, the health visitor would support this. P3 is a charity and social enterprise, made up of passionate people, who care about people. They run a variety of services, across the UK, that aim to give everyone the chance to be part of the community they live in and feel connected to society. The Review Panel contacted P3 but were informed that information was no longer held by them.

---

[52] Section 17 Children Act 1989

[53] https://www.lincolnshire.gov.uk/keeping-children-safe/team-around-child#:~:text=Team%20Around%20the%20Child%20(TAC,and%20coordinated%20support%20is%20required.

[54] The Whooley questions were introduced by the National Institute for Clinical Excellence (NICE 2007) when they reviewed their guidelines for Antenatal and Postnatal Mental Health. The questions are a screening tool which is designed to try and identify two symptoms that may be present in depression.

[55] https://www.p3charity.org/?gclid=Cj0KCQiA3rKQBhCNARIsACUEW_aOD2qIc7u4SsGRrT4WIKHz41-xNlgzkUWLYN1_zrb2ROiQYuPJZRwaAhtwEALw_wcB

14.8.7 Helena had been directed by the health visitor to the children's centre in the local community. It was recorded that Helena was aware of groups and activities that she could attend. During contact on 3 April, the health visitor discussed domestic abuse with Helena. Helena did not report any current domestic abuse within her relationship with Rodrigo. Helena was not signposted to other agencies for support.

14.8.8 The police provided Helena with options in relation to the criminal offences that had been identified during the assaults on Helena; however, this was with the exception of the incident reported in May 2019. As the assault Helena reported had occurred two to three years earlier, it was outside of the statutory timescales (six months) for further action.

14.8.9 The police signposted Helena to other agencies, such as Children's Social Care; however, Helena did not provide consent for information to be shared. The Review Panel has been informed of work that is taking place to share domestic abuse incidents with health visitors and midwifes. [See Term 9].

14.8.10 There were no referrals to EDAN Lincs. The Review Panel has been informed that since the death of Helena, the police have published information on the police intranet about EDAN Lincs, and how victims can be signposted for support. The police DASH PPN process ensures that officers must explain EDAN Lincs to a victim and show a video of what EDAN Lincs is and how it can help victims. Since December 2020, the PPN has been used as the referral document rather than the EDAN Lincs online form, and all standard and medium DASH PPNs are referred to EDAN Lincs, with victim consent. All high-risk DASH PPNs are referred to MARAC, regardless of consent. The Review Panel has been provided with additional information regarding referral to EDAN Lincs. [See Term 9].

14.8.11 The Review Panel discussed what support had been offered to Helena, including referrals to agencies who could provide support in relation to the domestic abuse. It was documented, within police records, that during all contact with the police, Helena had declined support and did not provide consent for information to be shared. The Review Panel was informed that the police can only share information with EDAN Lincs (a service to support victims of domestic abuse) when consent has been obtained, or if an incident has been classed as high-risk, and a referral has been made to MARAC.

14.8.12 The Review Panel discussed Helena's decision not to consent to information being shared. Whilst the Review Panel acknowledged that these were Helena's decisions at that time, the Review Panel was keen to understand if

Helena had been provided with information as to how she could self-refer or gain access to information (such as via online resources), and if Helena had been informed of these options.

14.8.13 The Review Panel discussed the response of agencies to offer and/or refer Helena and Rodrigo for support and whether these agencies were accessible. Had Helena consented to a referral or made contact with EDAN Lincs, they would have undertaken an initial contact with her: during which, a pre-assessment would have been completed. EDAN Lincs offer a tiered approach to support within their Outreach Support Service for Adults and Children. The outreach service provides support to adult victims and children in the community that have been affected by domestic abuse. Service users are supported in relation to risk, safety planning and, if required, crisis intervention. Once the immediate risks and threat of abuse have been addressed, their Specialist Domestic Abuse Workers (SDAW) can provide further support, if required: this may be over the telephone, face to face, or online interventions.

14.8.14 The cultural expert told the Review Panel that the Portuguese will not proactively seek support outside of the family environment and that within the Portuguese culture, the mother is seen as the person who 'rules the roost', but that the father will have the last word, i.e., whether to go out, etc. The cultural expert further explained that the Portuguese communities are very private, for example, going to their own churches. The main reason that Portuguese people come to the United Kingdom is to work and make a better living for themselves, with the idea of going back to Portugal. Furthermore, that Portuguese people do not necessarily claim support from the state: they see it as demeaning, and they would rather work for a living.

14.8.15 The cultural expert further explained that some of the main issues encountered, are language barriers and a general mistrust of 'state' run organisations. Examples were provided to the Review Panel, by the cultural expert, of Portuguese nationals not using the NHS – a lot of people continue to go back to their own doctor in Portugal, as the GP is normally the family doctor. Within Portugal, people use private doctors, specialists, and paediatricians. When they cannot find the equivalent in the United Kingdom, this can cause confusion, with them relying on attending Accident and Emergency Departments instead of a GP practice.

14.8.16 The Review Panel identified learning around the role of agencies and support services for members of minoritised communities, with a need for proactive work to be undertaken. In addition, the Review Panel identified that professionals working with minoritised communities, needed to have

an understanding of culture and how this can reflect in their responses to engagement and contact with agencies.

14.8.17 The Review Panel was informed that these areas of learning had been identified in previous DHRs undertaken within Lincolnshire, and that work is currently taking place to address these recommendations. This includes, but is not exhaustive:

- The Domestic Abuse Partnership Board's needs assessment, identified the requirement for commissioned domestic abuse services to detail accessibility and engagement.

- A bulletin and fact sheet has been produced, covering elements of religion and culture in relation to the communities within Lincolnshire.

- Training programmes have been updated.

- An outreach and engagement team are to work directly with communities.

- Introduction of Domestic Abuse Champions.

14.8.18 The Review Panel agreed that the learning from this review should be used to inform ongoing work to address the previous learning and recommendations, as well as the work of the Domestic Abuse Partnership Board's strategy on these matters. The Review Panel has made a relevant recommendation.

14.9 Term 9

Were single and multi-agency policies and procedures, including the MARAC, followed? Are the procedures embedded in practice, and were any gaps identified?

<u>EMAS</u>

14.9.1 EMAS has an up-to-date Safeguarding Adults and Children Policy, and Domestic Abuse Policy. Staff have access to the safeguarding policies at their work base and via the intranet. Compliance with policy and procedure is demonstrated through audit.

14.9.2 EMAS delivers education using a 'Think Family approach', which includes domestic abuse. At the end of 2019 – 2020, EMAS was 93% compliant

(Trust-wide) for safeguarding education. Safeguarding education is delivered in a variety of ways within EMAS – promoting a blended approach, in a rolling programme over a three-year period and incorporating:

- Face to Face
- Work Book
- eLearning Package
- Reflective Supervision

14.9.3 A supplementary domestic abuse training session is also available to all EMAS staff, via the in-house online training e-portal: this has been designed specifically for ambulance crews in recognising and responding to domestic abuse. The EMAS safeguarding team continue to work with the regional divisions to ensure learning is disseminated from any DHRs, or other statutory reviews, where domestic abuse has been identified as a feature.

GP Surgery

14.9.4 The GP practice has a safeguarding policy and procedure in place, which includes domestic abuse. Practice staff have completed relevant safeguarding training, as required by role, and regularly attend GP forum updates. The safeguarding policy is reviewed monthly by the GP safeguarding lead. The GP practice holds regular safeguarding meetings where cases are discussed and up-to-date information is shared.

Lincolnshire Community Health Services

14.9.5 The Lincolnshire Multi-Agency Domestic Abuse Policy and Procedures is embedded in children's services' practice.

Lincolnshire County Council Children's Services

14.9.6 There was a delay in undertaking the health visitor review of the children and family, following information sharing by the social worker in January 2020. However, there had been no previous concerns identified by the health visitor prior to receipt of this information, and the information shared by the social worker, at this time, identified that there were no safeguarding or welfare concerns for the children.

14.9.7 In line with Children's Health Covid Guidelines – following the Health Protection (Coronavirus, Restrictions) (England) Regulations 2020 coming into force on the 26 March 2020 – the health visitor made a telephone contact with Helena on the 3 April 2020. The contact was to see how the family were coping with lockdown and to review any further risk factors

regarding domestic abuse. Helena did not make any disclosures. She was advised to contact the health visiting SPA if she required any support. Helena followed this advice, on the afternoon of the 8 April 2020, and contacted SPA to request support after the domestic abuse incident that morning.

United Lincolnshire Hospitals NHS Trust

14.9.8 Domestic abuse routine enquiry (Maternity) and professional curiosity were exercised, as expected, during Helena's contacts with ULHT services: no disclosures or indicators of domestic abuse were identified. The Review Panel was informed that had such concerns arisen, agreed multi-agency policies and procedures were available to support staff in managing any concerns.

14.9.9 ULHT provides training to all clinical staff in relation to the recognition and management of domestic abuse disclosures/concerns, and locally recognised resources are available within the Trust's Domestic Abuse Policy and also via the Trust's intranet. In addition to support available via the Trust's Safeguarding Team, ULHT has access to two hospital IDVAs who are also available to provide training and support to staff members, as required.

14.9.10 Compliance with Trust-specific and local domestic abuse processes, is audited by the safeguarding team on a quarterly basis – with non-compliance concerns escalated via divisional and Trust-wide safeguarding meetings.

14.9.11 The Review Panel has been informed by ULHT that, at the time of this case, they were reliant on pregnant patients disclosing domestic abuse during contact, in response to the use of routine enquiry, or via concerns being raised and explored in relation to their general presentation. Alternatively, information about domestic abuse would have been shared at MARAC. Information relating to incidents in which the police had been in attendance, but which had not warranted progression into the MARAC arena, would not have been shared with healthcare services/midwives as a matter of routine. This process has now changed, and information is shared directly by the police. [See 14.9.13].

14.9.12 During the DHR process, discussions have taken place between the police and midwifery services: this has resulted in an agreement for the police to share information with the midwifery safeguarding team in Lincolnshire, should they be involved in any incidents involving a pregnant lady.

Lincolnshire Police

14.9.13 Following the incident on 8 April 2020, a supervisor increased the risk assessment to high, and a MARAC referral was made. However, the case had not been heard at the time of Helena's death.

14.9.14 Lincolnshire Police's Domestic Violence and Abuse Policy has been in place since September 2013. The Review Panel was informed that the policy contains detailed procedures for dealing with concerns about domestic abuse, including procedures for risk assessments. One of the principal aims is to adopt a proactive multi-agency approach in preventing and reducing domestic abuse. The policies and procedures, in respect of domestic abuse, take account of, and reflect, national guidance and the recommended good practice: these have been professionally accepted as being effective. They were revised and introduced following the release of the NPCC (National Police Chief's Council) and the Home Office's new definition of domestic violence and abuse. The policies and procedures mirror national policy and guidance.

14.9.15 The Protecting Vulnerable People Safeguarding Hub (PSH) also supports the Force's response to domestic abuse, by being the point of contact for partner agencies. The PSH provides additional scrutiny over high-risk cases, ensuring liaison and referral to MARAC.

14.9.16 The police have told the Review Panel that it is accepted that there are gaps in frontline officers' knowledge of DVPNs and DVPOs, and the Force have commissioned further training to all frontline staff, by means of the DA Matters programme, which commenced in February 2022.

14.10 Term 10

Were there any issues in relation to capacity or resources in your agency, that affected its ability to provide services to the subjects of this review, or on your agency's ability to work effectively with other agencies? N.B. Please also consider any additional capacity/resource issues, with agency contact, during the Covid-19 pandemic.

14.10.1 The Review Panel has seen evidence of good multi-agency working between Grantham community midwives, Nottingham University Hospital, and Glenfield Hospital, to meet Helena's complex cardiac and maternity needs.

14.10.2 Helena's death occurred shortly after the national lockdown restrictions (imposed in March 2020) due to the Covid-19 pandemic. Helena's GP

practice had the AskmyGP[56] service in place prior to, and during, the Covid-19 pandemic. This meant that all patients could contact their GP surgery by phone or online, and the GP practice would respond via email/video/phone or the offer of a face-to-face appointment: the response would consider the individual's request and depend on what was clinically appropriate/required.

14.10.3 The police responded to two incidents on 8 April 2020. Both incidents were recorded as priority (attendance of police within 60 minutes) and urgent (attendance by police within 15 minutes), and the police attended in the required time.

14.10.4 On 8 April when Rodrigo was released from custody, Lincolnshire Police were adopting a policy[57] whereby arrested persons were not being kept in custody unless the police were seeking to apply for a remand in custody from the courts. The police can only seek a decision from the Crown Prosecution Service (CPS), on whether to charge an individual who is in custody, where the police are seeking to keep that person in custody after the charge has been authorised. When these circumstances do not apply, all persons in custody will either be released and no further action taken, released on bail, or released under investigation for charging decisions to be made by the CPS. The only cases where CPS are asked for charging decisions when a person is in custody, are those cases deemed to be high risk. This did not apply in the case of Rodrigo. In addition to the police's policy, Lincolnshire Police's custody lead had sent an email to staff (7 April 2020), which stated that: 'there needed to be reduction in footfall through custody, meaning less prisoners in custody suites.'

14.10.5 Following access to the overview report the family sought further information as to why Rodrigo was released on bail. The family stated – 'We acknowledge the covid policy however, the perpetrator admitted harming Helena on several occasions, the police held witness statements, photographic evidence and the case was graded high risk. On what grounds during the covid restrictions would a person actually be held in custody to await the CPS decision or was the policy literally no prisoners left in custody? This seems like a reckless decision especially given Rodrigo's track record of returning to the property to reoffend. Should a

[56] https://askmygp.uk/
askmyGP is an online consultation and workflow system that helps GPs manage patient caseload through operational change and digital triage. We make it easier for patients to talk to their own doctor and help GPs to prioritise and deliver care through message, phone, and video.
[57] Covid guidance policy (dated 1st April).

MG7[58] have been submitted to seek a remand in custody due to the high risks, vulnerability of Helena, escalating violence and threats to kill her?'

14.10.6 In responding to these comments, the Review Panel took account of information held within the IOPC report, of which the family have access, which details the decision making on the case. Due to the limitations set out in paragraph 5.16 the Review Panel have been unable to analyse this issue further.

14.11 Term 11

How did your agency take account of any racial, cultural, linguistic, faith or other diversity issues, when completing assessments and providing services to the subjects of this review?

14.11.1 This has been addressed under Section 11 and other Terms of Reference within Section 14. Learning has been identified and therefore will not be repeated here.

14.12 Term 12

Were there any examples of outstanding or innovative practice?

14.12.1 The Review Panel saw no evidence of outstanding or innovative practice during the completion of this review.

14.13. Term 13

What learning did your agency identify?

<u>EMAS</u>

14.13.1 EMAS identified the continued need for crews to ensure that they document the names of other people present in the home and consider any risk they may pose. EMAS had already recognised this as an area for improvement for 2020 – 2021, and this is included in all face-to-face training, e-learning, workbook, and learning from events sessions. An article was also sent out in 2021, via internal communications (ENEWs), which included information about the importance of recording names of all people on scene.

[58] Police form

GP Surgery

14.13.2 Practitioners must consider the impact of additional health problems on the wider family, in addition to the individual. The completion of the IMR also reinforced the importance of professional curiosity and risk assessment to ensure the correct services are available to support an individual and/or wider family.

14.13.3 Action taken to address this learning:

Safeguarding meetings are now held with the midwife in addition to the health visitor, and safeguarding is discussed at the monthly practice meetings.

The care co-ordinator now reviews and discusses all high attendances with the relevant neighbourhood team.

Lincolnshire County Council Children's Services

14.13.4 Timeliness of contact with a victim and children by the health visiting service following receipt of information related to domestic abuse.

14.13.5 Importance of completion of a DASH at the point of initial contact when domestic abuse is identified.

14.13.6 All victims of domestic abuse should be provided with the details of local domestic abuse services, regardless of whether they accept that abuse has occurred or not.

14.13.7 Every effort should be made to facilitate fathers/other significant carers to contribute to the assessment and child & family progress plan.

14.13.8 Children's Services to consider an internal process for the sharing of domestic abuse notifications with children's health.

14.13.9 Actions taken to address this learning:

Children's Services has already started to take action in respect of the learning identified within this review. A domestic abuse update presentation is being delivered to Children's Services' practitioners, and the findings are being shared in the Children's Services bulletin.

The importance of completion of a DASH at initial point of disclosure or concern, is reiterated in training and via safeguarding supervision.

Lincolnshire Police

14.13.10 Although the DVPN/DVPO and DVDS have been highlighted in this review, training in respect of the schemes has been included in the initial training

for new officers since July 2014, in DASH training since March 2014, and in Vulnerability and Risk training since October 2018. The Force also introduced a DVDS action plan in 2019/20, which focused on delivering this training to those operational officers who had not received it during their service. Lincolnshire Police have commissioned further training to all frontline staff, by means of the DA Matters programme, which commenced in February 2022.

14.13.11 The police also identified gaps in relation to referrals to partner agencies, such as EDAN Lincs, whereby analysis of data between January 2020 and June 2020, had shown only 64 referrals to specialist domestic abuse services. The main inhibitors in reviewing these figures were that the referral form was not readily accessible to officers, and that officers did not understand the role of EDAN Lincs. The Review Panel was informed that what has been put in place to address this, has shown that within the first six months (between January 2021 and June 2021), referrals increased by 623%.

14.13.12 In December 2019, the supervisor did not record that the victim was a repeat victim. The IMR author from the police has stated that if this had occurred, it would have likely altered the grading of the DASH risk assessment to medium. The Review Panel agree with this analysis. [See 14.3.8].

Nottingham University Hospital

14.13.13 Nottingham University Hospital identified learning, early on in the DHR process, in relation to the use of 'routine enquiry' during Helena's consultancy-led care. This has been addressed in Term 1.

14.14 Term 14

Do the lessons arising from this review appear in other reviews held by this Safer Lincolnshire Partnership?

14.14.1 From this review, the panel has identified the following areas of learning that have appeared in previous reviews undertaken by Safer Lincolnshire Partnership:

- Professional curiosity.
- Impact of culture, nationality, religion, and language.
- Review of previous incidents of domestic abuse.

14.15 Term 15

Has any relevant practice changed since the events under review?

EMAS

14.15.1 Domestic abuse and its associated agendas have been rolled out during safeguarding training to all frontline staff during the 2020 – 2021 educational year: this is now a core subject. Staff have been provided with the skills to recognise domestic abuse and signpost individuals to the appropriate services and information.

14.15.2 A live learning from events session: this was co-delivered by the police and an independent author for Domestic Homicide Reviews. This session was delivered to all frontline staff and looked at two DHRs that EMAS had been involved in. Key areas for learning were identified, which included recording of all people who are present during attendances and gaining consent for domestic abuse referrals. EMAS will continue to include domestic violence and abuse updates on a yearly basis, as part of safeguarding training.

14.15.3 A sticker has been developed since 2020. This sticker goes into all patients' homes on crew equipment and states: 'Domestic Abuse is not OK and it can happen to anyone. EMAS has a zero tolerance for domestic abuse, speak to me or contact the helpline on 0808 2000 247'. This has been introduced to help victims have the confidence to come forward and ask crew for help. It also identifies EMAS as a service people can access support if they are experiencing domestic abuse, and it aids the signposting to the National Helpline.

Lincolnshire Community Health Services

14.15.4 It is now expected practice when a patient attends an Urgent Treatment Centre, to record who they attend with, and whether they are a child or an adult – as it is recognised that this could be of significance in working to keep people safe.

Lincolnshire County Council Children's Services

14.15.5 Children's Health has updated internal domestic abuse training and shared guidance for practitioners on how to ask about domestic abuse.

14.15.6 The importance of sharing contact information for local domestic abuse services, irrespective of a family's acceptance/acknowledgement of concerns raised regarding domestic abuse, will be shared within the Childrens' Services Bulletin.

Lincolnshire Police

14.15.7 In September 2021, Lincolnshire Police launched a new system called QLIK, which is a business intelligence tool that allows users to navigate vast amounts of real time data from multiple sources. The system is being used by Lincolnshire Protecting Vulnerable People (PVP) department in relation to identifying repeat victims and repeat perpetrators. This will ensure that any repeat victims are provided with adequate support regarding the use of DVPNs, DVDS, welfare, etc. Repeat victims will be easily highlighted by a specialist team in the PVP department – with less reliance on officers having to attend domestic incidents.

14.15.8 The IMR author for the police has identified that in times of austerity and heightened media scrutiny, in relation to how police deal with victims of domestic abuse and violence against women in particular (recent figures showed 71% of DA victims were women), that the police will be able to allocate the staff needed. The workload for the PVP department is well documented as being excessive, and this system of identifying and safeguarding repeat victims will increase their workload. The IMR author for the police, told the Review Panel that they were of the opinion that, given the changes, the police may require additional staff to assist in both the effective administration of justice and the well-being of domestic abuse victims. Lincolnshire Police have made a single agency recommendation in response to this area of learning.

14.15.9 Since 2022, Lincolnshire Police have implemented the following process in relation to DVPN/Os:

- The Offender Management Unit (OMU) has become increasingly involved in the process in force, which has seen an improvement in a number of ways and seen training provided across varying areas to Lincolnshire officers.

- Improved use of intelligence briefings and tasking.

- Rebranding and targeted comms plan for 2023 is the next task ahead – particularly now we know that the DAPO national pilot scheme is postponed a further year, to Spring 2024.

Nottingham University Hospital

14.15.10 There is ongoing mandatory training to inform/remind all staff of the importance of enquiring about domestic abuse, with additional training for maternity staff due to the increased risk of/from domestic abuse during pregnancy.

14.15.11 Due to Helena's heart condition during both pregnancies, she had consultant-led care and therefore had limited contact with midwives. Midwives incorporate routine questions about domestic abuse into their clinical practice, and the medical teams often rely on the midwives to undertake the use of routine questions: this may be missed if the patient does not access midwives during their pregnancy.

14.15.12 In response to this area of learning, the midwifery safeguarding lead has trained all of the obstetricians at Nottingham University Hospital. The training focuses on domestic abuse and the importance of routine questioning in pregnancy, the clear documentation of this, the responses, and any actions taken. This action was completed at the beginning of the DHR process.

15. CONCLUSIONS

15.1 Helena and Rodrigo were Portuguese. Helena had been born in Portugal and spoke fluent English. Rodrigo was born in Portugal and came to the United Kingdom as an adult: Portuguese was his first language.

15.2 Helena had been diagnosed with chronic myocarditis and was under the care of cardiology specialists. She continued to live a full life, including employment and later motherhood.

15.3 Helena and Rodrigo had been in a relationship for four years, and together, they had two children. During their relationship, Helena was the victim of domestic abuse. Rodrigo was the perpetrator of the abuse. Towards the end of 2019, there was an increase in reported incidents of domestic abuse, at which both children were present.

15.4 On the morning of her death, Helena reported that she had been assaulted by Rodrigo. Helena told the police of previous unreported incidents of domestic abuse. Rodrigo was arrested and later released from custody, with bail conditions not to contact Helena. Later that night, Helena reported to the police that Rodrigo had returned to their property, assaulted her, and then left. Helena was found deceased at the property. Both children were present.

15.5 A criminal investigation was undertaken, and Rodrigo was charged with Helena's murder. In March 2021, Rodrigo appeared at Crown Court, on three indictments: manslaughter of Helena, and two charges of Assault Occasioning Actual Bodily Harm on Helena. The charge of manslaughter was not progressed. Rodrigo pleaded guilty to both charges of assault.

15.6 Helena's mother told the Chair that she found the decision not to prosecute Rodrigo, for Helena's death, very difficult to understand. Helena's mother stated that Helena had recently seen a doctor as part of her forthcoming employment and had been deemed fit to work. Helena's mother stated that Rodrigo was aware of Helena's heart condition and knew that stress would cause her difficulty. Helena's mother told the Chair that it is her belief that Rodrigo is responsible for Helena's death because of the stress caused by his actions. The Chair discussed with Helena's mother that it is not the purpose of the DHR to identify who is responsible for Helena's death, as this is determined through other processes.

15.7 The Review Panel was supported throughout the review by a cultural expert. The Review Panel was informed about the barrier's Portuguese women, who live in the United Kingdom, may face in leaving a relationship, which included cultural, financial, accommodation, and isolation. The

Review Panel identified learning in relation to Helena and Rodrigo's culture. The panel also identified learning regarding how agencies: respond to victims of domestic abuse; respond to perpetrators of domestic abuse to address their offending behaviour; access and signpost to services; and provide awareness for family and friends to report and support victims of domestic abuse. These areas of learning have been addressed through relevant recommendations.

15.8 Helena's family and friends contributed to the review process. Following the family having access to the report they stated –

'As a family we feel that Rodrigo played the system. He used the language barrier card to his full advantage. At no point did Rodrigo deny assaulting Helena on any occasion so why was Rodrigo not charged earlier? He admitted to the crimes! It appears to us that as long as a violent perpetrator carefully selects their victim they can literally get away with murder. They can abuse, beat and torment a person until their body can literally take no more. Surely this isn't just a flaw in the agencies but actually a flaw in the legal/justice system. Surely this whole case gives out the wrong message to perpetrators and opens the floodgates of abuse for victims with health conditions making them more vulnerable than they already are'.

15.9 The Review Panel acknowledges the family's comments and observations in relation to the legal and judicial systems that have been, and are still ongoing on this case in relation to Helena's death.

15.10 The panel wish to extend their thanks for their contribution and comments.

16. LEARNING IDENTIFIED

16.1 The Domestic Homicide Review Panel's Learning (Arising from panel discussions)

16.1.1 The DHR panel identified the following learning. The panel did not repeat the learning already identified by agencies at Term 13. Each learning is preceded by a narrative, which seeks to set the context within which the learning sits. When a learning leads to an action, a cross reference is included within the header.

Learning 1 [Panel recommendation 1]
Narrative
The Review Panel identified that incidents of domestic abuse and risk increased over a short period of time; however, these incidents were not referred to MARAC or another multi-agency forum in which the risk could be addressed.
Learning
Agencies need to have in place a process that collates and reviews where there has been an increase in frequency and risk to victims of domestic abuse. This should include guidance as to how professionals should use their professional judgement to refer these cases to MARAC or other multi-agency forums, to respond to those risks.

Learning 2 [Panel recommendation 2]
Narrative
It was not until the last domestic abuse incident on this case, that the offending behaviour of the perpetrator was addressed through the criminal justice processes. Incidents prior to this time, did not result in any intervention or signposting to services, to address the offending behaviour.
Learning
Where the offending behaviour of perpetrators of domestic abuse is not being addressed through criminal justice processes, then professionals and perpetrators need to have access to alternative methods in which they can respond to the offending behaviour – to reduce the risk to victims of domestic abuse.

Learning 3 [Panel recommendation 3]
Narrative
There was an opportunity on this case for a DASH risk assessment to have been completed as part of the single assessment that was undertaken within child protection processes. The use of a DASH may

have enabled discussions on domestic abuse, risk factors, and the current relationship.
Learning
The completion of a DASH risk assessment provides professionals with an additional tool in which to capture detailed information on presenting and previous indicators of risk. This information can be used to inform assessment processes and aid discussions with victims of domestic abuse.

Learning 4 [Panel recommendation 4]
Narrative
The Review Panel identified that there had been significant changes to legislation around domestic abuse since this case. This included the introduction of the Domestic Abuse Act 2021 and legislation to respond to non-fatal strangulation.
Learning
Professionals need to keep abreast of changes in legislation in order to identify and respond to incidents of domestic abuse in accordance within the current legislative framework.

Learning 5 [Panel recommendation 5 and 6]
Narrative
The Review Panel heard that domestic abuse victims from the Portuguese community have additional cultural barriers, which may prevent them from engaging with agencies.
Learning
Cultural and language barriers have a role in reducing the likelihood that domestic abuse victims will report abuse or stay engaged with services if they do make a report. Information, materials, and services need to be accessible to all communities within Lincolnshire, including where English is not their first language. In addition, professionals working with minoritised communities need to have an understanding on those communities' cultures and beliefs, to help inform professionals' knowledge when seeking to engage and provide services.

17. RECOMMENDATIONS

17.1 Panel Recommendations

Number	Recommendation
1	That Lincolnshire's Domestic Abuse Partnership Board requests that agencies provide them with a report detailing how their agency collates, reviews, and responds to repeat incidents of abuse.
2	That the learning from this review is shared with Lincolnshire's Domestic Abuse Partnership Board to inform their ongoing work around the provision and access of services for perpetrators of domestic abuse, whose offending behaviour is not being addressed through criminal justice processes.
3	That Lincolnshire County Council Children's Services disseminates the learning on this case, in relation to the use of the DASH as a tool to aid discussions during assessments within child protection processes.
4	That Lincolnshire Domestic Partnership Board requests evidence and assurances from agencies as to how the provisions of the Domestic Abuse Act and legislation on non-fatal strangulation, have been embedded into practice. This could be achieved through the submission of a report that details the training provision, changes to policy and procedures and, if deemed necessary, for Lincolnshire Domestic Abuse Partnership Board, to review the outcomes of case audits to determine if learning is embedded into practice. This should also address how professionals will identify and respond to children who are victims of domestic abuse.
5	That Lincolnshire's Domestic Abuse Strategy documents how, as a partnership, it will respond to the availability of information and accessibility to services for all communities of Lincolnshire, where English is not their first language.
6	That the learning from this review is shared with Lincolnshire's Domestic Abuse Partnership Board, to inform them of the current ongoing work in responding to recommendations from previous Domestic Homicide Reviews and the Domestic Abuse Partnership Board strategy, on accessibility and engagement with minority communities.

17.2 Single-agency recommendations

17.2.1 Lincolnshire Police

Consideration to increasing staffing in the PVP department to deal with the likely increased number of repeat victims being highlighted.

Definition of Domestic Abuse (as in place within the timescales of this review)

Domestic violence and abuse: new definition

The cross-government definition of domestic violence and abuse is:
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:

- psychological
- physical
- sexual
- financial
- emotional
-

Controlling behaviour

Controlling behaviour is a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.

Coercive behaviour

Coercive behaviour is an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim. This is not a legal definition.

Appendix B

Controlling or Coercive Behaviour in an Intimate or Family Relationship

A Selected Extract from Statutory Guidance Framework[59]

- The Serious Crime Act 2015 [the 2015 Act] received royal assent on 3 March 2015. The Act creates a new offence of controlling or coercive behaviour in intimate or familial relationships [section 76]. The new offence closes a gap in the law around patterns of controlling or coercive behaviour in an ongoing relationship between intimate partners or family members. The offence carries a maximum sentence of 5 years' imprisonment, a fine or both.
- Controlling or coercive behaviour does not relate to a single incident, it is a purposeful pattern of behaviour which takes place over time for one individual to exert power, control or coercion over another.
- This offence is constituted by behaviour on the part of the perpetrator which takes place "repeatedly or continuously". The victim and alleged perpetrator must be "personally connected" at the time the behaviour takes place. The behaviour must have had a "serious effect" on the victim, meaning that it has caused the victim to fear violence will be used against them on "at least two occasions", or it has had a "substantial adverse effect on the victims' day to day activities". The alleged perpetrator must have known that their behaviour would have a serious effect on the victim, or the behaviour must have been such that he or she "ought to have known" it would have that effect.

Types of behaviour

The types of behaviour associated with coercion or control may or may not constitute a criminal offence. It is important to remember that the presence of controlling or coercive behaviour does not mean that no other offence has been committed or cannot be charged. However, the perpetrator may limit space for action and exhibit a story of ownership and entitlement over the victim. Such behaviours might 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;
- 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 of 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;

[59] Controlling or Coercive Behaviour in an Intimate or Family Relationship Statutory Guidance Framework. Home Office 2015.

- 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;
- threats to hurt or kill;
- threats to a child;
- threats to reveal or publish private information [e.g. threatening to 'out' someone].
- assault;
- criminal damage [such as destruction of household goods];
- rape;
- preventing a person from having access to transport or from working.

This is not an exhaustive list.