DOMESTIC HOMICIDE REVIEW

'Helena'

Date of death: April 2020

EXECUTIVE SUMMARY

October 2024

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

CONTENTS

1. The Review Process

1.1 This summary outlines the process undertaken by Safer Lincolnshire Partnership [the statutory Crime and Disorder Partnership] in reviewing the death of 'Helena', who was a resident in their area.

1.2 The following pseudonyms have been used in this review for the victim and perpetrator to protect their identities and those of their family members.

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

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[1]. In March 2021, Rodrigo

[1] 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.

appeared at Crown Court, on three indictments: manslaughter of Helena, and two charges of Assault Occasioning Actual Bodily Harm[2] on Helena. The charge of manslaughter was not progressed. Rodrigo pleaded guilty to both charges of assault.

1.6 In October 2024, an inquest was held into Helena's death. The jury concluded that Helena had been unlawfully killed.

1.7 The first meeting of the DHR panel was held in July 2020. Thereafter seven further meetings were held, and a draft report written. The meetings were held using online video facility and through a hybrid approach of face to face, with online video functionality.

1.8 The final overview report was agreed by Safer Lincolnshire Partnership on 3rd March 2023.

1.9 Helena's family were involved in the review process, having access to the report and meeting with the Review Chair and Author.

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").

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

2. Contributors to the review

2.1 Contributors to the review/agencies submitting Independent Management Reviews (IMRs).

Agency	IMR	Chronology	Report
Department for Works and Pensions			X
East Midlands Ambulance Service	X	X	
Glenfield Hospital		X	
GP Surgery[3]	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	

2.2 The authors of the Individual Management Reviews included in them a statement of their independence from any operational or management responsibility for the matters under examination.

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

3. Review Panel Members

3.1 The Review Panel Members were:

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[4]	Reviewing Officer for Lincolnshire Police	East Midlands Regional Review Unit
Jane Keenlyside	MARAC Manager	EDAN Lincs[5]
Ged McManus	Support to Independent Chair and Author	
Maria Joao Melo Nogueira[6]	Operations, Partnerships and Client Support Director	Respeito[7]
Richard Myszczyszyn[8]	Head of Protecting Vulnerable People	Lincolnshire Police
Hazel Noble	Independent Management Review Co-ordinator	Lincolnshire County Council Adult Social Care
Sarah Norburn[9]	Domestic Abuse Co-ordinator	Lincolnshire Police
Jennifer Parker	Deputy Named Nurse for Safeguarding	Lincolnshire Community Health Services
Martyn Parker[10]	Head of Protecting Vulnerable People	Lincolnshire Police

[4] Attended meetings to present police IMR.
[5] 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.
[6] Portuguese cultural advisor to the panel.
[7] https://respeito.org.uk/
[8] Replaced Martyn Parker.
[9] Attended to deputise for Head of Protecting Vulnerable People for Lincolnshire Police.
[10] Martyn Parker attended initial panel meetings.

Rebecca Pinder[11]	Safeguarding and Mortality Review Nurse	NHS Lincolnshire Clinical Commissioning Group
Karen Ratcliff	Service Manager	We Are With You[12]
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

3.2 The Panel Chair was satisfied that the members were independent and did not have operational and management involvement with the events under scrutiny.

[11] Representing GP Surgery.

[12] 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.

4. Chair and Author of the Overview Report

4.1 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.

4.2 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[13].

4.3 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.

4.4 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.

4.5 Neither of them has previously worked for any agency involved in this review. Carol Ellwood-Clarke was the Author of a previous Lincolnshire DHR[14]. Both have recently concluded a DHR[15] in Lincolnshire.

[13] https://safelives.org.uk/
[14] DHR2018L
[15] DHR2020G

5. Terms of reference

5.1 These were set as -

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)

5.2 **Specific Terms**

1. What indicators of domestic abuse, including coercive and controlling behaviour,[16] 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?

[16] 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).

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.

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?

5.3 Timescale

The review covers the period from 1 January 2016 to 9 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.

6. Summary Chronology

6.1 Helena

6.1.1 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'.

6.1.2 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.

6.2 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.

6.3 Helena and Rodrigo's relationship

6.3.1 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. 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."

6.3.2 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.

6.4 Events in 2016 and 2017

6.4.1 Throughout the time period of the review, Helena had contact with health professionals in relation to her heart condition include periods of engagement which focused on maternity care.

6.5 Events in 2018

6.5.1 Around the end of 2017 and early 2018, Helena was assaulted by Rodrigo and when she was around five months pregnant with her eldest child, Rodrigo had started to strangle her. These incidents were reported to the police in April 2020.

6.5.2 In September, Helena attended at hospital with a fracture to her finger and 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.

6.5.3 At the end of September, Rodrigo moved out of the property and Helena informed the DWP that her relationship had ended with Rodrigo.

6.6 Events in 2019

6.6.1 In May, Helena contacted the police, to report a domestic abuse incident involving Rodrigo. Their young child was present, and Helena was five months pregnant with their second child. When Police attended Helena disclosed a previous assault by Rodrigo, which had occurred two to three

years earlier. Helena stated that Rodrigo was using drugs and that he was becoming more controlling. Helena provided a statement. A DASH was recorded and graded as standard. The incident was not shared with other agencies. Rodrigo was not seen by the police.

6.6.2 In 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. 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.

6.6.3 In September and November Helena contacted the police to report Rodrigo missing. On both occasions Rodrigo returned home. Helena's friend told the Chair that these 'missing episodes' were controlling tactics of Rodrigo.

6.6.4 On 6 November Helena called the police and reported a domestic abuse incident. Helena reported that there had been an argument over finances, and that she suspected Rodrigo of spending money on drugs. 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. Helena also disclosed a previous assault two days earlier. (at various points during their relationship).

6.6.5 The police contacted Rodrigo, and he agreed to stay away from the house. A DASH was completed, and the incident risk assessed as medium. 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.

6.6.6 On 29 December, Helena called the police and reported that she had been assaulted by Rodrigo on 25 and 26 December. 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. Helena was provided with safety advice and 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.

6.7 Events in 2020

6.7.1 On 6 January, Children's Social Care screened the notification from the police about the December incident and requested additional information. The case was allocated to a social worker to undertake a Child and Family Assessment.

6.7.2 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. The social worker made several attempts to contact Rodrigo. However, all contact were unsuccessful.

6.7.3 On 24 January, the social worker informed the health visitor of the domestic abuse incidents. On 13 February, the Child and Family Assessment was closed.

6.7.4 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 and photographs of previous injuries that Helena alleged had been caused by Rodrigo. Information was also provided in relation to Rodrigo's alleged drug use, and that when Helena had spoken to Rodrigo about, he had assaulted her. 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.

6.7.5 On 28 March, Helena was assaulted by Rodrigo. The incident was not reported to the police until 8 April. During this incident Rodrigo had grabbed and twisted her arm behind her back, causing bruising, pushed her into a wardrobe, before pushing her onto the bed, where he climbed on top of her and put his arm across her neck to stop her breathing. This had left an imprint from the jumper that he was wearing on her skin. Helena told the police that, on this occasion, she thought he may kill her. The bruising had been seen by Helena's friend and family.

6.7.6 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 he had then thrown her onto the bed and climbed on top of her. During the assault, Rodrigo placed his arm across her throat, restricting her breathing. This left a bruise on her neck. As Rodrigo was leaving the property, he pushed the door back, trapping Helena between the door and the wall.

6.7.7 Rodrigo was arrested at lunchtime. 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 was made to MARAC.

6.7.8 Late afternoon, Helena telephoned the Children's Health Single Point of Access[17] (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.

6.7.9 In the early evening, Rodrigo was released from custody 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.

6.7.10 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.

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

7. Key issues arising from the review.

7.1 Helena was a victim of domestic abuse. Incidents of domestic abuse and risk increased over a period of time. The increase in these incidents, including the increase of risk was not referred to MARAC or discussed in a multi-agency forum.

7.2 With the exception of the last incident of domestic abuse, prior to Helena's death, there was no intervention or interaction with Rodrigo to address the abuse that he perpetrated.

7.3 Opportunities arose for the completion of a DASH to support other assessment processes taking place and identify the current risk and identify areas for further support and intervention.

7.4 Whilst legislation in relation to domestic abuse had changed since the timescales of this case, the changes that the legislation had introduced need to be embedded into practice.

7.5 Understanding cultural and language barriers will support Professionals in identification and engagement with victims and perpetrators of domestic abuse.

8. Conclusion

8.1 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.

8.2 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.

8.3 Helena and Rodrigo had been in a relationship for since 2016, 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.

8.4 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.

8.5 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.

8.6 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.

8.7 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. These areas of learning have been addressed through relevant recommendations.

8.8 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'.

8.9 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.

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

9. Learning

9.1 The DHR panel identified the following learning. Each point is preceded by a narrative which seeks to set the context within which the learning sits. Where 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.

9.2 Agencies Learning

9.2.1 <u>EMAS</u>

- Recording of names of other people present in the home and consider any risk they may pose.

Action taken to address this learning –

- 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.

9.2.2 GP Surgery

- Practitioners must consider the impact of additional health problems on the wider family, in addition to the individual.
- Importance of professional curiosity and risk assessment to ensure the correct services are available to support an individual and/or wider family.

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.

9.2.3 Lincolnshire County Council Children's Services

- Timeliness of contact with a victim and children by the health visiting service following receipt of information related to domestic abuse.
- Importance of completion of a DASH at the point of initial contact when domestic abuse is identified.
- 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.
- Every effort should be made to facilitate fathers/other significant carers to contribute to the assessment and child & family progress plan.
- Children's Services to consider an internal process for the sharing of domestic abuse notifications with children's health.

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.

9.2.4 Lincolnshire Police

- Consideration of DVPN/DVPO and DVDS.
- Referrals to partners agencies, such as EDAN Lincs
- Recording on police systems.

Action taken to address this learning –

- Inclusion in training programmes.
- Introduction of DVDS action plan which focused on delivering training to 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.
- Training delivered has seen increase by over 600% to partner agencies.

9.3.5 Nottingham University Hospital

- Use of 'routine enquiry'.

Actions taken to address this learning -

- Learning disseminated at completion of review process to health professionals.

10. RECOMMENDATIONS

10.1 Panel and Agency Recommendations

10.1.1 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.

10.1.2 Agency Recommendations

Lincolnshire Police

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