Domestic Abuse Related Death Review

Executive Summary

Cambridge

Ava

Born: November 1984

Died: January 2024

Chair and Author: Christian Brazier

Date of completion: 7th June 2025

Glossary of Terms

Acronym	Name
ACMHS	Adult Community Mental Health Service
CIN	Child In Need
CGL	Change, Grow, Live (drug and alcohol support)
CPFT	Cambridgeshire and Peterborough Foundation Trust[1]
CPP	Child Protection Plan
CSC	Children's Social Services
DA	Domestic Abuse
DASH	Domestic Abuse Stalking and Harassment Risk Assessment
DARDR	Domestic Abuse Related Death Review
DARAC	Domestic Abuse Risk Assessment for Children
DVPN	Domestic Violence Prevention Notice
DVPO	Domestic Violence Prevention Order
EH(W)	Early Help (Worker)[1]
FGC	Family Group Conference
IDVA	Independent Domestic Violence Advisor
IGVA	Independent Gender Violence Advocate
MASH	Multi Agency Safeguarding Hub
MARAC	Multi Agency Risk Assessment Conference
NCD	Non Crime Domestic
OCD	Obsessive Compulsive Disorder
PCMHS	Primary Care Mental Health Service
PNC	Police National Computer
PNMHT	Perinatal Mental Health Team
SDAC	Specialist Domestic Abuse Court
SPA	Single Point of Access[1]
SOP	Standard Operating Procedures
SWKR	Social Worker
TAC	Team Around the Child
TAF	Team Around the Family
UC	Universal Credit

[1] Home | CPFT NHS Trust The CPFT deliver many of the NHS services that are provided outside of hospital and in the community, such as physical and mental health, and specialist services - About us | CPFT NHS Trust

DARDR EXECUTIVE SUMMARY INTO THE DEATH OF AVA – JANUARY 2024

Preface

The author and panel wish to express their deepest condolences to Ava's family and friends. Ava was clearly a loved individual and will be missed by many. The author and panel also wish to express their thanks to those family and friends who contributed to the review and gave insight into Ava's life and personality.

Introduction

1.1 Domestic Homicide Reviews (DHRs), or as is being transitioned to, Domestic Abuse Related Death Reviews (DARDR)[2] came into force on the 13th April 2011. For the purposes of this review the acronym DARDR will be used. The panel felt this more accurately reflected the circumstances. They were established on a statutory basis under Section 9 of the Domestic Violence, Crime and Victims Act (2004). The Act states that a DARDR should be a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by-

(a) A person to whom she was related or with whom she was or had been in an intimate personal relationship or

(b) A member of the same household as herself; with a view to identifying the lessons to be learnt from the death.

1.2 Within Section 18 of the 2016 Multi Agency Statutory Guidance for the Conduct of DARDRs, provision was made for reviews to be conducted:

"Where a victim took their own life (suicide) and the circumstances give rise to concern, for example it emerges that there was coercive controlling behaviour in the relationship, a review should be undertaken, even if a suspect is not charged with an offence or they are tried and acquitted. Reviews are not about who is culpable." [3]

1.3 The purpose of a DARDR 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.

[2] The acronym DARDR will predominantly be used for this review as it better reflects the circumstances.
[3] DHR-Statutory-Guidance-161206.pdf (publishing.service.gov.uk)

- 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 policies and procedures as appropriate; and identify what needs to change in order to reduce the risk of such tragedies happening in the future to prevent domestic homicide and improve service responses for all domestic violence victims and their children through improved intra- and inter-agency working.

1.4 This DARDR examines the circumstances leading up to the death of Ava who died in January 2024 after entering a coma in October 2023. Domestic abuse was known by agencies throughout her relationship with Len with a serious domestic abuse incident occurring just prior to Ava entering a coma following a drugs overdose. The decision to undertake the review was made by the South Cambridgeshire Community Safety Partnership on 25th July 2024 having been notified of her death the day before. The Home Office were duly informed. An Independent Chair was appointed on 22nd August 2024.The Panel met for the first on 26th September 2024 where relevant IMRs (Individual Management Reviews) were requested. There were further meetings of the panel online on:

Panel Meeting 2	-	11th February 2025
Panel Meeting 3	-	28th March 2025
Panel Meeting 4	-	19th May 2025

2 Overview and Summary

Persons involved in this DHR:

Name	**Relationship**	**Age at time of Ava's death**	**Ethnicity**
Ava	Subject of Review	39	White British
Len	Partner at time of death	36	White British
Julian	Child of Len and Ava	2 years 2 months	White British
Seb	Ex-partner and father of Kyron	unknown	Unknown
Kyron	Ava and Seb's son	14	White British

All names are pseudonyms, with Ava's name chosen by the chair and confirmed with Ava's mother. The children have had names chosen for them so as to connect the reader with them. Pseudonyms may or may not be representative of their birth sex. 9

Overview:

Summary of the case

Background prior to scoping period

The scoping period chosen for this review was Nov 2018 to Jan 2024, when Ava died. Initial information suggested this was when Len and Ava began their relationship. However, information provided to the review suggested there was a significant, relevant history prior to this. This contained incidents of Ava self-harming, suicidal ideation, domestic abuse involving Ava and her ex partners, alcohol use and child safeguarding concerns in relation to Ava's first child Kyron.

Kyron, Ava's first born, initially became known to Children's Social Care briefly in June 2010 following a report of domestic abuse where both parents had been drinking alcohol and an argument escalated to violence, allegedly from Seb, Kyron's father, towards Ava. Police were called but after investigation, no further action was taken and the Social Care assessment was closed soon afterwards.

There was then a period with no known agency involvement until October 2014 when Kyron would have been approximately 4 years old. Social Care assessed Kyron's welfare after receiving concerns relating to *"volatile behaviour between the parents"* exacerbated by alcohol use. Ava's mental health was cited as a concern with one particularly traumatic incident when she allegedly attempted to hang herself upstairs with Kyron in the home. Some of Ava's alcohol fuelled behaviour towards other adults was reportedly frightening and aggressive and witnessed by her son and other children. The culmination of these and other factors resulted in a decision for Kyron to be made subject to a child protection plan from 4th November 2014 – 1st July 2015.

When Ava separated from Seb in October 2015 there appeared to be a further deterioration in her mental health and an escalation in her alcohol use. Further aggressive behaviour from Ava towards others was recorded. She was admitted to hospital in October 2015 after overdosing on prescribed anti-depressants. She reported no intent to take her life when a suicide risk assessment was conducted. Here she had contact with the Liaison Psychiatry Service (LPS) within the hospital and subsequently further support from the GP. Medication was prescribed to help alleviate low mood.

Kyron came off the child protection plan in July 2015, but ongoing concerns resulted in a return to a protection plan in February 2016.

Kyron was more permanently removed from Ava's care by his father in July 2016, a transition supported by Children's Social Care. This appears to coincide with Ava having increased contact with the Police. She was arrested in September 2016 due to

domestic abuse where she was reportedly the aggressor. Her arrests increased in frequency after this with aggressive incidents fuelled by alcohol being a significant pattern.

In March 2017 it appears life had deteriorated further as Ava was assessed by the Dual Diagnosis Street Homeless Team. She agreed to re-engage with alcohol services and address her drinking. The assessment conducted by this team recorded Ava was both "the victim and perpetrator of domestic abuse". In the same month hospital staff witnessed Ava "hit her partner repeatedly in the head" with him hitting her aswell.

Ava became well known to MARAC[4] (Multi Agency Risk Assessment Conference) for the high risk / high harm nature of the domestic abuse. She was heard predominantly as the primary perpetrator of the abuse. These discussions related to a new partner who was reportedly extremely violent to Ava and subjected her to severe physical abuse. Dates her situation was discussed are below and give a sense of how frequent her and her partner were coming to the attention of services.

- 06/09/2016
- 11/11/2016
- 11/04/2017
- 20/04/2017
- 30/06/2017
- 21/09/2017
- 29/09/2017
- 21/02/2018

In February 2018 Ava's father reported she had attended his address when drunk. He said she had been verbally abusive and had been banging on the door demanding to be let inside. He said he did not want her to risk being homeless and was aware she was being abused by her current partner at the time.

In March 2018 Ava was assessed again by the Liaison Psychiatry Service (LPS) after presenting with abdominal pain and vomiting. She said she had been reducing her alcohol intake and had previously consumed alcohol with her ex-partner but he had recently gone to prison. This assessment commented on Ava's difficulty in acknowledging the serious nature of the domestic abuse and she declined support from an IDVA service. Ava reportedly wanted to be discharged quickly to focus on housing matters.

[4] What is a MARAC?.

The child protection plan ended for a second time in April 2018. At this point Ava was having contact with Kyron at her mother's house.

After receiving agency reports for this review, it is now believed Ava and Len began a relationship in June 2018, several months earlier than the agreed scoping period. In late June, Probation, whom Len was on license with for an unrelated assault, were informed he was in said relationship. They received information that his partner was likely to be living in all female accommodation after police had been contacted to advise Len was hiding under her bed. Ava had spoken to staff and showed them a note which said someone was under her bed. She had also spoken to residents about being fearful of her partner although it is believed she meant her ex partner who was due to be coming out of prison a week later. Records from the housing provider have been seen as part of this review and it remains difficult to accurately analyse these circumstances. What is clear is Ava had experienced extensive domestic abuse by this point, was highly fearful of her ex and was getting into confrontations with other residents. The contributed to her eventual eviction in early October 2018.

Around the same time, Police received a report of a male attacking a female at a women-only accommodation in the city area. Police were told Ava had been doing some clothes washing there for Len who was homeless. They had met in a nearby street earlier, argued, and he had insisted on coming into the accommodation which was not allowed. Ava said he had grabbed her around the throat before she was able to escape and run towards her accommodation. He had run after her and pushed her into the doorway. Ava had been able to shut herself in a bathroom and asked another resident to call the police. When police arrived, Ava said she did not want to make a statement but said she'd known Len for about six months. She said they were just friends. She said he was suffering from withdrawal due to a change in his prescribed medication. Despite Ava not wanting to make an official statement, Len was arrested. However, no third-party evidence was identified by police and so no further action was taken.

A few days later in the early hours of 12th October 2018, the Police received a third party report of a male slapping a female in the face. He allegedly said, *"see what you made me do"* and demanded sex from her. When Police arrived, they saw Len and Ava standing outside of the public toilets, the same location the witness had cited. Police noticed a slight cut at the top of Ava's forehead which she said was self-inflicted. Police noted they were intoxicated through drink and / or drugs. Ava said she had been 'kicked out' from her home and was homeless. This appears accurate as records indicate she had been evicted on 10th October 2018. She said they'd argued as she was panicking about her housing situation and Len had grabbed her to try to calm her down. She denied she'd been assaulted. Despite this, police arrested Len on suspicion of assault. This was his second arrest within the space of six days for assaulting Ava. Due to a lack of evidence there was no further enforcement action.

Summary Chronology

The scoping period agreed at panel began in November 2018. At this time, several services were involved Len and Ava. Probation and CGL with Len, CPFT Dual Diagnosis Street Team[5] and CGL for Ava. Probation and CGL held a joint appointment with Len in late 2019 in which CGL expressed concern for him. They mentioned they had witnessed controlling behaviour from Ava towards him such as Ava answering his phone, refusing to let CGL speak to him and limiting his access to his phone. Len had previously told them Ava "belittled" him.

Another assault was recorded by the police in early December where Len was seen by a member of the public allegedly punching Ava in the face. Len was arrested but due to evidential difficulties this did not lead to a charge. At the same time, he was arrested for five theft related offences. This alleged assault did result in a referral to MARAC[6] with this meeting taking place on 23rd January 2019. Within this, Len's previous offending was disclosed which included alleged use of non-fatal strangulation, a propensity for violence (predominantly outside of relationships), acquisitive crime, numerous drug class A drug offences and a disregard for control measures such as a previous breach of a restraining order. After several attempts, IDVA (Independent Domestic Violence Advisor) spoke to Ava who she said there has not been any domestic abuse in their relationship and she declined further support.

Over the following months Ava encountered services such as the GP, Police, Liaison Psychiatry Service (LPS) at the hospital and the ambulance service. On one occasion she was tended to by the ambulance after being found unconscious and intoxicated. After a night's sleep and treatment for alcohol withdrawal she said life had been difficult in relation to ongoing struggles to find accommodation. She reported an increase in alcohol intake and said she thought about wanting to end her life because she felt she had let her son Kyron down. When discussing domestic abuse she said she had been assaulted numerous times by her ex but her current partner did not hurt her in any way. To the assessor, she appeared focussed on her future and agreed to support from CGL for alcohol use and mental health support. The nurse provided support to find a local night shelter and she was prescribed anti-depressants.

Throughout 2019 Len had periods both in prison and in the community. These were predominantly due to theft offences and non-compliance with his probation order. Probation reported he was either not attending his appointments or being aggressive if he did. During this time, domestic abuse risk was not accurately assessed. Old

[5] Service detail | CPFT NHS Trust
[6] Learn more about the Marac - SafeLives

assessments were pulled through on Probation's internal system and not accurately updated.

In mid / late 2019 Ava had several more interactions with ambulance and hospital services due to concerns for her physical wellbeing after potential drug overdoses. On one occasion she said she had been forcibly injected with heroin by an ex partner. At this time Len was in prison and the identity of this person remains unknown.

Family, who had been trying to support Ava throughout 2019, called the mental health line for advice in late October. Ava had reportedly been threatening to cut her hair off so they'd needed to remove scissors from her. Ava spoke to the call taker over the phone and said she was hearing a buzzing tone which she described as "like the devil". She said she wanted to take a heroin overdose and stand infront of a train. She also said she was having panic attacks and headaches, her body was aching, she was experiencing shaking and blurry vision with "random sparkles". When it was queried whether it could drug or alcohol related she became agitated. She said she had abstained from drugs for three weeks while at her father's but had been drinking which she did not find strong enough.

Following this, Ava attended the hospital accompanied by her stepmother. During her assessment she said she had fleeting thoughts of suicide and felt like she didn't want to wake up every day. She said there had been recent tensions due to Kyron's dad making changes to the child contact arrangements. The assessor felt Ava showed insight into her mental health and the need to seek help, but struggled to understand the negative impact of alcohol or the reason it would be beneficial to engage consistently with alcohol services. She was asked directly about her experiences of domestic abuse and the assessor felt she 'played down the significance'; "just a bit of slapping around, not really serious". The assessor could see from medical records the previous assaults were serious and deemed her as highly vulnerable and at risk. A plan was made following her discharge for her to see CGL and a mental health crisis plan was written. More than one referral was made to adult social care in 2019, but these did not result in any intervention as Ava was deemed not to have any care and support needs.

It is clear the relationship between Len and Ava was continuing to some degree as in November 2019 she was arrested after being seen to pass what was suspected to be an illicit substance to Len during a prison visit. Despite investigations, the substance could not be identified.

In late December, Ava was found unresponsive in the street due to a suspected heroin overdose. She was given naloxone and recovered. A man described as her boyfriend called the hospital to ask to be updated when she was ready to leave. This man was not

Len. Ava disclosed feeling high levels of anxiety in the lead up to a court case in relation to her son Kyron.

Ava was recorded as engaging positively with CGL in early 2020, attending group work and showing a willingness to address her substance use. This engagement tailed off in February 2020 with it becoming increasingly difficult to maintain communication. It is unknown why.

The UK went into lockdown due to the Covid pandemic in March 2020. A month later Len was released from prison. Soon after this he disclosed injecting two bags of heroin a day to Probation.

Ava and Len appeared to continue their relationship as in June 2020 they were evicted from housing due to Len allegedly stealing a bike. At around the same time Ava told CGL she was using crack cocaine and heroin. She showed a want to reduce and stop as she asked CGL to place her on a script and support her with finding permanent housing. By late July 2020 CGL recorded Ava sounding more positive and intent on moving out of the city centre with Len to avoid associates involved in drugs. By this point Len had returned to prison and she was unsure when he would be out. She commented that she felt the break would be good for them.

There is a lack of information with regards to Ava over the next few months with the only available information indicating she may have been struggling. She missed script collections and had been arrested by the police for shoplifting.

Len was released from prison in December 2020 and was soon evicted from his accommodation for aggressive behaviour and having a female guest staying which was against the tenancy agreement. It is suspected this was Ava due to disclosures she made to agencies about her movements.

In early March 2021 Ava attended her GP surgery and disclosed being 7 weeks pregnant which she was happy about. She confirmed she had been in a relationship with Len for “about 4 years”, was free of drugs, engaging regularly with CGL, drinking one cider per day and smoking tobacco. She consented to a referral to the specialist midwife and contacted them soon afterwards.

Due to the history and concerns around the wellbeing of the unborn baby, a strategy meeting was held later that March. The outcome was for a Section 47 enquiry[7] to begin. Following assessment, it was agreed for the case to progress to an ICPC (Initial Child

[7] Section 47 Enquiry

Protection Conference) in early April 2021 where a Child Protection Plan was implemented due to the significant risk of neglect. This was due to the recent history of drug use, domestic abuse concerns and mental health issues.

Ava attended the GP in May 2021 to gain support for her mental health. She was referred to the primary care mental health service to assess her needs but several weeks later, this service closed her referral after they called her, a male picked up her phone, and Ava then told them she no longer required this support. Given the services involved with Ava, this was a missed opportunity to engage her in much needed mental health input.

Both Ava and Len reportedly engaged well with maternity services, attending groups and engaging positively with birth classes. This engagement appeared at odds with other information, particularly around drug and alcohol use with Ava reportedly seen drinking before a child protection conference and Len becoming frustrated with having to collect his script weekly. The GP noted controlling traits from him aswell as various cancelled or non-attended appointments.

Following Julian's birth in October 2021 there were concerns noted from the midwife who felt both parents were over-focused on their Methadone script with Ava saying she had taken some of Len's prescription. They reported their methadone had gone missing. CGL liaised with a doctor due to concerns around alcohol withdrawal and honesty.

The couple's engagement with CGL continued to be challenging throughout 2021 although some reduction in drug use was noted. Concerns began to mount in late 2021 / early 2022 as several appointments were missed such as:

- hepatology for Ava's Hep C treatment
- Neonatal appointment
- Paediatric appointment

Despite these missed appointments, a Review Child Protection Conference in February 2022, it was agreed for the case down early to CIN (Child In Need) due to "positive progress". Social Care have reflected how overly optimistic this seemed given the circumstances.

Having been in a caravan up till this time, the couple moved into more permanent accommodation in late Feb 2022. A month later the provider contacted Social Care as Ava had a black eye. Alternative stories were given for how this occurred but ultimately it was accepted this was not domestic abuse and had been an accident. There was a lack of reflection on the history and patterns at this juncture. The main concerns noted at this time were related to Ava's anxiety, depression and panic attacks which she disclosed to a health visitor.

In an apparent attempt to address domestic abuse concerns, one healthy relationship session was conducted in June 2022 by Social Care. The parents felt they did not require this and stopped. Given the MARAC and domestic abuse history this would not have been a thorough enough or appropriate intervention. Ava was also requested to complete an online course for female perpetrators of domestic abuse. Again, this request did not accurately reflect the need. This could have potentially lead to Ava thinking she was completely at fault for relationship problems and Len thinking he had no issues to address. This could have exacerbated the domestic abuse further although there is no evidence of it doing so on this occasion.

In July 2022 there was a further decrease in monitoring as the case stepped down from Child In Need to Early Help. It is noted how there were several different social workers around this time which may well have impacted on consistency of approach and a thorough understanding of the history. Regardless, there is no evidence of the family engaging in Early Help processes.

In early August 2022 police became involved again as Len reported Ava had 'smashed a can of stella around his head' causing a cut to his left cheek and Ava had put out a cigarette on the back of his neck. He said Ava was trying to take the baby "aggressively" and he was attempting to stop her due to her intoxication. A further police call was made a week later by him due to Ava's "aggressive behaviour". Infact, Len is the only one of the couple to contact the police between this point and October 2023.

Also in August 2022 the Service Manager at the couple's accommodation sent an e-mail to the Social Worker detailing their concerns for the family such as money management, lack of food, the "chaotic" behaviours of both parents and the combined impact on their son. They said Ava had received a verbal and written warning from housing regarding her use of "language, shouting and screaming".

Several weeks later, in response to these concerns, a limited Social Care assessment (as acknowledged within this review) concluded a Child In Need plan would be sufficient to address them. However, concerns escalated over the next few days with Len being assessed as 16 on the DASH (risk assessment) and offered refuge for himself and Julian which he declined. It is noted Safelives guidance is for a case to be heard at MARAC if it scores 14+ and the threshold of 17+ is local policy. Following more escalation over the next 24 – 48 hours, Julian was removed and placed with a paternal aunt temporarily.

Julian would not return to his parent's care. Contact was held in a contact centre until the final court decision in September 2023. Prior to this, Ava had shown progress with CGL and appeared to be gaining some positive results around a reduction in alcohol use. She came off her opioid substitute treatment and continued to accept 1:1 support. This is relevant as Ava's tolerance levels would likely have been lower due to the efforts she was making to reduce her drug and alcohol use.

The day after the court made their final decision for Julian not to return, Len assaulted Ava after arguing in the street. He was prosecuted due to CCTV and other available evidence. This was not heard at the local domestic abuse court which has been analysed in depth in the full report. This was due to the domestic abuse court not being available on the day he appeared at court. For this offence he received a fine and no orders were made.

In early October, Len was arrested again for allegedly strangling Ava, punching her and threatening to burn the house down. He was given bail conditions not to contact her. He breached these the following day by attending her house. Len stated Ava had asked him to come and he was worried she was going to overdose. Ultimately Len was not convicted of any of this offences.

The day after this, Ava entered a coma after either injecting or being injected with heroin. She would remain in this coma until she died in early January 2024.

3. Parallel reviews

The Coroner waited for the conclusion of this review to commence proceedings.

Other than those mentioned within the chronology there were no further domestic abuse related investigations from the police.

4. Domestic Abuse Related Death Review Panel

The following agencies and individuals were on the DARDR panel:

Name	Organisation	Job Title
Vickie Crompton	Cambridgeshire and Peterborough Domestic Abuse & Sexual Violence Partnership	DASV Partnership Manager
Christian Brazier	Independent	Independent Chair and Author
Lisa Watson	CGL	Designated Safeguarding & MASH Lead
Agata Ciesielska	NPS	Senior Probation Officer
Kathryn Hawkes	Communities Manager	South Cambridgeshire District Council (accountable body for South Cams CSP)
Heather Wood	South Cambridgeshire District Council	Housing Advice and Options Service Manager
Liz Clarke	Children's Services	Service Director for quality assurance and practise improvement
Linda Katte	ICB – Primary Care	Deputy Designated Safeguarding People/MCA Lead
Ellie Nicholson	Hospital	Named midwife for safeguarding

Sarah Cowan	Impakt	Head of Domestic Abuse
Susie Talbot	Cambridgeshire Public Health Team	
Julia Cullum	Cambridgeshire and Peterborough Domestic Abuse & Sexual Violence Partnership	Interim Head of Domestic Abuse Sexual Violence
Tom Rowe	Cambridgeshire Police	Detective Chief Inspector
Tracy Brown	Cambridge University Hospitals	Adult Safeguarding Lead

None of the representatives at the panel, nor authors of the IMRs, had any direct involvement with the family and were independent.

5. Independence

This review is chaired and authored by Christian Brazier. He is independent of all statutory and non-statutory services of Cambridgeshire Council and has never had contact with the family prior to this review.

Christian worked in frontline practice within the Police, Family Intervention and Domestic Abuse sectors for nearly 15 years. In 2016, he specialised in domestic abuse perpetrator interventions working within medium and high risk domestic abuse perpetrator projects as a Skills Enhancer and Deputy Manager. Following this he worked for the national domestic abuse organisation Respect as a Drive Practice Advisor - high risk domestic abuse intervention, and later as a Make A Change practice lead - an early intervention domestic abuse intervention. Here he created tools and workshops for friends, family and colleagues who might be concerned about people using harmful behaviour towards their loved ones. He is an associate trainer for the national domestic abuse charity Safelives facilitating their high harm perpetrators and MARAC sessions as well as their Engaging Those Who Use Harm training. Christian attended the Advocacy After Fatal Domestic Abuse Chair's Training in January 2023 and completed the Home Office Domestic Abuse Related Death Review Chair's Training in September 2024. He qualified as a journalist in 2013.

6. Terms of Reference and Scope

During the initial panel meeting the panel decided to explore agency involvement with Len and Ava from 1st November 2018 (approximate date of first police report) to date of death 6th January 2024. Agencies were tasked with providing a chronology of their involvement between this time. As mentioned, information latterly confirmed the couple had known each other for several months prior to this.

Early discussions centred on what the panel wanted to focus on and learn. Key lines of enquiry were agreed upon as being of particular importance to explore as below:

- To understand what was known of the domestic abuse between Ava and Len and how effective multi agency forums were in addressing this.

- To explore how agencies worked together to analyse domestic abuse, share information and offer appropriate interventions.

- To understand how mental health, drugs / alcohol use and domestic abuse were addressed.

- To explore what support was provided to Ava before, during and after the removal of Julian.

A full terms of reference can be found in Appendix A.

7. Confidentiality and dissemination

The findings of each review are confidential until such a time as the review has been approved for publication by the Home Office. Ava's mother was provided a draft copy of the review but, aside from this, information was available only to participating professionals and their line managers. The chair gave a presentation to the local Community Safety Partnership Board on 7th June 2025 prior to submission to the Home Office.

8. Methodology

The following agencies confirmed that they had had relevant, significant contact with either Ava (victim), Len (alleged perpetrator) or Julian (child), and therefore were asked to undertake Independent Management Reviews (IMR). These were:

- Children's Social Care
- Police
- CGL (Change, Grow, Live – Drug and Alcohol)
- GP
- Housing Advice and Options Service
- Probation
- Sanctuary Housing
- IDVA Service

Short reports were requested from:

- Health Visiting
- Midwifery
- Ambulance Service

The CPFT and DWP sent in scoping information at the beginning of the review process. It was not deemed necessary to request a report from them initially. Regarding the CPFT, towards the end of the review it was clear there were discrepancies around whether perinatal mental health support was or was not referred to and additional information was requested from this team.

Following receipt of further information, contact was made with Cyrenians Housing Project to gain some insight into their involvement in late 2018.

This executive summary and the full report are anthologies of information and facts gathered from:

- The Individual Management Reviews (IMRs)
- DHR Panel discussions
- Information from Ava's mother.

Involvement of family, friends, colleagues, neighbours and wider community.

The chair sought to locate family and friends who were willing to shed light on the situation, give their perspective and provide insight into Ava and her life.

Contribution from Ava's mother Tracey

Tracey described Ava as a beautiful soul and a caring mum who adored both her children. She described her childhood with her little brother (5 years younger) as a happy one with many family holidays in the UK and abroad and fond memories of times with extended family and friends. She described an outwardly happy family life with hobbies such as horse riding being a particular love of her daughter's. But behind closed doors there was abusive behaviour experienced by Ava's mother from her father. This consisted of alleged controlling behaviour but also of alcohol fuelled physical abuse which culminated in Tracey being assaulted by her then husband, him setting her car on fire and being arrested. Subsequently Tracey left the family home. This was when Ava was 17. Upon hearing something had happened between her parents Ava reportedly said, "He's done it again hasn't he?" indicating this was not an isolated incident and she had been aware of previous abuse. For Tracey, this was not her only experience of domestic violence as her father had also been abusive to her mother (Ava's grandparents).

After this, Ava and her brother stayed with their father and visited Tracey. Their relationship was positive until Tracey began a new relationship and Ava struggled to accept her mother's new partner.

Tracey said Ava had been in intimate relationships prior to Len. She was reportedly bitten by her first partner who may well have had mental health concerns as he, to Tracey's knowledge, ended his life a few years prior to this review. Ava had signed up to attend beauty college after leaving school but withdrew after beginning a relationship with an older man who left her to return to Wales. She eventually left home when she was 20 years old to move in with her partner Seb who would later be the father of her first child Kyron. Although Tracey did not believe this to be a physically abusive relationship Tracey felt there were some controlling elements with Ava feeling pressured not to work or being bought clothes to wear rather than choosing her own wardrobe. Ava was happy to have a child but this appears to be when concerns about her alcohol use first began. Tracey suggested boredom may have been a contributing factor. Alcohol consumption soon became detrimental and social services investigated, in part, due to the impact of her alcohol use on the care of Kyron aswell as a disclosure she had tried to hang herself.

Tracey described Ava's character when she'd had a drink as Jekyll and Hyde. When she wasn't drinking she was the same beautiful soul she had always known but she could become aggressive and say hurtful, abusive things when she had drunk. Her father was reportedly the only person in the family able to calm her down as he was "direct with her". But he was also described as mentally abusive towards Ava and having a very different relationship with her to that of her brother.

Ava's behaviour when under the influence of alcohol was clearly unsettling for her son Kyron as when Tracey would take him for contact with his mum he would present as worried and not wanting to be in her sole care if she'd been drinking. Ava struggled to address her alcohol use and allegedly asked a friend to provide a urine sample so she could continue to see her son.

Tracey felt Ava could feel very jealous and insecure in relationships, always wanting to know where her partner was and ensure they weren't with other women. She lacked confidence in herself and Tracey felt it had been knocked out of her by various abusive men.

Ava's difficulties with alcohol consumption continued after social care's assessment for Kyron to remain with his father Seb. Aswell as the relationship difficulties, she faced financial and housing precarity due to not paying the rent in one particular house and was therefore evicted. Her next relationship was particularly violent and alcohol fuelled and Tracey worried she could have been killed had they remained together.

Then Ava met Len. She had originally been staying in a women's only accommodation but had to leave after Len attended. She reportedly said he made her feel safe. Tracey found it difficult to describe Len but said he was sly and manipulative and that he used drugs which Ava would not have been into prior to meeting him. Tracey would often be present when they were together and would witness them "bicker and argue". He would

not let people finish their sentences which would serve to continue the arguments between them. He would often be shouting and Tracey recalled being present on a Social Care meeting where Len was shouting through the door.

Social services involvement with Len, Ava and their son Julian was particularly noteworthy as Tracey said they had seen 29 Social Workers in total. She felt the social care staff tried their best but did not think they had the necessary training to work with a couple such as Len and Ava. Often, they were seen together which did not work due to the aforementioned communication issues. Tracey felt Ava never got the mental health support nor the diagnosis she needed. When she did try to get support in May / June 2023 she was reportedly told mental health services did not have "the capacity" to support her. This was a phrase Tracey posited must be true as it was professional speak and not something Ava would say.

Tracey described many times how the family had tried to support Ava, from housing her but Ava "smashed their house up", to times when she was missing and the whole family were out looking for her across Cambridgeshire. It is clear the family continued to care greatly for her right up until the end of her life, but were contending with a complex set of circumstances involving mental health concerns, alcohol and drug use and domestic abuse. Ava's own behaviour could be aggressive when she had consumed alcohol and required police intervention on more than one occasion. From childhood Ava often found it difficult to accept a situation when she didn't get her own way. But this did not detract from her sober moments where she was loving, caring and the beautiful soul she was.

Meeting with Len (Ava's ex partner)

Len met with the chair in early June 2025 whilst in custody for unrelated offending. He described a difficult childhood where his father left the family when he was 10 years old and his mother had severe drug and alcohol difficulties. This lead to him being in and out of the care system as a child. He described his male role models as 'hard men', adults involved in crime who encouraged Len to follow this route. He spoke of his ADHD and OCD. He did not feel he wanted ADHD medication and viewed it as part of his identity. He also described having borderline personality disorder, depression and anxiety for which he had had some therapy in the past but felt he had learned as much as he could from it.

Len spoke of his relationship with Ava as having good times and described going on dates in the early stages of the relationship. He said where they argued, it would often be about money. He described coming off of Class A drugs as Ava was starting to increase her own use. Len said he stayed in the relationship because he loved Ava and when she became pregnant, he felt the prospect of having a family unit was something meaningful for them both and something he had not experienced himself. He felt they could both live drug and drink free and said they were close to doing so but couldn't sustain the necessary changes as a couple. Len said he was aware of the potential for

Ava to overdose and was concerned it could happen. He said when the final court decision was made for Julian to be permanently removed from their care Ava lost hope. Len said he tried to convince her they could still work to see Julian over the coming years but she would say "he's gone, it's too late".

Len also described his own belief system as someone who doesn't believe in being a grass. This may be pertinent when considering someone's internal drivers for engagement and change.

9. Equality and diversity

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

- Age
- Disability
- Gender reassignment
- Sex
- Sexual orientation
- Marriage and civil partnership
- Pregnancy and maternity
- Race
- Religion or belief

Those considered relevant to this review are:

Sex - In considering the above characteristics sex was a significant factor. Domestic abuse and domestic homicide are crimes that disproportionately affect women. Women make up the majority of victims and with the majority of perpetrators being male. For the year ending March 2024, the Crime Survey for England and Wales (CSEW) estimated that out of 2,307,000 people who experienced domestic abuse, 1.4 million women and 751,000 men aged 16 years and over experienced domestic abuse in the last year. This is a prevalence rate of approximately 6 in 100 women and 3 in 100 men. [i] This fact does not diminish the importance of addressing same sex domestic abuse, familial abuse or any other form of domestic abuse but is important to consider and is relevant to this review.

Furthermore, in a review of the 32 published Domestic Homicide Reviews (DHRs) where a victim had taken their own life, 25 of the 32 victims were female.[ii]

Pregnancy and maternity – During the scoping period Ava gave birth to Julian. This was a birth she was happy about but, having previously lost custody of a child through child protection processes, she was highly anxious about losing another. This is a key element of this review and one which has been explored in depth. It is known that pregnancy and birth of a child can increase the risk of domestic abuse, in part as the victim's attentions can be taken away from the perpetrator triggering jealousy. But this did not appear to apply in this case, from the evidence gained. There were deeper layers

with Ava having previously lost custody of a child and so was extremely anxious for history not to repeat itself. This will have change the dynamic between Len and Ava with Len, at times appearing to be the protective parent to the network, something which would have significantly impacted on Ava's anxiety levels.

10. Conclusions

Ava experienced domestic abuse throughout much of her life and sadly this continued up to the moment she entered a coma. Len, in comparison to her previous intimate relationships, may have appeared a safer, more caring partner but there is still significant evidence of domestic abuse, especially in the early stages of the relationship when the couple met the threshold and were subsequently heard at the local MARAC, a high harm, high risk multi agency forum share information and identify safeguarding actions. The earliest police report in relation to both Ava and Len (June 2018), highlighted how he had allegedly attempted to protect her from her previous partner who was known to be extremely violent. This may have contributed to her feeling he was going to protect and support her.

The review has heard how Ava could be aggressive to staff, friends and family, predominantly when she drank alcohol. This is certainly not the whole of Ava but it is a significant factor when considering the complexities services were witnessing and behaviours being reported. This was one of the elements which lead to Julian being removed from his parent's care in November 2022. Accommodation staff had received numerous reports and directly witnessed Ava using aggressive and abusive language. Her alcohol, drug use and behaviour when drinking was an ongoing battle for her as evidenced within the chronology. The review also heard how she had previously had a child removed from her care and placed into her ex-partner's, a move supported by children's social care. Ava was fearful of losing her second child in similar circumstances. Additionally, Len was known to have a long history of dishonesty based offences with consistent breaches of orders aswell as his own drug and alcohol concerns and stints in custody. This combination:

- Evidence of dishonesty with services
- Drug and alcohol use
- Previous loss of child to the care system
- Previous experience of domestic abuse

is a reminder for services to analyse all available evidence, step back and consider what is going on under the surface. It would have been extremely hard to see underneath the behaviours being presented. This is the key learning of this review, the need for services to 'Stop and Think', take a step back and communicate with each other with a domestic abuse lense. Services should consider use of a domestic abuse chronology which

includes any periods in prison, previous history of domestic abuse, evidence of abuse in the relationship and analyse it's use (e.g possible intentions of the behaviour). Consideration of inviting a domestic abuse professional should be considered to support such a consultation. This review has seen a limited understanding of the domestic abuse dynamic but also a confused picture of next actions. For example:

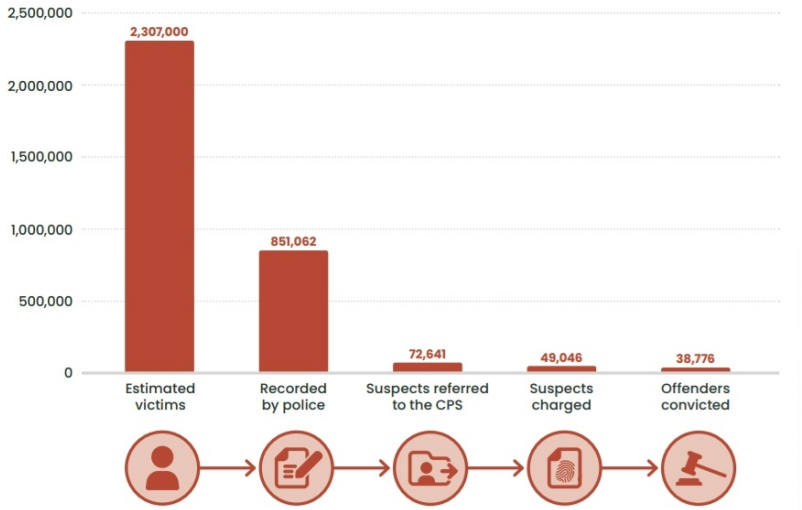
- Ava offered an IDVA and heard at MARAC as primary victim - January 2019.
- Ava recommended to attend an online female perpetrators of domestic abuse course - August 2022.
- A social worker conducting a one off healthy relationship session with both Len and Ava – June 2022

It is notable how Len was the person contacting the police with relationship based concerns in 2022. It wasn't until several days prior to Ava entering a coma she spoke to police in any detail about her experiences of Len's domestic abuse. It could be Len was genuinely trying to safeguard Julian but other information suggests he was presenting as the primary victim of abuse when this was not the entire reality. For example, police viewed CCTV which contradicted Len's initial claims of experiencing domestic abuse and identified he was providing misleading information. There was another piece of information which suggested he had left the door off the latch allowing Ava entry, against safety planning. There are several points where Ava was seen as the primary perpetrator of abuse and, at times, she *did* use aggressive behaviour. This is something her own family have acknowledged. It is not unreasonable to suggest both Len and Ava could have benefitted from looking at their behaviour and reactions in relationships to better understand the roots and develop healthier strategies in the future. The work only reached this stage on one known occasion with the attempt of "healthy relationship work" with the couple together. It appears this consisted of going through the power and control wheel[8], a tool developed in the late 1980s highlighting the many forms of abuse which can lead to one having power and control over another. This session indicates the domestic abuse dynamic had not been adequately assessed and longer-term interventions were not considered as it is not advisable to conduct such a session where high harm behaviours are known to have occurred without thorough assessment, analysis, prior intervention and agreement from partner services.

The turnover of Children's Social Care and CGL staff will have undoubtedly impacted delivery of service and understanding of the dynamic between the couple. The panel heard from Ava's mother how fatigued Ava became with telling her story. The issue of social worker retention is wider than the scope of this review but it does highlight the need to be clear about the assessment of domestic abuse on file so it is easily found by the next worker continuing the intervention.

[8] Understanding the Power and Control Wheel - Domestic Abuse Intervention Programs

The Domestic Abuse Commissioner's Shifting the Scales report details the difficulty with gaining domestic abuse convictions, as the below chart highlights:



In comparison to the estimated volume of domestic abuse, a conviction is a rarity. Yet, Len gained a fine for common assault towards Ava during the scoping period. The sentencing guidelines can be found here: common assault sentencing guidelines and require a magistrate to consider culpabaility and harm. This offence can receive a maximum 6 months in prison. Regardless of whether the fine was appropriate, a restraining order could also have been imposed which would have provided increased legilsative protection for Ava. This did not occur as has been analysed within the full report.

A key learning point of this review is the child removal process and maintaining a care and consideration for parent's wellbeing reardless of the court outcome. This is challenging for many reasons. Parents will often see agencies involved as complicit in the removal of their child. They may not wish to speak with them nor consider them to have their best interests at heart. Therefore, the consistency of conversations amongst professionals prior to a court's decision is cruical. This will only occur if all professionals involved have a clear understanding of the risk, concerns and what is required of the parents to increase the safety towards the child. This therefore ties back in with all services havig an in depth understanding of the relationship dynamic and be in agreement of what support should be prioritised. The ToR has highlighted several deaths locally following child removal. It is vital these lessons are taken on board to improve the care and safety planning for those having children removed.

The panel has been mindful of it's language throughout the review and agreed to be cautious around use of the term suicide. It is not clear what Ava's intention was on the day she entered the coma and, as mentioned, the line between intent to end ones life

and escapsim when experiencing deep emotional hurt is thin. But it was known she had suicidality within her past and had experienced several overdoses before. It may be with the benefit of hindsight but one can see how, after losing her second child, Ava would have been extremely heightened, upset and felt let down by the system, services and her partner. The likelihood of overdose was increased and this required recognition from agencies prior and post the court decision. It is hoped the learning from this review will contribute to increased recognition of safety plans which include increased risk of domestic abue, suicide and overdose in future.

11. Key findings and lessons to be learned

Lesson 1 – Multi Agency analysis of the domestic abuse dynamic – Stop and Think

Narrative

Services lacked a clear understanding of the domestic abuse dynamic throughout the course of the scoping period. The approach taken overall was reactive. Len, at one point, was offered safe accommodation for himself and Julian. Without a thorough analysis of the available information there is a risk incorrect services and interventions are offered. Inaccurate risk assessments can contribute to a confused picture.

Lesson to be learned

Services should consider promoting a **Stop and Think** approach. This is an initiative aimed to encourage professionals to meet together, away from the family, to analyse and understand the information available so informed responses and interventions can be provided.

Lesson 2 – Risk of overdose to be considered within pre / post court multiagency intervention

Narrative

Ava had a history of overdose and suicidality. This was known by the multi agency network. She had previously had a child removed from her primary care and was frightened of this happening again. There was a heightened risk of overdose one Ava was faced with losing Julian. Within child welfare proceedings parents often make increased attempts to reduce drug and alcohol use which leaves them more vulnerable to overdose post court decision.

Lesson to be learned

The increased risk of overdose should be factored into suicide prevention / safety planning pre and post court decision. There should be an openness and transparency about the possibility of child removal so safety planning can be established prior to final decisions.

Lesson 3 – The increased risk of domestic abuse should be considered within pre / post court intervention.

Narrative

Similarly to Lesson 2, domestic abuse was known. On the day of the court's decision Len was arrested for assaulting Ava in the street, an offence witnessed by a member of the public and CCTV. He was convicted the day after and received a fine. There was a heightened risk of a domestic abuse incident. The couple were likely to have placed blame on each other for the loss of Julian.

Lesson to be learned

Where the decision to remove a child is imminent, the risk of domestic abuse increases. The safety plans conducted with BOTH parties should reflect this. This re-enforces the importance of working with both parents.

Lesson 4 – Final court date should be communicated amongst the multiagency network in a timely fashion.

Narrative

The final court hearing is a significant date as it can signify the end of hope of a child returning to its parent's care. It is also a time of grief as the contact with the child is highly likely to reduce further.

Lesson to be learned

The final court date should be communicated to the wider network. This should allow for multi agency work to occur prior to this date which can include safety planning which considers increased risk of domestic abuse, overdose and suicide.

Lesson 5 - Court proceedings (child removal) are another opportunity to consider and analyse whether an NMO is appropriate.

Narrative

The court arena provides an opportunity to gain protective measures where domestic abuse is known. This was not utilised within the scoping period.

Lesson to be learned

Social services should consider utilising the opportunity for a non-molestation order where child removal situations are within court. Other agencies should be aware this is possible and ask whether this can be considered where appropriate.

Lesson 6 – Services must be mindful of language, especially in cases with counter allegations.

Narrative

The situation presented to services was complex with drug / alcohol needs, fears of child removal, dishonesty and minimisation all making it difficult to see the true picture. One aspect agencies did have control over was the language used. The review has found use of the terms volatile, co-dependent and unhealthy relationship all of which makes it more difficult to understand who is doing what to who.

Lesson to be learned

Services must be mindful of language, especially in cases where counter allegations are apparent. Use of the terms volatile, unhealthy, co-dependent should be avoided as they can further mask the true relationship dynamic.

Police

Lesson 7 – Breach of bail should be treated like a new offence in harassment / stalking cases.

Narrative

Len was released on police bail for assault and non fatal strangulation of Ava and immediately breach this upon release by attending Ava's address. If someone has breached police bail, it's a sign of escalating behaviour and a disregard to the

authorities by that individual. Where there are breaches of bail, new types of criminal allegations should also be considered and don't appear to routinely be.

Lesson to be learned

If there is a breach of bail in a domestic abuse context, this should be investigated and a new offence of stalking / harassment explored.

Lesson 8 – Breach of bail in domestic abuse (DA) cases should be responded to as a priority.

Narrative

Where any breach of police bail or court-imposed bail in DA cases is identified, resources should be deployed as soon as practicable to establish the nature and gravity of the breach and whether other offences e.g. stalking are present.

Lesson to be learned

Appropriate action should be taken against the alleged perpetrator at the earliest opportunity to ensure safeguarding of the victim in consideration of any escalation of risk.

Lesson 9 - Body Worn Video (BWV) can and should be used for safeguarding purposes, not just for criminal justice evidence.

Narrative

Police will often not be in a position to charge or even arrest when attending a report of domestic abuse. However, their BWV may support safeguarding processes, evidence safeguarding concerns and provide crucial insight.

Lesson to be learned

Police should share body worn video with safeguarding partners to increase insight and awareness of safeguarding concerns.

Lesson 10 – Audio / video ABE (achieving best evidence) at the earliest opportunity in domestic abuse cases.

Narrative

In October 2023, Ava reported Len had woken her up and punched her in the face. She spoke to police which she rarely did but the statement lacked significant detail. This was an opportunity to support Ava to provide evidence via video / audio. This could involve a supporter (friend / agency) attending with Ava to provide evidence in a secure location. The longer account taking is left, the likelihood of withdrawal from the process increases.

Lesson to be learned

Police should utilise the earliest opportunity for video / audio evidence and utilise known networks (family, agencies) to support one to provide evidence.

Lesson 11 – Utilising domestic abuse convictions to update police warning markers.

Narrative:

Once Len was convicted of common assault in September 2023 there was no change to his PNC (Police National Computer) warning markers[9]. This would have swiftly alerted officers he was a risk to partners or family members.

Lesson to be learned:

Where someone is convicted of domestic abuse a warning marker added to their PNCID would alert future officers who come into contact with him said person to the fact they post a domestic abuse risk.

Lesson 12 - The history of MARAC (Jan 2019) being used to better understand the relationship dynamic.

Narrative

The significance of the prior MARAC hearing for Len and Ava in Jan 2019 did not appear to be considered within multiagency analysis, risk assessment or intervention. This appeared to be a missed opportunity to gain valuable evidence and relationship history to increase agency understanding and recommend appropriate intervention.

Lesson to be Learned

Services should ensure they check their records for previous MARAC attendance for their service users and review how long MARAC flags stay on file.

[9] A PNC warning marker is a flag on the PNC database that alerts police officers and other authorized personnel about a potential risk or vulnerability associated with an individual.

Lesson 13 – Consideration of overdose and wording adaption in suicide prevention planning

Narrative

Ava was asked often whether she intended to end her life when sobering from a drugs overdose. She always answered no but it was recorded in 2019 how she had a 'passive death wish'. Learning and insight from those who have experienced similar situations suggests a tweak to the wording may illicit a different response.

Lesson to be learned

Regardless of whether someone says no when asked whether they intend to end their life, the risk of overdose should be considered within safety planning where there are known drug and alcohol concerns. "Are you looking for an escape?" is a potential alternative.

Lesson 14 – In Child Protection cases, where parents remove consent for services, Social Care must be informed.

Narrative

ToR 4.16 (full report) highlights Ava requesting mental health support via her GP. Three weeks later, after contact with the triage team, she stated she no longer wanted this. Julian, though not yet born, was on a child protection plan at this point.

Lesson to be learned

Where there is a Child Protection Plan, CPFT, or any other relevant service, should ensure the child/unborn's social worker is informed that consent for the relevant service has been withdrawn. This can help ensure gaps in intervention are not missed.

12. Panel Recommendations

Please note: For a full break down of agency's single agency recommendations please see the overview report.

NATIONAL

DAC (Domestic Abuse Commissioner's office) proposes domestic abuse training is embedded into Social Work England's standards for how the Early Careers Framework is delivered in universities to new Social Workers. It is the panel's recommendation for this training to include counter allegations, coercive control, effective risk assessment and other relevant learning from this review.

LOCAL

Recommendation 1

The suicide prevention strategy should include consideration of heightened risk of death by overdose, either intentional or unintentional, within their advice and guidance and utilise learning from this review to shape responses.

Recommendation 2

A multi-agency task and finish group should be set up to discuss deaths of parents post child removal. The focus can include:

- support pre and post court decision,
- who is best placed to support (bearing in mind the likelihood of disengagement with services who have been part of safeguarding decisions),
- whether bereavement support could be widened to include consideration of those who have had children removed,
- to consider co-production with those with lived experience,
- consider a mechanism for collating numbers of deaths in these circumstances going forward. and whether it is feasible for defendants to appear before the dedicated domestic abuse court.

Recommendation 3

Services involved with parents where child removal is likely should communicate openly and transparently with parents about this potential. Safety plans should consider increased risk of overdose, suicide and domestic abuse once this decision is final. This approach should be lead by Children's Social Care.

Recommendation 4 – "Stop and Think"

Services must share known information about the domestic abuse history, dynamic and patterns with each other to ensure a thorough shared and consistent understanding. This is especially pertinent in cases with counter allegations, drug and alcohol needs, a history of dishonest type offending (Len), previous child removal and other characteristics seen in this review. A Stop and Think professionals meeting should be convened to analyse what is known and plan next steps.

Recommendation 5

The current system of charge and remand by the police when refusing bail in domestic abuse cases should be reviewed by the Criminal Justice Command in collaboration with the Senior Clerk to the Magistrates to understand if this gap in practice can be effectively addressed and whether it is feasible for defendants to appear before the dedicated domestic abuse court.

Recommendation 6

All relevant court services in domestic abuse cases must be consulted before sentencing if the dedicated domestic abuse court is not the sentencing court.

Recommendation 7

National policy guidance for PNC should be reviewed to consider whether DA warning signals should be appended to the PNC record where there is a conviction for intimate partner common assault. The learning should be referred to the PNC Manager BCH to establish whether this is worthy of raising to the nationally responsible officer PNC.

The Police National Computer (PNC) will gradually be decommissioned, in a phased process to a new operating system called the national Law Enforcement Data Service (LEDS)

Appendix A

Complete Terms of Reference

Domestic Abuse

Whether family, friends, neighbours and hostel residents were aware of any abusive or concerning behaviour between the perpetrator and victim (or other persons). Were there any barriers they may have experienced in reporting concerns if they knew how and felt able to?

Whether Ava and Len had any previous history of abusive behaviour towards each other or anyone else, and which agencies this was known to.

It is recorded Len breached bail conditions after his arrest of in early October 2023. Was harassment and stalking considered appropriately?

Was coercive control and its impact considered by professionals?

Protective Measures

Were opportunities to support Ava to apply for legal orders (e.g. non-molestation orders (NMO)) recognised and utilised?

Counter Allegations

Were thorough assessments made to fully understand and appreciate the dynamic between the couple. For example, the who does what to whom assessment?

Where a service user presents as a victim but may be perpetrating abuse, is there adequate training and / or guidance to help practitioners identify, address and safely challenge this?

Disrupting DA perpetration

On the 15th September 2023 Len appeared at court for common assault of Ava for which he received a fine. Was a restraining order[10] (RO) applied for?

Was the Domestic Abuse Court utilised appropriately and if not, what gaps prevent this from happening.

Were there services available locally for those using harmful behaviour and if so, were these known about and were there opportunities to consider these within interventions. Were practitioners confident in knowing how to ask these questions?

Did Len have a relevant domestic abuse history to share. If so, was this shared with the victim appropriately? (e.g. Domestic Violence Disclosure Scheme)

Risk Assessment

Whether Ava and Len's domestic abuse related history was considered when assessing risk. Were appropriate referrals made from these assessments?

The police were the predominant users of the DA risk assessment (DASH). Were these assessments used appropriately? Additionally, did other agencies consider the domestic abuse risk, assess and offer the appropriate interventions?

Mutli Agency Collaboration / MA Forums

A review of the effectiveness of any Multi-Agency Risk Assessment Conference (MARAC) involvement. Where there wasn't any, could there have been?

[10] Restraining Orders | The Crown Prosecution Service

Did agencies collaborate effectively to address the multiple issues, fully understand risk and offer the necessary interventions to reduce risk. If not, to review why this might have been and offer actions to address this moving forward.

Mental Health Support

If known, were Ava's domestic abuse experiences considered within the mental health support she sought or was referred to?

Were suicide prevention / safety plans utilised at any juncture with Ava considering her prior attempts to end her life and did these include consideration of domestic abuse?

Removal of child

When a child is removed, vulnerability increases as does risk of overdose where drug use is present. What support was put in place? What early interventions can be utilised in the future to reduce the risk of overdose or suicide where a child is removed?

Training / Policy / Procedures

An exploration of any training or awareness raising requirements necessary to ensure a greater knowledge and understanding of domestic abuse within each service.

Whether the work undertaken by the services in this case is consistent with its own professional standards, compliant with its own protocols, guidelines, policies and procedures.

A review of communication to the general public and non-specialist services about available specialist services related to domestic abuse.

Do the lessons arising from this review appear in other reviews held by this Community Safety Partnership? This includes any drug / alcohol related deaths.

Any other information that becomes relevant during the conduct of the review.

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[i] Domestic abuse victim characteristics, England and Wale s - Office for National Statistics (ons.gov.uk)
[ii] 999368 Law_Domestic Violence MAIN Research Report Final FINAL PRE-PRINT.pdf (aafda.org.uk)