

Domestic Abuse Related Death Review
South Cambridgeshire Community Safety Partnership

Ava

Born: November 1984

Died: January 2024

Chair and Author: Christian Brazier

Date of completion: 7th June 2025

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Glossary:

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](#)

Pen Portrait:

Ava (pseudonym), a beautiful soul and mother who cared deeply for her children. When sober, Ava was the loving, caring woman known to her family; drinking was her Achilles heel and coping mechanism which could often mask the person beneath.

Ava's life was a complex tapestry of love, struggle, and resilience — a woman who, despite her battles with mental health, addiction, and abuse, showed moments of profound love and care, embodying the beautiful soul her family loved.

Preface:

The author and panel wish to express their deepest condolences to Ava and her family. They wish to place on record their thanks to Ava's mother for her involvement in this review.

Section One

Summary of Circumstances leading to the review:

- 1.1.1 On a day in October 2023 Ava (pseudonym) was found unconscious by the East of England Ambulance Service in a flat. Another man present said he'd witnessed her inject heroin and she had consequently entered a coma. Ava was to remain in the coma until January 2024 when she died in hospital.
- 1.1.2 Ava had been in a relationship with her boyfriend Len for several years and had recently had their one and only child Julian removed from their care by the local authority. Two days before the overdose, Ava had contacted the police and alleged Len had strangled and assaulted her. At the time of her overdose he was on bail for these offences and had already breached the terms of this by attending her address.
- 1.1.3 The key purpose for undertaking Domestic Homicide Reviews / Domestic Abuse Related Death Reviews is to enable lessons to be learned. In order for these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each domestic abuse related death, and most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future.

Commented [SF1]: Should read East of England Ambulance Service

Reasons for Conducting the Review

- 1.2.1 This Domestic Homicide Review / Domestic Abuse Related Death Review is carried out in accordance with the statutory requirement set out in Section 9 of the Domestic Violence, Crime and Victims Act 2004.
- 1.2.2 The review must, according to the Act, 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 he was related or with whom he was or had been in an intimate personal relationship, or
 - b) A member of the same household as himself, held with a view to identifying the lessons to be learnt from the death.

In this case, the victim was Ava, Len's partner.

- 1.2.3 Within Section 18 of the 2016 Multi Agency Statutory Guidance for the Conduct of DHRs, provision was made for DHRs to be conducted:

"Where a victim took their own life (suicide) [in the case of Ava, this remains' unknown, it has been referred to as an overdose and not referred to as a 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.”²

Due to the knowledge Ava had been in a long term relationship with Len where domestic abuse had been reported on multiple occasions, and Len was on bail for domestic abuse towards her at the time of Ava entering a coma, it was deemed appropriate to commence a review in order to learn valuable lessons.

1.2.4 The purpose of the DARDR is to:

- Establish what lessons are to be learned from the Domestic Homicide / Victim Suicide 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 those lessons to service responses including changes to policies and procedures as appropriate
- Prevent domestic violence homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working.
- Contribute to a better understanding of the nature of domestic abuse.
- Highlight good practice.

Timescales

1.3.1 The South Cambridgeshire Community Safety Partnership was notified of the death of Ava on 24th July 2024.

1.3.2 On the 25th July 2024 the Community Safety Partnership decided the criteria had been made to conduct to a Domestic Abuse Related Death Review.

1.3.3 The Home Office were notified of this decision on 30th July 2024.

1.3.4 On the 22nd August 2024 a chair and author was appointed.

² [DHR-Statutory-Guidance-161206.pdf \(publishing.service.gov.uk\)](#)

1.3.5 Scoping documents were sent out to ascertain which agencies had some knowledge of the couple. Those services with contact were invited to a panel to discuss the review and their participation within it. Panel meetings were held via Microsoft Teams on:

- Initial Panel Meeting - 26th September 2024

Due to the number of similar reviews being undertaken locally at the same time, and the length of the scoping period, an extended period was agreed for agencies to complete their individual management reviews.

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

Individual meetings were held with services separately as appropriate outside of these meetings.

Confidentiality

- 1.4.1 The findings of each review are confidential until such a time as the review has been approved for publication by the Home Office. Information is available only to participating professionals and their line managers.
- 1.4.2 To protect the identity of the deceased and her family, pseudonyms have been used throughout this review.

Methodology

- 1.5.1 During the initial panel meeting on 26th September 2024 it was agreed for the scoping period to range from 1st November 2018 (approximate date of first police report) to January 2024. Agencies were tasked with providing a chronology of their involvement between this time.
- 1.5.2 Agencies were asked to complete Individual Management Reviews (IMRs). IMRs are an opportunity to internally explore a service's work, identify areas of good practice and any improvements. Agencies were asked to go beyond whether or not processes were followed and consider changes / enhancements for future practice.
- 1.5.3 Agencies were reminded the process is not about blame but about learning to reduce the likelihood of future incidents of this nature.

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1.5.4 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 sent in scoping information at the beginning of the review process. It was not deemed necessary to request a report from them initially. 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 further information contact was made with Cyrenians Housing Project to gain some insight into their involvement in late 2018.

Terms of Reference

1.6.1 The panel, as well as those completing IMRs, were asked to consider the following:

- To review current roles, responsibilities, policies, and practices in relation to victims of domestic abuse with specific consideration of coercive control – to build up a picture of what should have happened.
- To review this against what happened to draw out the strengths and areas for improvement.
- To review national best practice in respect of protecting adults and children from domestic abuse.
- To draw out conclusions about how organisations and partnerships can improve their working in the future to support victims of domestic abuse.

- 1.6.2 A full terms of reference forms the analysis in Section Four and can also be found in Appendix B.
- 1.6.3 If any information of relevance prior to the scoping period became apparent, agencies were asked to share it so more context could be gained and lessons learned.
- 1.6.4 Ava's mother was liaised with throughout and provided opportunities to feedback on the terms of reference and report.

Key lines of enquiry

- 1.7.1 These were fundamental points to explore based on the information known. They were broken down in detail within the Terms of Reference.
- 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.

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

The chair and panel would like to place on record special thanks to Ava's mother Tracey (pseudonym) for providing insight into her daughter's experiences. At what is a difficult time, this contribution is much appreciated and highly valued. Tracey was provided [AAFDA](#) and Home Office information about the process and available support. Other family members were sought but declined involvement in this review. Consent was declined to enable Kyron's voice to be captured.

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 ultimately 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 as well as a disclosure she had tried or threatened 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. As well 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 often "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 led 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 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.

Contributors to the Review

- 1.9.1 Those contributing to the review do so under Section 2 (4) of the statutory guidance for the conduct of DHRs / DARDRs, and it is the duty of any person or body participating in the review to have regard for the guidance.
- 1.9.2 All individuals interviewed by the Chair were made aware of the aims of the DARDR and referenced the statutory guidance. They confirmed their independence from the family and individuals involved in the review.
- 1.9.3 The following agencies contributed to the review:

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 Cambs 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

1.9.4 Many of the agencies were contacted separately via e-mail to clarify points or had separate video call meetings to talk through pertinent issues. The CPFT provided clarification towards the end of the review process having initially submitted a scoping document.

The Author of the Overview Review Report

1.10 This report 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.

Parallel Reviews

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

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

Equality and Diversity

1.12.1 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

Ava and Len were both white British. It was felt their ethnicity and nationality had no significant impact on their experiences relevant to this review.

Those considered relevant to this review are:

1.12.2 **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

1.12.3 **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.

1.13 Dissemination List

Cllr Sally Ann Hart – SDCD & Vict Chair of Community Safety Partnership
Scott Fretwel – Station Commander Cambs Fire and Rescue – Community Risk Manager
James Ashby – SCDC Principle Officer for People and Protection Team
Katie Ixer, Community Co-ordinator, Cambridgeshire County Council
Claire Gilbey, Housing Enforcement Team Leader, SCDC
Cllr Helene Leeming, SCDC
Cambridgeshire Police and Crime Commissioner
Domestic Abuse Commissioner

Section Two
Background Information

Pseudonyms chosen by the chair and confirmed by Ava’s mother were:

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

Background prior to scoping period

- 2.1 There is a significant, relevant history prior to the agreed scoping period. This contains incidents of Ava self-harming, suicidal ideation, domestic abuse, alcohol use and child safeguarding concerns in relation to Ava’s first child Kyron. As it predates the agreed scoping period it is summarised below which should not diminish its significance.
- 2.2 Kyron, Ava’s first born, briefly became known to Children’s Social Care 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.
- 2.3 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 his 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.
- 2.4 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.

- 2.5 Kyron came off the child protection plan in July 2015, but ongoing concerns resulted in a return to a plan in February 2016.
- 2.6 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 alcohol being a significant pattern.
- 2.7 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 as well.
- 2.8 Ava became well known to MARAC³ (Multi Agency Risk Assessment Conference) for the high risk / high harm nature of the domestic abuse. She was heard predominantly as the primary victim 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
- 2.9 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.

³ [What is a MARAC?](#)

- 2.10 In March 2018 Ava was assessed again by the Hospital's 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.
- 2.11 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.
- 2.12 It is believed Ava and Len began a relationship in June 2018, several months earlier than the agreed scoping period. Later that month 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. It is clear Ava had experienced extensive domestic abuse by this point, was highly fearful of her ex and was getting into confrontations with other residents. Ava was eventually evicted from this accommodation in early October 2018 due to her prior cumulative behaviour impacting other residents and "breaking the accommodation's rules" but detail of these rule breaches are unknown. The accommodation worked alongside the street triage team to try and find alternative accommodation for Ava though options were limited.
- 2.13 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 earlier met in a nearby street, 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 the refuge. 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.

2.14 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.

Section 3 – Chronology

The following chronology is compiled from agency records and individual management reviews. It would benefit from being seen through the lens of coercive control and trauma.

Beginning of Scoping Period:

- 3.1 On 21st November 2018 CGL and Probation jointly met with Len. He reported using heroin by injecting into his groin and crack cocaine. He said he had overdosed the week before and an ambulance had been called. He alluded to the “volatile” relationship between him and his girlfriend but said they were hoping to get a place of their own together. CGL expressed concern saying they had witnessed controlling behaviour 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 “belittles” him.
- 3.2 Later that month Ava self-referred to the CPFT Dual Diagnosis Street Team⁴ for support. She became distressed during the assessment and wanted to find her partner, believed to be Len, so left before finishing. The assessment was completed on the 23rd November after persistence from the practitioner. A support plan was agreed and they saw Ava several times a week up until 14th January 2019.
- 3.3 On the 27th of November 2018 Police received information which confirmed Len and Ava were in a relationship. The information said, *‘They regularly have violent physical fights with each other and this week were using a bicycle as a weapon hitting and pushing each other with it’*.
- 3.4 In early December 2018 a member of the public reported having seen a man they believed to be Len punch Ava in the face. A security guard at a local university had challenged two people who were inside a university block unauthorised. They both denied breaking the door and left the site. Information suggested they were connected to the nearby night shelter and bedding inside the building suggested rough sleeping. The guard was then told by a student they had just witnessed the theft of a bike from the front of the university, had followed the suspects and taken photographs of them. They said they saw the same man hit the woman in the face. Len was subsequently arrested but denied the assault, as did Ava. However, he was charged with five other matters he had been wanted for. By the time the police investigation was reviewed internally, the CCTV footage had been lost and the witness was unsure they could identify the individuals concerned. Therefore, due to a lack of evidence, there was no realistic prospect of a conviction for the assault and so the charge was dropped.

⁴ [Service detail | CPFT NHS Trust](#)

- 3.5 When spoken to, Ava did not want to complete a domestic abuse risk assessment (DASH) but the officer in charge was tasked to complete one based on all available information. Her case was referred to MARAC based on the escalation policy of three or more reported incidents within 12 months⁵. A domestic violence action plan (DVAP) was placed on the respective systems against the victim, address (which was referenced as her recent accommodation) and telephone numbers by the MASH (multi agency safeguarding hub).
- 3.6 On 20th December 2018 Len made a single person Universal Credit (UC) claim. He said he was living alone in temporary accommodation (night shelter), was unemployed and had health conditions depression, obsessive compulsive disorder (OCD), attention deficit hyperactivity disorder (ADHD) and a chest infection. However, his nominated bank account was Ava's.
- 3.7 With the referral for MARAC already underway, the Independent Domestic Violence Advisor (IDVA) made their first call to Ava on 18th January 2019 but her phone was switched off. On their second attempt several days later, Ava answered but denied any domestic abuse. A male voice was heard in the background, so the IDVA ended the call as per policy. Several more attempts were made with the next successful contact occurring on 31st January 2019. The IDVA provided an update on the MARAC meeting. Ava declined the IDVA support and so the service closed her referral. There were no further referrals to an IDVA service in relation to Ava until 16th October 2023.
- 3.8 Within the MARAC meeting on 23rd January 2019 Len's previous offending was disclosed and discussed. By understanding someone's pattern of behaviour agencies can better understand the risk of recurrence so this was good practice. Behaviour listed for Len was:
- use of violence including strangulation
 - propensity for violence outside DA context
 - extensive offending history – mostly acquisitive crime
 - disregard for control measures
 - harassment behaviour (breach of RO (restraining order) previously)
 - drugs misuse – heroin, cannabis, crack cocaine, benzodiazepines, sleeping tablets and occasionally drinks beer
 - Mental health (MH) – (Attention Deficit Hyperactivity Disorder) ADHD, MH issues, depression, self-harming.
 - serial perpetrator – listed for DA with a previous partner.

Within the MARAC notes, education services were clearly recorded as having concerns for Kyron's wellbeing due to the impact of his mother's mental health, alcohol use and

⁵ Multiagency Safeguarding Hub (MASH) policy at that time

domestic abuse. They correctly challenged the local authority who were recorded as assessing the situation for Kyron to be of an Early Help level (see Appendix A for explanation of children's social care tiers).

- 3.9 Ava was seen on 25th January 2019 by a practice nurse wanting her contraceptive implant removed, she was signposted to get this done and was asked to attend to discuss Hepatitis A and B vaccination with a GP.
- 3.10 On the 25th of January 2019 Ava's stepfather called the Police due to Ava being "drunk and causing a disturbance". Ava had made a call herself shortly before but it had been silent and not separately responded to. On arrival, Police were told Ava had 'swept' items off a dressing table and her behaviour had been witnessed by Kyron who was temporarily living with Ava's mother and stepfather. Len had also been present. Len escorted Ava away to seek emergency accommodation as they were both homeless and had been staying at the address when no other accommodation was available. Len was reported as being sober. No offences were recorded and police submitted an adult at risk form for Ava and a child safeguarding referral for Kyron.
- 3.11 The MASH assessed the referrals made and recorded how Ava appeared to be "*burning all her bridges with those willing to help her*".
- 3.12 On the 12th of February 2019, Len was sentenced to a period of imprisonment of ten weeks for theft offences.
- 3.13 On the 21st April 2019, Ava was seen by the Liaison Psychiatry Service (LPS)⁶ in hospital after being tended to by the ambulance service who had found her unconscious and intoxicated. She disclosed drug / alcohol intoxication or withdrawal and suicidal ideation. After a night's sleep and treatment she appeared brighter. She said life had been difficult in relation to ongoing struggles to find accommodation. She reported an increase to around 4-6 cans of strong cider per day and initially denied any plans or thoughts to harm herself. She was with her current partner Len, who by this point had been released from prison, but asked him to leave at one point. When he'd left, she said she did think about wanting to end her life because she felt she had let her son 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. She appeared focussed on her future and agreed to support from CGL for alcohol use and mental health support. The nurse called the local night shelter to hold a bed for her which was good practice and she was prescribed anti-depressants on a weekly basis to reduce the risk of overdose.

⁶ The LPS is a CPFT Service embedded within Cambridge University Hospitals.

- 3.14 Probation initiated a recall for Len on 10th May 2019 due to non-attendance as well as attending appointments under the influence and being aggressive. Probation have reflected how his relationship with Ava was not accurately considered within risk assessments, despite the recent appearance at the MARAC in January. This has / had significant implications for effective risk management which will be discussed within the analysis.
- 3.15 In late May 2019 information received by the police indicated Len and Ava were again rough sleeping, this time in the city centre. A short time after these reports further information was received stating they were both involved in 'street level' drug supply.
- 3.16 On the 29th of May 2019 Len and a woman believed to be Ava were reported to have stolen a bike as witnessed by the owner. As the owner intervened, he was assaulted by Len and the couple left.
- 3.17 On 2nd June 2019, Ava attended the reception at the local night shelter and said she had been assaulted by an unknown person. At this time, she was sharing a tent with Len but he was not present whilst she was reporting. Staff at the night shelter suspected the offender to be Len. Although police attended, Ava declined to engage with them, despite the support of night shelter staff. Her injuries were reported to have been of a "moderate but not serious nature" with no sexual motivation for the assault identified. There was no domestic abuse risk assessment recorded from this incident and the report was not recorded as a crime.
- 3.18 Len was not picked up by police for his probation recall until 26th June 2019 when he came to their attention a few days earlier for anti-social behaviour. It appeared he had been using the bike sheds at a block of flats to sleep in with Ava and there had been an argument between them. After being recalled, he was released again on 9th July.
- 3.19 On the 24th July 2019 Ava made a single person claim to Universal Credit (UC), stating that she lived with close relatives, had one child, was unemployed, and declaring her health conditions as severe depression, anxiety, and panic attacks.
- 3.20 On the 7th August 2019, a report was made to the police by the Ambulance Control of a female in cardiac arrest in some public toilets in Cambridge. Ava was comatose, having either been supplied with or taken, what was believed to be heroin. The paramedics reported a man walking away from the immediate area when they arrived who they believed may have been involved. When Ava came to she was heard to call out for Len several times. However, Ava also told ambulance crew she was upset her partner had not come home for 2 days. It remained unclear who the man walking away was.

- 3.21 The next day Ava was seen again by the hospital's Liaison Psychiatry Service (LPS) with alcohol related issues. During the assessment she said she had a "short fuse" when drinking and would get into fights. She said she would place herself at risk having "unprotected one-night stands" with strangers. She reported being in a new relationship and believed she was 'less at risk' by being in the relationship. In addition to alcohol she reported crack cocaine use and injecting herself with heroin 2 / 3 times a week.
- 3.22 Len is known to have been in prison from 6th September 2019 to 24th April 2020 due to theft and dishonesty related offences committed between July and September 2019. A Probation OASys (an assessment tool used by probation) review in August 2019 again did not reflect the abuse dynamic between Ava and Len and appeared to have been pulled through from the last assessment.
- 3.23 On 1st September 2019 Ava was brought into the hospital after a concern she was in cardiac arrest. She had been found asleep in a stairway. She said she had drunk a bottle of prosecco and had been injected with crack and heroin by a "person she had met".
- 3.24 In early October 2019 Ava was again seen by ambulance crew and said her "ex-partner" had forcibly injected her with heroin into her breast and buttock. It was noted her ex-partner started CPR. She later named this man. A referral was made to adult social care with this information. After assessment they did not deem the situation necessary for social care input as they did not identify any care or support needs for Ava. As mentioned, Len was in prison at this time.
- 3.25 A day later a multi-agency meeting was held, chaired by the street outreach team. The report of Ava being forcibly injected with heroin was discussed. It was noted that other agencies who knew Ava did not have concerns about her being in an abusive relationship at that time. They felt she was able to care for herself and look after herself. They had observed her behaviour as having been violent towards others and suspected she may have financially exploited others too.
- 3.26 On the 21st October 2019 Ava's step mother called the mental health line for advice. She said Ava had been threatening to cut her hair off so they'd needed to remove the scissors. They said she would hide when the doorbell rang. 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 in front of a train. She also said she was having panic attacks, her body was aching, she was experiencing headaches, shaking and blurry vision with "random sparkles". When it was queried whether it could be 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.

- 3.27 The result of this phone call was for Ava to attend 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 contact arrangements. The assessor felt she 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 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.
- 3.28 On 21st November 2019 Ava visited Len in prison and was seen to remove an item from her underwear and pass it to him. When challenged he removed and swallowed the package. Both Ava and Len said it was tobacco. Although deemed unlikely by investigators, a body scan and other methods could not confirm the substance. Ava was arrested and interviewed but due to a lack of evidence no charges resulted. She said she had made the decision to bring the package into prison and was not under pressure to do so.
- 3.29 Whilst under arrest Ava was seen by the CPFT Liaison and Diversion (LaDS) Service. She was assessed for risk of suicide, acknowledged fleeting thoughts but said she had no active plans to do so. She said her son was her protective factor. She acknowledged her previous overdose attempt and said she had cut her legs a year ago with a razor blade. Domestic abuse was asked about and Ava said she had experienced domestic abuse 5 years ago, but said she ended the relationship and was no longer experiencing any kind of abuse.
- Additionally, Ava spoke about her keyworker at CGL and said she was waiting to do a community detox with the support of her father. She said she had used heroin and crack but after "nearly dying" 8 – 9 weeks previously no longer used these substances and only drank alcohol.
- 3.30 CGL recorded how Ava had mentioned "tensions" between herself and her partner in December 2019. However, it is not clear who she meant by 'partner' as on 24th December she was found unresponsive 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.

- 3.31 In mid-December 2019 Len had a keyworker session in custody where he appeared to be under the influence of a 'psychoactive' substance and reported being in debt to others in prison.
- 3.32 Ava did not attend any meetings with CGL at the start of January 2020 but got in touch midway through the month to apologise saying she had dropped her phone in the toilet. She re-engaged, partaking in group work with notes detailing good engagement and an intention to continue her alcohol use reduction.
- 3.33 Unfortunately, by February her attendance had stopped and she was closed on the CGL system. A letter was sent to her requesting contact and her GP was informed. CGL have reflected how contact attempts were limited and not as persistent as they had been at the start of January.
- 3.34 In March 2020 the UK went into lockdown⁷ due to the Covid 19 pandemic.
- 3.35 Len was released from prison in April 2020 after spending 7 months inside. By the end of May he was reporting low mood and injecting two bags of heroin into his groin per day.
- 3.36 Ava re-engaged with CGL in June 2020 and during her initial assessment acknowledged using 3-4 bags of heroin and crack cocaine and had begun injecting herself. She was also drinking 4 cans of cider daily. She said she wanted to get on a script and find permanent housing. She disclosed occasional shoplifting to fund her drug use. It appears Ava was living with Len at this time as there is a record to say they were evicted from their accommodation due to him stealing a bike.
- 3.37 As part of her engagement with CGL, Ava had a medical assessment a few weeks later. She self reported using 5-6 bags of heroin daily by injection and crack cocaine use. She said she had been using at this level for 6 months and had first used just over a year ago. She detailed a long history of alcohol use and previous withdrawal symptoms such as shaking and sweating. She said she had last picked up her antidepressants over 5 months ago but wanted them again as her mental health was "not great". When asked about her personal history she denied any abuse in childhood and said she left school at 15 with no formal qualifications. She requested to be placed on methadone to reduce the likelihood of seeking heroin. She said she was not currently having contact with her son Kyron.
- 3.38 By late July 2020 Ava was reported to be sounding more positive and intent on moving out of the city centre with Len to avoid associates involved in drugs. However, she said Len

⁷ [timeline-coronavirus-lockdown-december-2021](#)

was currently in prison for theft offences and was unsure whether it would be for 28 days or until November. She said the break was good for both of them. Len was imprisoned from July 2020 to early December 2020.

- 3.39 By September it appears life had declined or was declining for Ava. She missed several script collections and received a caution for shoplifting from the Police. She attended the emergency department in September 2020 for an unknown reason but did not wait to be seen.
- 3.40 On 5th November 2020 the UK went into the second national lockdown due to the Covid 19 pandemic.
- 3.41 By December 2020 Len had been released from prison and was in temporary accommodation in Peterborough. This was short lived however, as on 18th December 2020 he was evicted from his housing due to aggressive behaviour and a “suspected female guest staying”. On inspection of his room there was a crack pipe and two cosh type weapons found. Ava had told CGL she had been travelling to and from Peterborough so it is highly likely this referenced her.
- 3.42 On 6th January 2021 the UK went into the third national lockdown.
- 3.43 In mid-January 2021, an ambulance crew referred to adult safeguarding as they had been called to Ava who was unconscious through drug use. She declined all support as she came round. When Ava was contacted later, she again declined any support. She was told she could get in contact if she changed her mind.
- 3.44 A day later she was seen by the drug and alcohol team who noted positive test results for morphine and cocaine despite Ava claiming abstinence from each for 2 months and 4 weeks respectively.
- 3.45 In early March 2021 Ava attended her GP surgery. She informed the doctor she was 7 weeks pregnant which she was happy about. She reported having shelter and not being street homeless. 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 made contact with them soon afterwards.
- 3.46 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 enquiry⁸ to begin.

⁸ [Section 47 Enquiry](#)

This is an assessment to ascertain whether there is risk of harm to a child and meaning intervention from Children's Social Care is required. At this meeting concerns were noted in relation to Len's "offending behaviours / criminal history" although it is not clear what information was disclosed. The notes detailed a "significant history of alcohol dependence and substance misuse". It was stated Ava had been using drugs relatively recently but had stopped once finding out she was pregnant. She said she'd had the "odd beer" but nothing more. She offered to take part in daily drug screening. Within this meeting it was reported Ava used to be homeless and had previously lived a "chaotic lifestyle". Kyron's history was shared. The outcome was for the case to progress to an ICPC (Initial Child Protection Conference) in early April 2021 where a Child Protection Plan was agreed under the category of neglect.

3.47 In late April 2021 blood tests confirmed Ava had tested positive for Hepatitis C.

3.48 On 11th May 2021 Ava visited her GP to request help for her mental health. The concerns listed within the subsequent referral from the GP for mental health support were as follows:

- Child protection plan for the unborn baby due to neglect concerns,
- long history of depression and self harm,
- not currently medicated for mental health issues due to concerns about the impact of medication on the unborn child,
- drug and alcohol use,
- current mood swings.

The doctor ticked a box for perinatal mental health support on the referral form, but this referral never reached the perinatal mental health team (PNMHT). The primary care mental health triage team received the referral and attempted to call Ava on the phone to assess her severity of mental health needs. Three weeks later, after unsuccessfully attempting several phone calls, a male voice answered Ava's phone before passing the assessor onto Ava. She subsequently declined mental health support, saying she had told her GP she no longer needed it, and the referral was closed. For someone with the extensive needs Ava had, with multiple agencies involved, this appeared to be a missed opportunity and will be reflected on further in ToR 4.16.

3.49 Also in mid-May 2021, CGL had a clinical discussion with the doctor in relation to Len's treatment for alcohol and substance use. He had cancelled his 3rd medical review in a row. The doctor was concerned about Len showing some controlling traits and suggested he be "referred to safeguarding". Len had either not responded to appointment requests or blamed a clash with probation appointments as to why he couldn't attend. He consistently voiced annoyance at not being able to reduce the frequency of his script collections.

- 3.50 In contrast to the above, maternity services reported Ava had been attending all appointments and was “engaging well with all services”. Len was engaging with groups too and reportedly reading books to support this. Maternity services recorded how both parents were keen to engage in birth classes.
- 3.51 Child protection core group meetings continued but in June 2021 a concern was raised from CGL in relation to Ava drinking on the day of the review conference. Social Care have reflected how this what not explored in the necessary depth.
- 3.52 At this time, Len and Ava were living together in a caravan.
- 3.53 Julian (pseudonym) was born in mid / late 2021. Whilst in hospital the family had contact with a midwife after Julian’s birth. The midwife felt both parents appeared focussed on their Methadone⁹, and Ava said she had taken some of Len’s prescription. They reported their Methadone had gone missing. CGL liaised with a doctor and there were concerns around elements of alcohol withdrawal and honesty. The collection routine was reviewed based on this information.
- 3.54 Julian was not brought in for his 6-8 week health check in November 2021, a concern escalated as a safeguarding issue by Ava’s doctor. This check did take place a month later with Len and Ava present. They were referred to a social prescriber¹⁰ primarily due to not being able to attend appointments and “financial difficulties with increasing gas prices.”
- 3.55 Contact via phone was challenging for agencies at this time as it appears the couple shared a mobile. Len was having four weekly drug screening checks which showed positive for buprenorphine¹¹ only. Ava continued to be drug screened too and was testing positive for Methadone only. However, CGL attended a core group facilitated by Children’s Social Care where it was noted Julian was not putting on much weight and the couple were late to see the GP for these concerns. The couple said they wanted another baby and were having unprotected sex. There was a discussion about poor attendance at appointments and Ava agreed to start using a diary. Ava advised she was spending some time at her dad’s as she felt isolated in the caravan.
- 3.56 Ava did not attend a hepatology appointment in early Jan 2022 which continued to delay her Hepatitis C treatment. The letter to her noted she had missed several such appointments. This was communicated to her health visitor. The parents missed Julian’s

⁹ [Methadone – medicine used to treat heroin dependence - NHS](#)

¹⁰ [NHS England » Social prescribing](#)

¹¹ [About buprenorphine for pain - NHS](#)

neonatal appointment in February 2022 and he was not taken for a paediatric appointment for Hep C screening in late February 2022 as arranged. Phone calls were not answered by either parent and messages were not responded to.

- 3.57 On 3rd February 2022 a Review Child Protection Conference (RCPC) was held to ascertain whether the threshold was still being met for Julian to be on a statutory protection plan. It was agreed for this to be stepped down to Child In Need (CIN) level, a lower level of monitoring and intensity, in recognition “of ongoing positive progress”. This conference was held earlier than usual timeframes would dictate in recognition of said progress. The notes of the conference reference the parents as being ‘abstinent from illicit substances and alcohol since December 2020’. However, Ava was seen consuming alcohol in June 21 by CGL. It is Social Services reflection this was overly optimistic when the history is considered.
- 3.58 On the 14th February 2022 Len and Ava asked for housing advice from the council due to “poor living conditions”. Temporary accommodation was provided to them in a self-contained flat whilst homelessness enquiries began. These enquiries resulted in SCDC (South Cambridgeshire District Council) deciding they had a housing duty on 9th August 2022 which meant they would support Len, Ava and Julian to find longer term settled accommodation, when it became available.
- 3.59 Ava and Len moved into their temporary housing within a block of flats provided by Sanctuary Housing¹² on 16th February 2022. They were both named on the initial license agreement.
- 3.60 Soon after moving in, on 15th March 2022 staff at the housing provider sent an email to the family’s social worker which stated Ava had a black eye. Both Len and Ava were spoken to by Social Care separately about this and said their child had accidentally hit Ava in the face with a toy. A response from the local authority was received 10 days later stating they had explored this and had no lasting concerns about domestic abuse. At the same time a discussion was held between the Social Worker and Health Visitor via e-mail. The Social Worker said they had met with Len who told them of an incident on 15th March 2022 where there had been a “*disagreement*” and Len had “*accidentally poked Ava in her eye with his finger and she had a little bruise*”. The rest of the e-mail is written in full with only names changed. This is for learning purposes and will be explored further in the analysis section of this report:

¹² [Cambridgeshire Homelessness | Sanctuary Supported Living](#)

“I have also been told on that day Ava has been drinking a few cans of beer while Len was providing care to Julian. Then I have also been told there was a Police check completed by Police at Ava’s mother address next day.

Police [received information from a third party stating] THAT BOTH THE FEMALE AND MALE LOOK LIKE THEY ARE ON DRUGS AND ARE NOT ABLE TO LOOK AFTER THE BABY IN THAT STATE.

The outcome was that Police had no concerns following their contact with child & parents. I followed up above concerns and I met with parents and accommodation staff yesterday to explore what really happened.

Following my discussion and information gathered from partner services I felt reassured that the incident between parents was just an accident and there is no evidence to suggest DA (domestic abuse).

I spoke to Ava about drinking and she openly stated that she had a couple of beers that day first time since she stopped drinking in 2020. She stated that she does not drink on a regular basis and said Len does not drink at all.

During my discussion with Len about Ava, he shared with me Ava was previously in two highly abusive relationships and now suffers with a high anxiety and sometimes gets paranoid. Ava was reluctant to admit to me about the anxiety as she stated that she was worried that this will impact on the Social Care involvement. I reassured her that this is not the case and I suggested accessing help in order to manage anxiety effectively. She stated that also she feels depressed but does not feel confident in accessing help from GP as her previous doctors left the practice and she does not want to meet with a stranger and repeat all her story again. She feels really worried about being judged by others.

As she is not feeling confident in accessing support from GP I would like to ask you, would it be possible to refer Ava to perinatal service to access support with mental health, or would you recommend any other service which may help? Please let me know your thoughts.”

A Child In Need meeting was held on 30th March 2022 but neither parent attended nor were reachable by phone. Only the Health Visitor and Social Worker were noted as attending.

- 3.61 On 21st April 2022 the Health Visitor attended the home and met with Ava who said she did not feel anxious or low but was experiencing panic attacks at times when faced with life stresses. She said she was happy to see a different GP which was contrary to what she’d said the previous month. She was seen by a new doctor a week later who diagnosed “Mild Postnatal Depression” and re-prescribed fluoxetine. The term mild is

significant and further exploration can be seen in ToR 4.16. She was also seen in early May by CGL and provided a high breathalyser test for alcohol.

- 3.62 On 20th May 2022 the Health Visitor visited Ava and assessed her as having anxiety and depression. Ava said she felt as though her anxiety had improved since she started medication. Within this meeting the health visitor asked Ava about her relationship with Len. She said they would sometimes have verbal arguments but denied any shouting. Ava agreed to “healthy relationship work” with one session held on 24th June 2022 with the Social Worker. This would not have been sufficient nor appropriate given the domestic abuse history. (see ToR 4.15).
- 3.63 On 12th July 2022 a CIN (Child In Need) meeting was held via video link. In attendance were the health visitor, housing, child practitioner, family worker and the parents. The decision was made to “step down to Early Help” (see Appendix A) which meant another decrease in monitoring. This decision would typically reflect a reduction in risk, less concern and more protective factors in place meaning the parents required less support to care for their child effectively. It was noted they needed to re-book Julian’s Hep C screen as there had not been enough blood in the sample.
- 3.64 On 21st July 2022 the Health Visitor visited for the scheduled 10-12 month health review. They noted there had still been no appointment made for Julian’s Hep C screening and he had a skin rash on his chest and back.
- 3.65 In early August 2022 Police received a report of an argument in the street with a baby present in a pram. Len said 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. He refused any police involvement. Nonetheless, Police arrested Ava who admitted assaulting Len. She received an adult caution. The condition¹³ of this was that she continue to engage with CGL for her alcohol use. It was later assessed she did not comply with these conditions and so in November 2022 she was summonsed for assault and convicted, pleaded guilty and received a conditional discharge. The incident was graded as a medium risk via a DASH. Whilst in custody Ava was assessed by the CPFT Liaison and Diversion (LaDS)¹⁴ as getting all the help and support she needed through CGL, apart from her mental health needs. She was encouraged to make an appointment with her GP for low mood. The assessor made a referral to Children’s Safeguarding and informed the GP.

¹³ Where a person fails or refuses to comply with the conditions, they can be summonsed to appear for the original offence.

¹⁴ [Service detail | CPFT NHS Trust](#)

- 3.66 The referral from Police to Social Care noted the following: *The child is very vulnerable due to age and is completely dependent on parents, looked to be physically sick, with rash over face and did vomit a couple of times, however not necessarily out of the ordinary for a 10-month-old. The flat was quite messy and there were sick stains on the bed and food mess on the floor which was cleaned up by Len during attendance. Ava was arrested on 2nd August 2022 after allegedly causing ABH level injuries to her partner following an argument. She had been drinking heavily and said she drinks approx. 6-8 cans of strong cider a day alongside her methadone and is supported by CGL for her alcohol intake. She states she is bottle feeding and breast feeding her baby, so I am concerned that baby is suffering as a consequence of this.*
- 3.67 At the same time housing staff notified the local authority of the recent incident. Within this communication it was confirmed the family were supposed to be receiving fortnightly visits from an Early Help Family Worker who had planned to organise a TAF (Team Around the Family) meeting. This review has confirmed the family were not engaging with Early Help. It is noted within the Social Care IMR (Individual Management Review) how Ava was required to complete an online course for female perpetrators of domestic abuse.
- 3.68 Ten days later Len called the Police after an argument with Ava. On attendance they could hear a female voice from inside shouting. When the door was opened Ava was seen to be intoxicated and was “shouting and behaving in an aggressive manner”. Police separated the couple and spoke to Len alone who said Ava had returned home drunk and accused him of cheating on her. He said he was worried for their 10-month-old. He said he just wanted her to go to bed and told officers she was alcohol dependent and wanted her to get help for her drinking.
- 3.69 On the 15th August 2022, Ava’s single person UC claim was closed after she made a joint claim with Len. They declared two children living with them and said they were both unemployed. This was clearly not the case as Kyron remained living with Seb.
- 3.70 In the same week 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”.
- 3.71 A strategy meeting was held on 7th September 2022 to discuss the various concerns with Ava being identified as a perpetrator of domestic abuse towards Len. The outcome of this meeting was for a Section 47 enquiry to commence. This concluded on 27th October 2022 stating the threshold for ICPC (Initial Child Protection Conference) was met, but

“after exploring children's services' worries with the parents; they have both agreed to a CIN (Child In Need) Plan to be implemented”. A change of Social Worker occurred within this enquiry. This is a theme of social care intervention with 12 different Social Workers noted within the entirety of Julian’s intervention. Social Care have reflected how the enquiry outcome, given the risk, was not proportionate. On 7th November 2022 the assessment was finalised but was extremely limited with some sections left blank and a CIN Plan recommended.

- 3.72 On the same day the assessment was completed Len called the Police to report arguing from Ava. He said she had been drinking and mentioned drug use. He said Social Care had advised him to call them if Ava was “playing up” as if he didn’t it would seem as though he was not looking after his child. On further exploration Police learned the couple had been arguing for much of the day. The context given was Len being detoxed from Subutex which led to Ava “storming off and consuming more alcohol”. Ava was not present when Police arrived. After Police left the address Ava returned. When Police were called back she was again not present. Therefore, it appears this was only Len’s version of events.
- 3.73 On the same day a resident reported concerns to the housing provider about Ava’s behaviour. Housing staff checked CCTV which showed Ava “causing anti-social behaviour” between 5:40pm and 10:17pm, being abusive to other residents and kicking their doors within the building. A resident reported they had looked through the spy hole and could hear from Ava’s tone she was “under the influence”. They could also hear Len telling her to leave as she was “upsetting everyone and causing a scene”. Housing staff later informed Social Care Ava reportedly spat at Len.
- 3.74 On the 9th of November 2022, Len called Police saying Ava was causing a disturbance. The call-taker noted what they thought was violence occurring in the background. On arrival Ava was calm and there was nothing to suggest violence had occurred. She told officers she had been upset at not being invited to Kyrn’s birthday. The couple were spoken to separately but with no allegations made, police left.
- 3.75 Ten minutes later Len called again saying Ava had continued her behaviour from before as soon as officers left. Police returned but Ava had gone. A child safeguarding referral was made due to the continued risk of exposure to domestic abuse between the parents and ‘poor’ home conditions.
- 3.76 Social care received the notifications about the concerns for Julian’s welfare and visited the family a day later. Ava was reported to be ‘under the influence and had locked Len out of the flat’. Social care notes referenced Police removing Ava the day previously who had allegedly been verbally aggressive towards Len and made threats to kill. This

appears in contrast to the police information which has not highlighted any such threat. As a result of this, and continued concerns for Ava's mental health and substance use, alternative accommodation for Len and Julian was explored as part of a safety plan and a DASH risk assessment was completed with Len which scored 16. This score indicates high risk of serious harm or death as per Safelives guidance¹⁵. However, there is no evidence a MARAC referral was submitted as would be the protocol if someone had been deemed at high risk of harm. This is a nuance to agreed processes in Cambridgeshire. It was agreed for Ava to stay with family in the absence of other accommodation. However, Ava returned later in the evening. It is believed Len left the latch off to facilitate this.

- 3.77 CCTV viewed by the housing provider from 10th November 2022, showed Len and Ava arguing and fighting whilst one of them was holding the baby.
- 3.78 Another call to the Police was made later that day, this time by accommodation staff. They said Ava had returned and the couple were arguing again. Other residents were now getting involved. They were increasingly concerned the situation was getting out of hand. Officers attended by which time Ava was outside of the building. Len said Ava had started causing issues earlier that morning and was refusing to leave. Officers recorded a concern about child neglect due to the animosity between the parents. Ava was reportedly sleeping in the bedroom, Len in the sitting room. Julian was seen and appeared 'happy' although noted to be clumsy and repeatedly falling over, but they determined police protection was not necessary. No offences in relation to this incident were recorded although there had clearly been a disturbance prior to police attendance.
- 3.79 On the same day Len requested housing help from the local authority reporting he was a victim of domestic abuse. He requested help to find safe accommodation for both himself and Julian. He was provided with the male domestic abuse helpline information and offered temporary accommodation for him and Julian away from Ava. The Housing Adviser was unable to reach Len to advise him of these arrangements and so asked Sanctuary staff to visit him on site – this visit happened at 4:50pm the same day and staff reported Ava was not allowing Len to access to his phone. When Len was spoken to, he turned down the offer of temporary accommodation.
- 3.80 Police were called again later that evening as Ava was threatening to harm herself following the meeting with Social Workers. The call was responded to via the CPFT First Response Service (FRS) and the Joint Response Mental Health Police Vehicle. Ava informed them there had been a meeting that day about her baby who was under a Child In Need Plan (CIN) and Social Care had raised concerns about violence from her

¹⁵ [Marac referral criteria and form - SafeLives](#)

towards her partner. There were concerns Ava had consumed cocaine prior to this meeting.

- 3.81 Whilst responding to this incident, staff at the hostel made the attending officer aware they had reviewed the CCTV of the 7th November incident. This showed Len assaulting Ava whilst she was holding Julian which was contrary to Len's initial report. The attending officer viewed the footage with the staff and notified the investigating officer of the alleged assault on the 7th November. The CCTV was eventually seized although not at that time. This was a different series of events than Len's original allegation described.
- 3.82 Following multiple reports, Police used their powers to remove Julian and place him temporarily with a paternal aunt to protect him from further harm.
- 3.83 Social services held a strategy discussion meeting on 11th November 2022 to discuss whether further immediate actions were required to protect Julian from harm. Concerns noted included Ava's mental health, alcohol / substances misuse, and the parental relationship with the phrase "pushing each other whilst holding Julian" noted. It was again deemed Len was a victim of DA. Julian was noted to have a bruise on his head and it was unclear how he gained this. It was agreed for a medical to be arranged for Julian and for legal advice to be sought. It duly was and a decision was reached to issue care proceedings. An emergency protection order was gained on 14th November 2022.
- 3.84 On the 23rd November 2022 there was another 3rd party report of arguing from Len and Ava's address. The caller said both Len and Ava appeared intoxicated. Len initially told police he had been assaulted but would not give further information. He said he was being controlled by Ava but when police said they would need to arrest Ava he withdrew his allegation. Nonetheless, Ava was arrested but then showed officers bruises and said Len had caused them. He was arrested some time later due to this allegation but a decision was made to cancel the crime as there was "no evidence either was assaulted". Whilst the allegations were investigated, Ava was given bail conditions not to attend the address nor be in direct / indirect contact with Len.
- 3.85 By 1st December 2022, housing had received notification of bail conditions for Ava which prevented her from visiting Len at their address. As a result, the Housing Adviser separated the couple's homeless application and arranged for Ava to be accommodated separately.
- 3.86 From the 23rd November 2022 until the final court hearing both parents were able to visit Julian in a contact centre three times a week. It is noted this was contact with both parents together. The reflection of services is this must be reviewed where there are

domestic abuse allegations and especially where there are bail conditions preventing contact between parents.

- 3.87 On 8th December 2022 the couple's joint claim was closed as Ava had made a single claim to UC (Universal Credit). She declared she had two children living with her. On the same day Len claimed UC as a single person and said he had one child living with him. He declared a change of address and a bank account which was in his name.
- 3.88 Ava registered with a new GP surgery on 1st Dec 2022 and saw her doctor two weeks later who noted she "felt very depressed as her son had been taken into foster care". Blood tests were ordered, mirtazapine was restarted and propranolol for anxiety begun. Ava scored 27 out of a possible 27 on her depression-screening questionnaire. There were several failed contacts with the practice, mostly nursing, following this and missed hepatology appointments.
- 3.89 By January 2023 Len was telling services he was no longer taking Class A drugs following the birth of his son. He denied being in a relationship with Ava and wanted to gain custody of their son who was with a foster family at that time. He asked CGL to no longer share information about their situation with her. He attended a relapse prevention group in mid-January. He said he hoped Julian would live with Ava's mother for a few months and then with him once he had been provided a two-bedroom property via the council.

One agency record stated the following: Len clearly loves the boy and was quick to show a photo of them together. He became tearful when speaking about him and stated that he wants to be a good role model for him when he's older. He avoids his old haunts and associates and is currently doing a construction course with hope of getting work in the near future.

It appears the couple were possibly still in a relationship at this time and within the same month Len was hesitant to take a drugs test as he said he would likely test positive for crack cocaine due to 'accidentally smoking it at a friend's house'.

- 3.90 On the 11th February 2023 Len called the police and claimed Ava had climbed through a window to get into his address. He told police they were separated, and he didn't want her there as their child had been taken into care and he was emotional. Ava told Police she had asked him for her medication as she wanted to go to sleep and not wake up. Police took her to her father's address and advised her to call 111 if she needed help with her mental health.

- 3.91 In early March Len informed his CGL worker Ava and he would be moving back in together. He said there were no longer bail conditions in place and he attended a group programme called Foundations of Change.¹⁶
- 3.92 On the 26th March 2023 Len called the police stating he had concerns for Ava. He described her as having a mental health episode due to not taking her medication. He said she was becoming paranoid and had accused him of taking drugs in a neighbouring flat. Ava was spoken to separately and confirmed she had been worried Len had been trying to 'score'. While officers spoke to Ava, Len entered the flat and asked them to remove her which triggered an argument in front of officers. Police took her to her father's address.
- 3.93 In late April Social Care's parenting assessment concluded it would not be safe for Julian to return to either parent's care and adoption processes would commence.
- 3.94 On 17th May 2023 Len attended a CGL appointment in person and explained he was feeling agitated at CAFCASS¹⁷ who, he felt, were discrediting the positive progress he had made in his recovery journey. He said he felt overwhelmed with all the tasks that he had to complete. He was distracted and concerned about Ava who was continually calling during the appointment.
- 3.95 On the 26th May 2023 Ava attended the GP saying she wanted a 'diagnosis' and proof she and Len were seeking help. She said her child had been taken into foster care and since then her anxiety and depression were worsening. She said her urine tests were negative, and she last saw CGL in April 2023. This was accurate but her alcohol use had been noted as escalating throughout April. She described lots of anxiety/panic symptoms which affected behaviour e.g hiding things and over checking. She denied any thoughts of deliberate self-harm or suicide. The GP referred once more for primary care mental health interventions.
- 3.96 Ava continued seeing CGL in June 2023 which appeared to be gaining some reduction in alcohol use. She came off her opioid substitute treatment¹⁸ and continued to accept 1:1 support. She had a notable appointment in late June 2023 where she attended the CGL office without an appointment and advised she had stopped taking her physeptone (methadone) recently which resulted in her feeling 'shivery'. She asked not to be breathalysed as she had drunk two cans of cider. The worker queried why she would choose the strongest strength cider if she felt triggered and she suggested it was a rebellion against Len. She said she gets angry with him, "*he acts as though his poo*

¹⁶ [Foundations of Personal Wellbeing](#)

¹⁷ [Cafcass advises the family courts about the welfare of children and what is in their best interests | Cafcass](#)

¹⁸ [Part 1: introducing opioid substitution treatment \(OST\) - GOV.UK](#)

doesn't stink. He is using cannabis daily and is horrible when he doesn't have it." She asked for this to be broached with his CGL worker. The CGL practitioner said they could not do this due to a lack of consent and attempted to work with Ava on her reactions focussing on things she could control.

- 3.97 On the 31st of July 2023 an online report was received by the Police control room after a neighbour reported ongoing issues with Len and his partner. The following narrative was recorded; *"This is an ongoing issue with our upstairs neighbours who have recently moved in. Every other night they're intoxicated arguing, shouting, swearing and throwing items around the flat. The report continued; it does sound like there is domestic abuse happening from female towards the male. It goes on for hours and gets very heated between them both. I have heard things smash on the floor."*
- 3.98 The force control room assessed the report. They deemed there to be no immediate or ongoing incident so it was appropriate for a 'slow time' Police response. Due to a lack of resources this action was deferred until a subsequent incident on the 5th of August had been responded to.
- 3.99 On 5th August 2023 Len called Police stating he had concerns for Ava and her mental health. He said she had "smashed the address up" including some of his belongings. Police did not take any punitive action regarding the damage but removed Ava to her mother's address for the night. Officers completed safeguarding referrals with the following comments: *Upon speaking to both parties they explained they were having a difficult time as their son was in care. Ava said she was receiving support for her depression but felt this wasn't enough and wanted more support for her mental health. She said she struggles to control her emotions and this led to the incident. She said she was seeing CGL in relation to drugs and alcohol and was now completely off drugs and has even stopped taking methadone. In terms of alcohol, she has said that she has a small amount of cider every morning and evening. However, while at the address she appeared intoxicated, although she denied this.*
- 3.100 In August 2023 Ava told CGL she had achieved a period of abstinence from alcohol and felt she was doing well. It is of note hair stand tests were ordered by the court but evidence suggests Ava did not engage with this process.
- 3.101 On the 16th August 2023 Police received a call in relation to an argument. Officers attended and initially decided to leave without taking any action. However, Len later asked Police to remove her as *"she was still being argumentative"*. Police decided to ask Len to leave as Ava refused to go. He spoke to CGL about this who described him as being distressed. He insinuated coercive control from Ava although the notes on CGL's

recording system were not clear. On review they felt there was a lack of risk assessment and curiosity about this.

- 3.102 On 29th August 2023 Len was seen by his new GP. He reported he had recently moved to the local village and had a “successful detox with CGL” which is inaccurate. He asked for Gabapentin for shoulder pain. He said he was slapped twice which had affected his hearing and was diagnosed with a torn eardrum. No other information was recorded about this disclosure. He was told it would heal in 4 weeks. Information later provided by Ava to CGL suggested he had been selling his Gabapentin.
- 3.103 A couple of days later Ava had her bloods taken by a practice nurse. Whilst there Ava said she was ‘trying to turn her life around’ but was tearful and difficult to interrupt during the appointment. She explained she was having feelings of paranoia and daily panic attacks. She said she was waiting for counselling. She reported having recently moved into the village with her partner and was anxious about the upcoming adoption proceedings for Julian. She reported a significant reduction in alcohol use and being 5 months clean off heroin. She was started on a low dose of Quetiapine for sleep, paranoia and agitation.
- 3.104 From September onwards Ava became less contactable to CGL and her alcohol use appeared to increase again. She called them on 1st September saying Len was taking her money and being spiteful. She said he had taken Julian's clothes because he bought them. She sounded drunk to the call taker. Around the same time she requested consent be withdrawn from Len so he could no longer liaise with CGL on her behalf.
- 3.105 On 4th Sept 2023 Len came into the GP surgery with Ava. It was noted they seemed to be arguing. Len did not wait for his appointment. A day later a local pharmacist reported the Len was verbally abusive demanding Gabapentin. He was advised he would be banned if it happened again.
- 3.106 In mid-September 2023, a Court Order was obtained to gain permanent adoption for Julian. Ava contacted CGL out of hours later that day. She was upset after the conclusion of the court case. She sounded intoxicated and spoke of “topping herself” although said she would “never do that”.
- 3.107 In the early hours of the day after this, a member of the public called Police saying they had witnessed a male punch a female in the face in Cambridge city centre which was confirmed by CCTV. Len was arrested and charged with common assault. Ava was spoken to but declined to provide a statement and initially gave a false name to officers. A DASH risk assessment was completed and graded as medium. Len was remanded to court and given a fine at Cambridge Magistrates Court the following day. The chair / author of this report viewed the CCTV of this offence and was provided a copy of Len's

basis of plea which was submitted to the court. This will be further explored within the analysis.

- 3.108 Ava had her last medical consultation at Cambridge Access Surgery a few days later. She was initially seen on her own. She reiterated having regular panic attacks and distress regarding the adoption of her child who she worried she may never see again. She reported feeling her medication was helping and she had stopped any illegal drug use. It was noted she remained on the waiting list for an in house counsellor. She denied drinking heavily. The doctor began discussing breathing techniques at which point Ava requested her partner Len come in so he could listen, understand the advice and help her. This request was granted. She was also prescribed oral contraception and signposted for an implant. Later that day Ava called reception and described having a confrontation with a pharmacist who was refusing to release her medication.
- 3.109 In early October 2023 a member of the public called the police after witnessing a couple arguing in a car park. Police attended and found Ava and Len. Len said he had been chasing Ava as he had been worried she was going to try and buy heroin. He said *he* was fleeing domestic abuse and said he was skinny because he was in a controlling and abusive relationship, couldn't eat and was depressed.
- 3.110 Ava was spoken to separately and said she had come into the city centre to get domestic abuse support. She disclosed "an extensive history of domestic violence from Len" and said he had been following her everywhere. She mentioned his court appearance two weeks previously where he had been fined for assaulting her. She told police about two other assaults over the past 48 hours, one where he punched her in the face and one on the morning of the 3rd October 2023 where he grabbed her by the neck and restricted her breathing. This was after she had, allegedly, accidentally woken him up in the early hours of the morning due to her cough. Ava also alleged he had threatened to burn their flat down the previous night. She gave a statement to this effect, the first time she had provided a witness statement in relation to abuse from Len who was subsequently arrested for non-fatal strangulation and common assault. During his interview he told officers Ava had been "going off the rails" after their child was adopted. He said the allegations were lies. He said he was a victim of her "coercive and controlling behaviour". The Officer looked at the Len's phone whilst with him and saw several messages from Ava asking him to contact her which Len had seemingly not responded to. He was released on police bail with conditions not to have contact with Ava. A DASH was graded as high risk. This risk rating was subsequently downgraded to medium by a supervising officer which was inappropriate. This will be reflected on further within ToR 4.13.
- 3.111 On the same day Len contacted CGL stating Ava's behaviour had deteriorated and she had spent £1000 which had been provided to her for solicitor fees from family. No further

details were recorded but at the same time Ava's father contact CGL saying Len had been coercively controlling her which the police were aware of. CGL referred to MARAC.

3.112 The day after, in the early hours, Ava called the police and said Len had attended her address in the morning and had been calling and texting her. Her mother also called the Police to report his breach of bail conditions. An update was added to the police's crime report.

3.113 In the early hours of 5th October 2023 the ambulance service was called as Ava was in a cardiac arrest after overdosing. A male, not Len, was present and said she had injected the drugs into herself. She became comatose and remained in this state until her death in January 2024.

Post Ava entering a coma.

3.114 On the 10th October 2023 Len was arrested for breach of police bail and further interviewed for the offences alleged in early October. However, this later resulted in no further action. A day later the police applied to the court for a Domestic Violence Prevention Order¹⁹ (DVPO), the first and only time this was applied for, but this was not granted. Len informed his solicitor he still wanted to see Ava despite her being in a coma.

3.115 Len attended the hospital a day after this with suicidal ideation but was not admitted. He said he had concerns for his safety after threats made towards him by ex-partner's family who had, he alleged, stolen his television.

3.116 On 20th November Len contacted social care and raised concerns about Ava's drug use and domestic abuse although Ava remained in a coma. He was incoherent and was asking for contact with Julian.

3.117 Ava died in early January 2024.

¹⁹ [Domestic violence protection orders - GOV.UK](https://www.gov.uk/domestic-violence-protection-orders)

Section Four

Analysis

The terms of reference agreed by the panel has been used as the basis for this analysis.

Domestic Abuse

4.1 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?

As part of this review the accommodation Ava resided in during October 2018 was contacted. They house individuals with needs such as alcohol and drug use, mental health and ongoing housing and financial instability. They detailed an awareness of Ava and Len's relationship as well as Ava's often aggressive behaviour towards other residents. They reported frequent altercations in this regard. Residents informed staff Len was attending the property each evening as they saw his push bike and could hear the couple in the flat which was against accommodation rules. It will remain unknown how much Len coerced his way into being there or how much Ava enabled this, but it was one of the factors that led to her eviction in early / mid-October 2018.

From Ava's side of the family, only her mother was spoken to as part of this review, but she had an awareness of the concerns within her daughter's relationship with Len. For family, this was not the first abusive relationship Ava had been in, and it appeared safer than previous ones. They were often trying to support Ava with accommodation when she was struggling to maintain housing. This was difficult as there were several reports of Ava becoming aggressive at their homes. The situation facing everyone - friends, family and neighbours, was complex. To the outside, Ava would often present as aggressive when she had been drinking. This presentation is a barrier to seeing what may be going on beneath the surface. For hostel staff, they also have a responsibility to protect other residents which places them in a challenging position. Despite this, Ava's mother supported her to try and gain mental health support. They contacted the mental health crisis line in October 2019 and accompanied her to an assessment soon afterwards. There appeared to be an emphasis placed on Ava engaging with CGL and, as the review has found, longer term mental health support was limited in nature.

There is a lack of detailed advice for friends and family around how best to support those using or experiencing domestic abuse in general. There is some, such as [Help For Friends & Family Members Of Domestic Abuse Perpetrators | Respect UK](#) or [Supporting friends and family - SafeLives](#) or more locally via [Cambridgeshire County Council DASV Partnership - Information for Friends and Family](#) but it is likely this would not have been

sufficient for Ava's family given the complex circumstances at hand e.g mental health and drug / alcohol concerns. Given the number of professionals involved they would have been well placed to support and provide advice in relation to domestic abuse but a specialist in this area would likely have been better placed. [Al-Anon UK](#) provides support from friends and family of those with significant alcohol related concerns. Whether this was signposted to is unknown but is noted here for professionals consideration in future cases.

A Family Group Conference (FGC)²⁰ for both sides of the family was suggested but declined by the parents on 3rd November 2021. They 'felt they had good family support'. This statement appears to undervalue the importance of such a conference to ensure all family members are aware of concerns, are able to communicate effectively and be consistent with support. With the complexity of issues at hand it may have been beneficial to suggest this more assertively. Given the known domestic abuse, it would not have been advisable for this to be held with Len and Ava together. Family Group Conferences²¹ (FGCs) do have the capacity to split conferences but this does not appear to have been considered in this instance. From panel discussions it appears this is not widely known and may benefit from promotion to increase awareness.

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

As the chronology indicates, both Ava and Len were known to a variety of services prior to meeting each other. This included the police, social care (Ava), probation (Len), CGL as well as health services. In a domestic abuse context Ava was known to have experienced significant domestic abuse in at least two previous relationships which were deemed to be high risk in nature with numerous appearances at MARAC (see background information). She was known to have used abusive behaviour herself although it is unclear if this was to gain control over another or as a reaction to abuse that she was experiencing. There is evidence to suggest she struggled with feelings of jealousy and insecurity. For Len, he was well known to criminal justice services for dishonesty and drug related offences with some violence in a familial domestic abuse context and allegations of abuse in a previous relationship (see analysis 5.11).

²⁰ [What is a Family Group Conference? - Family Rights Group](#)

²¹ *FGC's work with family members to put plans in place to address the 'power dynamic' within the Family Group Conference, and especially the Private Planning Time. They can make contingency plans and regularly use advocates for more vulnerable members of the family group. Split meetings can be considered, so too a shuttle conference to ensure safety.*

The MARAC notes from January 2019 are a significant source of information for the agencies involved with both Ava and Len. However, they do not appear referenced or considered at any point within later agency intervention. This was a missed opportunity to fully consider the history, frequency, severity and dynamic of the abuse within the relationship. This is most pertinent to probation who were seeing Len for unrelated offences at this time. They do not appear to have used any of the MARAC information to reassess Len's risk or consider any appropriate restrictions which could have safeguarded Ava from future abuse.

The police did disclose Len's domestic abuse history in relation to a restraining order against his step father and another "vulnerable person" at the Initial Child Protection Conference in 2021. The sharing of this is good practice although it is unclear how useful this was in informing next steps / interventions.

The MARAC notes from January 2019 highlight the first months of the couple's relationship which had clear allegations of significant violence from Len towards Ava. They are detailed and provide a police history for both Ava and Len. It highlights Len's propensity for violence and Ava's history of experiencing abuse in relationships. Although Len's use of violence is predominantly outside a domestic abuse context it does include breach of restraining order, harassment and use of non-fatal strangulation. It highlights an extensive list of failures to comply with orders and dishonesty type offending which would have given a clear indicator for services to look for evidence to mitigate against the risk of disguised compliance²². It also detailed how in October 2018 Len was alleged to have grabbed Ava around the throat three times and pushed her over. All agencies signed up to the local MARAC information sharing process would have had access to these minutes but this review has raised a question for services to consider:

- How long MARAC flags and tags are kept on a person's file.
- When services should check to ascertain whether their clients have been heard before at MARAC.

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

Having been arrested for non-fatal strangulation and assault where he allegedly punched Ava in the face, Len was released on bail with conditions not to contact her on 3rd October 2023. He breached his conditions almost immediately by going to her address. The police have reflected on this and feel the reported breach of bail was not addressed in a timely manner. As per their DA policy, it should have been addressed on the day. The

²² [Disguised compliance: learning from case reviews | NSPCC Learning](#)

allegation was of strangulation, a behaviour acknowledged as a high harm behaviour often seen in previous Domestic Homicide Reviews. There had already been an assessment deeming the situation high-risk and therefore there was a need for an immediate response. The police have acknowledged they could and should have sought Len to arrest him immediately.

Regarding this specific ToR as to whether harassment and stalking²³ should have been considered the following definitions are important to consider:

Harassment - The legal guidance is that it should comprise two or more occasions of unwanted contact and so, as such, singular occurrences will not be sufficient for consideration.

Stalking – This may occur where an offender, follows a person, contacts or attempts to contact a person by any means, loiters in any place (public or private) interferes with property in possession of another person, watches or spies on a person. This is not an exhaustive list. Stalking is considered more of a sinister pattern of behaviour by the perpetrator and is generally considered to be understood as a pattern of fixated, obsessive, unwanted and repeated behaviour which is intrusive. A single occurrence would rarely be enough to meet the threshold.

As one breach of bail was being reported, it would not have met the threshold for either harassment or stalking. That does not negate the seriousness of Len's behaviour. It only means the threshold to arrest for either of these offences was not met.

Additionally, the police have reflected a domestic violence protection notice / order would not have been proportionate given the bail conditions which were in place.

4.4 Was coercive control and its impact considered by professionals?

Coercive control is defined as "Repeated or continued behaviour that is controlling or coercive and has a serious impact"²⁴ and can include:

- economic abuse including coerced debt, controlling spending/bank accounts/investments/mortgages/benefit payments
- threatening to harm a child
- isolating a person from their friends and family
- preventing a person from having access to transport or from working

Within this review it is clear the worry of losing custody of Julian was a significant concern for Ava and to Len. When Ava appeared to be struggling emotionally and there appeared

²³ [Stalking or Harassment | The Crown Prosecution Service](#)

²⁴ [Controlling or Coercive Behaviour in an Intimate or Family Relationship | The Crown Prosecution Service](#)

be an increase in drug and alcohol use, Len's calls to the police increased. This can be framed in different ways but it would have been important to consider this behaviour within the context of possible coercive control. Both parents often presented a united front to services. Prior to the period in November 2022, many opportunities were offered to both parents to disclose concerning behaviour, but nothing was forthcoming. Where physical injury was suspected it was explained via other means with limited evidence to the contrary.

This review is unable to say whether coercive control was or was not present within the relationship but there is no evidence to say its presence was considered amongst the professional network. There is evidence of language being used which opposes the notion of coercive control being present, such as para 3.11 where Ava is described as "burning bridges with all those willing to help her". The typical framing of the relationship from services suggested it was a co-dependent relationship with counter allegations on a backdrop of drug and alcohol use, mental health concerns and previous child removal for Ava. This description can mask the domestic abuse dynamic. When considering domestic abuse, it is vital for coercive control to be considered as part of any analysis.

Protective Measures

4.5 Were opportunities to support Ava to apply for legal orders (e.g. non-molestation orders²⁵ (NMO)) recognised and utilised?

Throughout the scoping period there were no protective legal orders applied for to protect Ava from harm from Len. There was the opportunity to apply for a restraining order in September 2023 via the criminal justice process when Len was convicted of common assault at court but this was a missed opportunity. The IDVA service in 2018 / 2019 had some brief conversations with Ava but she denied the presence of any domestic abuse and would not have been supportive of an NMO.

Overall, it is highly unlikely Ava would have accepted support to gain such an order. On the various occasions she was asked whether she was experiencing domestic abuse she indicated she wasn't. The couple presented as in a relationship throughout the majority of the scoping period.

Social Care's opportunity to apply for an NMO via court proceedings in 2023 would have been influenced by Ava instructing her legal representation to consider this and it will remain unknown as to whether she was aware of this option or would have had the inclination to do so. At this point Len and Ava presented as remaining in a relationship. However, Social Care have reflected how they also have some influence here. They can

²⁵ [Get an injunction if you've been the victim of domestic abuse: Who can apply: non-molestation order - GOV.UK](#)

consider whether this moment in proceedings is an opportunity to, at least, analyse whether an order such as an NMO could be considered. This is wider learning.

The terms “co-dependency” and “volatility” were used within records. These terms can hinder consideration of effective legal protection.

Counter Allegations

4.6 Were thorough assessments made to fully understand and appreciate the dynamic between the couple. For example, the who does what to whom assessment²⁶?

The short answer to this ToR is no. At the start of this DARDR the representative for Housing was of the understanding Len was the primary victim in the relationship. This indicates there was not a consistent understanding of the couple’s relationship dynamic, nor the domestic abuse history amongst agencies. Para 3.79 details how Len was offered temporary accommodation for himself and Julian away from Ava, an offer which may have unwittingly increased Ava’s hopelessness and trust in agencies if fully aware. This was prompted by his allegation of control from Ava towards himself, and Social Care’s domestic abuse risk assessment (DASH) which scored 16²⁷, a significant and concerning score (see ToR 5.13 for further analysis). But, as noted, Len had been viewed as the primary perpetrator of abuse towards Ava 3 ½ years previously at the high-risk forum MARAC. Their relationship had been punctuated by many months with Len in custody which may give the perception of risk reduction but DA incidents are far less likely to occur with one party in prison. There was a recorded history which required analysis. A chronology detailing the evidence known to the network would have assisted everyone’s understanding of the relationship dynamic but there does not appear to be a specific domestic abuse related chronology completed. This is a common theme within DHR / DARDRs and its vital for this to change if agencies are to better understand the dynamic at hand. It would have been good practice to provide one as it is not yet standard practice to do so. Had a chronology been available it may have provided insight into what actions / interventions could have supported both Len and Ava to focus on safety and behaviour within relationships. As the panel reflected, the domestic abuse was known, the ‘so what’ next steps were missing.

Counter allegations of domestic abuse between the couple were recorded but post Julian’s birth they were mainly relating to Ava’s behaviour towards Len which was framed

²⁶ [Respect-Toolkit-for-Work-with-Male-Victims-of-Domestic-Abuse-2019.pdf \(hubble-live-assets.s3.eu-west-1.amazonaws.com\)](#) p.41

²⁷ Within Cambridgeshire the policy adopted for referral to MARAC is a DASH score of 17 and above unless professional judgement suggests it needs to be heard at MARAC. If someone scores 14 – 16 they are offered an IDVA.

as either Ava's controlling behaviour or parental disagreement. This position was adopted in the final social work assessment and statement presented within the court proceedings. It also identified Len as the parent who had better capacity to meet Julian's needs but there was no evidence of the relationship history and previous domestic abuse incidents being sufficiently considered.

Social care also felt "There was no effective intervention offered to the couple to address this aspect of their relationship; instead there is a reactive approach to managing the presenting incidents of domestic abuse." This accurately summarises the collective approach to addressing domestic abuse.

4.7 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?

The panel reflected on this question and suggested there is a disparity across the local workforce with levels of domestic abuse training in general. Understanding counter allegations and how to effectively intervene was seen as an enhanced area of domestic abuse intervention where more experienced practitioners may be more adept at addressing it. However, even for professionals with significant experience it can be challenging to address domestic abuse situations such as those detailed here.

The question of mandatory domestic abuse training for social workers has been raised publicly with Domestic Abuse Commissioner (DAC) Nicole Jacobs speaking openly about this need²⁸. Within the most recent spending review²⁹ the development of robust and universal training for social workers on domestic abuse including controlling and coercive behaviour has been proposed. The reason given for this is "*The social care education curriculum has limited content on DA. Continuous Professional Development (CPD) training is also far from adequate for the scale of incidence and skills required.*"

The proposal recommends 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 and the use of chronologies.

How services came together to understand the relationship dynamic is a key learning point of this review. There has been a recent drive across Cambridgeshire for open and transparent conversations to occur with parents about their concerns for the wellbeing of their children. This is to be commended but this review is a clear example of how

²⁸ [Social workers 'must be taught' to spot controlling behaviour - BBC News](#)

²⁹ [Microsoft Word - DAC Submission - HMT Autumn 2024 Budget and SR - v.2](#)

agencies can benefit from stepping back and analysing all available information away from the family. Looking at the evidence as a whole is key.

The task of gaining consistent levels of domestic abuse training across all workforces will be an ongoing conversation indefinitely. Services have reflected on their own levels of domestic abuse training within their single agency recommendations. There will often be differing levels of DA knowledge, training and experiences across the agencies working with the same couple. Therefore, services must come together to 'stop and think', to look at the history and consider the intentions underneath the behaviour e.g were they reactive, were they a desire to control and instil fear into the partner, is there enough information to make such a judgement? Essentially, as a collective, what evidence do we have that tells us what the next steps should be? When there are multiple concerns such as drug and alcohol use, mental health needs, housing and many others, this aspect can be lost but requires a focus from the network.

College of Policing research has identified that Police Officers' identification of the primary victim and perpetrator in domestic abuse cases can be complex. It has been known for these complexities to lead to dual arrests, the misidentification of the primary perpetrator, and/or the denial of victim status, in particular for women. These issues are particularly pertinent in coercive control cases, where physical evidence may not always be evident, and the identification of victim and perpetrator is often reliant on the individual's testimony.

A current College of Policing project, commenced in 2023 and due for reporting in November 2025, is likely to assist officers in determining this specific question and is also likely to result in amendments to guidance and approved professional practice.

The aim of the project is to identify and evaluate:

- How are the victim and perpetrator identified by police officers in coercive control cases? When the victim and perpetrator are identified, what informs the actions taken (or not) by police officers?
- How do victim/survivors feel about the ways in which victims and perpetrators are identified during the police frontline response? If they have been (in)correctly identified as a victim/perpetrator, how did that impact upon their subsequent engagement in the investigation process?
- How might the process of victim identification be improved, if at all?

Disrupting DA perpetration

4.8 In September 2023 Len appeared at court for common assault of Ava for which he received a fine. Was a restraining order³⁰ (RO) applied for?

As highlighted in the chronology, Len was seen by a member of the public and via CCTV to punch Ava in the face in the early hours of a day in September 2023. This is within 24 hours of the final court decision regarding custody of Julian. Ava initially provided a false name to officers and declined to give a statement. However, due to the alternative evidence being available (CCTV and witness statement), Len was charged which was good practice. He gave no comment to all questions asked in interview. In the police's submission to the crown prosecution service (CPS) for charging, they wrote:

“it is in the public interest to prosecute this matter. This is a domestic-related incident with a vulnerable victim and as such there is a public expectation that offences of this nature are dealt with robustly and positively by both the police and the judicial system.”

Len pleaded guilty the following day, having been remanded to court. No orders were applied for which is an option where an individual is being convicted or, in some circumstances, acquitted of an offence in a court. The police have explored this ToR in depth as part of this review and state the Crown Prosecution Service (CPS) made reference to a restraining order within their charging decision rationale³¹. They felt, due to Ava's reported stance / comments, she would be unlikely to support the implementation of a restraining order. The panel looked at whether Ava's stance should be the deciding factor in such circumstances.

The following was provided to the panel to further explore this with further information here - [Restraining Orders | The Crown Prosecution Service](#) and is written here for learning purposes.

“The court's primary concern is whether it is necessary to make an order. They will want to know the views of the victim. If a victim is not supportive then human rights will be a consideration.

The cases of [R v Khellaf \[2016\] EWCA Crim 1297](#) and [R v Awan \(Osman\) \[2019\] EWCA Crim 1456](#) confirm that the victim's views on applying for a restraining order, its terms and its duration must be obtained. Prosecutors should confirm promptly with the police whether a restraining order is sought by the victim if this information has not been provided.

In some cases, victims may not want a restraining order to be imposed on a defendant. The courts have been clear that the law does not presently permit the criminal court to act to protect victims of domestic abuse against the consequences of decisions of this

³⁰ [Restraining Orders | The Crown Prosecution Service](#)

³¹ a document used to inform the police whether the CPS feel there is enough evidence for a realistic chance of conviction

kind which they freely make: *R v Herrington* [2017] EWCA Crim 889, see also *R v Brown* [2012] EWCA Crim 1152. If a victim wants to be contacted by the defendant, the criminal law cannot over-ride their autonomy, provided they are exercising a free choice and have the capacity to make that choice.

Where the defence say the victim objects to the granting of a restraining order and this is not supported by information provided by the police or where there is evidence that a victim may not be exercising free choice (for example, through fear for themselves or others) then this information should be presented to the court and the prosecution should ask for an adjournment to ascertain the correct position. The court should not be asked to make a restraining order against the free choice of the victim but if they are not exercising free choice the order can be sought, and the court should decide.”

In summary, the court **can** make an RO application where the victim is not supportive – but they are reluctant to do so.

The key phrase here appears to be ‘free choice’ which is significantly compromised if one is in an abusive relationship where coercive control is evident. This further supports the need for in-depth analysis of the domestic abuse dynamic and presence of coercive control so that, should an opportunity to apply for an order arise, services can be clear that free choice is inhibited.

A restraining order, if breached, can lead to up to 5 years in prison. There are a range of powers open to the courts for the offence of common assault from fines to 6 months in custody. It is not necessary for an assault to be heard in a specialised domestic abuse court for this order to be obtained. As the next ToR 5.9 will explore, there are domestic abuse courts locally but the sentencing for this offence occurred in Cambridge Magistrates Court.

Additionally, following Len’s conviction, his PNC (police national computer) record was not updated with a warning marker for violence or assault. A warning marker will ensure police dealing with Len in the future would know he has a propensity for violence. Police guidance does not encourage police officers to record a warning marker in these circumstances. The guidance indicates that, *a conviction for common assault alone would not normally warrant a violent warning signal. It should be remembered that to record a signal for any minor violent act could undermine the effectiveness of this marker.* This will be further addressed in the lessons learned section.

The decision to fine Len for common assault:

During panel discussions the court’s decision to fine Len for this domestic abuse was difficult to understand and so further exploration occurred. The CCTV footage, which was of very good quality, was viewed by the chair. This showed Ava walking and talking with another man along a city centre street. Len, who is some distance away, is then seen to

walk quickly up to the pair. As he does so, the unknown male turns with his hands up as though Len has called to him and accused him of something. This is the chair's interpretation, there is no audio available. Len is then seen to come between both Ava and the unknown male who then walks off. He leans over Ava who is smaller and slighter than he and pushes her with both hands to the ground before grabbing her with one hand to get her back up. His demeanour appears aggressive throughout.

The chair was forwarded Len's basis of plea which was provided to the courts. This said the following:

"Ava was intoxicated and I was trying to get her to go home but she wanted to get into a taxi elsewhere, I accept I have pushed her backwards away from the taxi but she has lost her balance and fallen over. I did not mean to knock her backwards and I picked her up straight afterwards but I accept that this amounts to an assault in law."

The mention of a taxi is undermined by the CCTV as it is 20 – 30 metres up the road when Len assaults Ava.

It is the chair's view Len's version is not an accurate summary of the offence. As has been described in this review, it is often the case victims of domestic abuse do not wish, or do not feel able, to provide evidence. Therefore, opportunities to utilise the criminal justice system to reduce the risk one poses are vital to grasp. This was a golden opportunity to tackle domestic abuse, not just for Ava but for any future victims. There are various sentencing options for this type of assault including fines, community orders, suspended prison sentences or prison. A community order to address one's use of domestic abuse could allow them to be monitored via probation and to firmly place domestic abuse risk on service's agenda. It remains unclear why a decision by the courts to fine Len for this offence was reached, nor whether the CCTV was viewed prior to sentencing. Unsuccessful attempts have been made to gain clarity on this question.

Following discussion with a legal advisor at the Cambridgeshire Legal Team they stated there is nothing in law requiring magistrates to view CCTV / evidence. The onus would be on the prosecution to advocate for the defence's basis of plea to be rejected, a Newton hearing (trial of fact) to be initiated and from there an evidence-based hearing to commence where the CCTV evidence could be presented. For this to occur the magistrates would need to agree there was a material difference in sentencing between the prosecution case and what the defence accept. This did not occur.

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

First piloted in 1999, Specialist Domestic Abuse Courts (SDACs) were introduced to improve the criminal justice response to domestic abuse offences. A 2022 study highlighted 57 of the 156 open magistrates courts in England and Wales as SDACs. A key difference between an SDAC and typical magistrates court is enhanced knowledge of domestic abuse amongst staff as well as an increased focus on victim / survivor access to domestic abuse support.³²

The local SDAC was not used in this case. There is an established protocol locally which specifies the court venue for those charged and refused bail. Dependent on the day they appear at court this can be either Peterborough, Cambridge or Huntingdon Magistrates court. Len was charged and held in custody to appear on the 15th September which was a Friday and fell on the Cambridge Magistrates court day (not an SDAC).

Within the current localised arrangements, determining whether someone should attend a specialised domestic abuse court can only be made when someone is charged and bailed, not when they are remanded to appear the next day as Len was.

The Magistrates Court Senior Legal Manager (SLM) detailed the complexity of this for the panel. They described how responses differ dependent on the day someone presents at court. For example, a specialist domestic abuse court is only available on particular days and one would not be adjourned back to a domestic abuse court if it was felt it could be handled via the remand court.

The panel have debated whether the outcome of Len's court appearance would have been any different had it been heard in an SDAC as opposed to a standard court. This will never be known but it prompted discussion of the differences between the courts. It was confirmed that Magistrates and District Judges have now all received DA training, which, in theory, reduces the potential 'lottery' of having different outcomes and decisions depending on the day someone arrives at court. An action arising for this review was to seek clarity on whether the magistrates / judges residing over Len's sentencing had completed this training and whether it requires a review.

The SLM reflected further: *"It was felt that the bench would have balanced Len's guilty plea, coupled with no support for further action from Ava and no order application. Coupled with lay DA training in DA the court would have been able to act there and then and impose the sentence."* It was commented that a fine for a domestic abuse offence was unusual but not implausible. To the panel, this felt like a significant missed opportunity to hold Len to account and focus on his behaviour via robust, rehabilitative sentencing. Additionally, as a result of this review, Probation have agreed to liaise with court services to ascertain what court preparation occurred pre-sentencing and whether this was adequate.

³² [National Specialist Domestic Abuse Court Mapping](#)

It is a recommendation from this review for the localised domestic abuse court arrangements to be reviewed by the Criminal Justice Command in collaboration with the Senior Clerk to the Magistrates to determine if this gap can be effectively addressed.

4.10 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?

Probation have access to a Building Better Relationships programme, a moderate-intensity cognitive-behavioural programme for adult men convicted of an Intimate Partner Violence (IPV) offence³³. However, as Len was not with probation for a domestic abuse (DA) related offence, nor was an appropriate assessment completed by them in relation to his DA risk, this was not an option. Para 3.67 notes a request from Early Help³⁴ (whom Len and Ava were not engaging with) for Ava to complete an online course for “female perpetrators of domestic abuse”. It remains unknown what course this references but this would not have been appropriate. It suggests the history had not been considered and was seemingly an unrealistic and inappropriate suggestion.

Currently, there are no domestic abuse perpetrator programmes commissioned within Cambridgeshire. These programmes are a postcode lottery across the country and vary in length and content³⁵. Even if there had been availability, it is unlikely either party would have been identified as requiring one as the necessary analysis of the domestic abuse had not occurred sufficiently.

This ToR considers “harmful behaviour” which is a broad term specifically used to encompass a variety of behaviours. It was known Ava had a propensity to become aggressive when drinking. Both Len and Ava were working with CGL to understand and address their drug and alcohol issues but this would be unlikely to adequately explore the root causes of abusive behaviour in an intimate partner context. It is worth noting, there are individuals who use alcohol and drugs and are not necessarily abusive to their partners, although it is acknowledged alcohol consumption can increase risk.

Additionally, there were counter allegations. Within paragraph 3.81 there is potentially evidence of Ava using ‘violent resistance’, a term used to provide an understanding of why harmful behaviour may be used as a reaction to a threat. This ToR can not be answered in isolation as the necessary analysis and assessment of the domestic abuse was not present during the scoping period. There is also a lack of services locally for those using abusive behaviours in a domestic abuse context. Therefore, whether practitioners were confident in knowing how to ask the necessary questions links to the availability and knowledge of what services are available. For example, had practitioners gained some

³³ [Evaluating the Building Better Relationships \(BBR\) programme](#)

³⁴ [Early Help processes | Cambridgeshire County Council](#)

³⁵ [Respect | Home](#)

insight and acceptance from the couple for the need to address their behaviour, what would the next steps have been, what services would have been available for them?

When Len was met during the course of this review, he said he had been worried about Ava overdosing and dying. Regardless of whether this reflects his true intent, advice for someone who is the partner of an individual with suicidal ideation and / or concerns about drug overdoses, is an area services may wish to consider in the future. Clearly detailing to them what is controlling behaviour and what one can genuinely do to help could form part of the overall domestic abuse intervention for the couple.

4.11 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)

The DVDS scheme, also known as Clare's Law, has two elements: the "Right to Ask" and the "Right to Know". An individual or third party (for example, a family member) can ask the police to check whether a current or ex-partner has a violent or abusive past. This is the "Right to Ask". If records show that an individual may be at risk of domestic abuse from a partner or ex-partner, the police will consider disclosing the information. The "Right to Know" enables the police to make a disclosure on their own initiative if they receive information about the violent or abusive behaviour of a person that may impact on the safety of that person's current or ex-partner. This could be information arising from a criminal investigation or from another source of police intelligence.³⁶ There can often be a disparity across forces as to what is disclosed and what is deemed relevant.³⁷

There is no evidence of a Clare's Law Disclosure being completed with Ava. Within the MARAC notes in January 2019 it is noted within the police update "*DVDS not viable whilst victim is entrenched and given relative minor previous.*" Within the same MARAC it was noted Len had a restraining order against his step father and previous allegations of generalised violence and dishonesty. The recorded comment indicates an assumption Ava would not have been receptive (e.g *victim is entrenched*) to such information. But, as we know, she was working alongside other services who may have been able to support such a disclosure. Len was soon in prison after this which may also have provided an ability to give her this information and for her to absorb it. The MARAC was within 6 months of the relationship starting which appears pertinent to highlight as the earlier disclosures can be made, the less time there has been for bonds to form and perpetrators of abuse to provide their narrative. This isn't recorded as being considered.

Risk Assessment

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

³⁶ Information may come from other statutory agencies.

³⁷ [Using criminal histories to empower victim-survivors of domestic abuse - Katerina Hadjimatheou, 2023](#)

4.13 The police were the predominant users of the DA risk indicator checklist (DASH). Was this tool used appropriately? Additionally, did other agencies consider the domestic abuse risk, assess and offer the appropriate interventions?

Terms 5.12 and 5.13 have been combined within the following analysis.

Overall, there is a lack of domestic abuse risk assessment evident throughout the scoping period and this situation required agencies to come together and analyse the domestic abuse dynamic.

A common tool used by services to better understand the risk of domestic abuse is the DASH (domestic abuse stalking and harassment risk indicator checklist)³⁸. It is important to note the DASH is not the only domestic abuse related risk assessment tool available. Probation, whom had significant involvement with Len from the beginning of the scoping period to June 2022, did not complete a Spousal Assault Risk Assessment (SARA) at any point, in contrast to policy. The HM Prison and Probation Service [Domestic Abuse Policy Framework](#) states a SARA is to be completed in every case where intimate partner abuse has been identified. This would have evaluated the risk of serious harm to Ava. When it was apparent circumstances were changing e.g a reported domestic abuse concern or Ava's pregnancy, this did not prompt a review.

The Police often attempted to complete DASH assessments, but these were declined, predominantly by Ava. Police will often be attempting to complete a risk assessment with an individual soon after an incident of alleged abuse. Where drugs or alcohol are involved it can be additionally challenging to gain an accurate account of the relationship. It is not solely for the police to evaluate domestic abuse risk. Though it appears assessing DA risk is most embedded within the police, they are arguably in the most compromised position to do so. Services who have an ongoing relationship with an individual, in this case probation (Len), CGL, maternity services, housing staff are well placed to build a relationship and gain a thorough understanding of the situation. Even for Social Care it is difficult to gain an accurate picture due to anxiety related to child removal. There can be numerous worries from the recipient of the DASH:

- Fear of getting partner into trouble
- Fear of having child removed by disclosing abuse
- Fear of repercussions from the perpetrator themselves

This is not an exhaustive list. Therefore, services who are well placed to gain an honest account of the relationship must utilise their opportunity to do so. In late 2018, Police recognised the high risk nature of the domestic abuse Ava had been experiencing from

³⁸ [Dash risk assessment resources for professionals - SafeLives](#)

Len and referred into the local MARAC. This was good practice. However, this significant history does not appear to have formed part of any DA risk assessment from any agency.

Social Care have acknowledged an absence of effective domestic abuse risk assessments and state “there is no evidence of risk assessment tools being utilised” which presumably is for Ava as the chronology highlights a score of 16 for Len on a DASH. Although domestic abuse was known and acknowledged, there was little to no intervention offered to address it and reduce the risk of incidents occurring.

During a mental health assessment in October 2019 the practitioner rightly recognised Ava minimising domestic abuse concerns and ensured there was liaison with CGL. But these concerns did not appear to translate further into domestic abuse risk assessment or additional support.

It is important to highlight a nuance in Cambridgeshire. A policy has been adopted where cases with a score of 17 and above on the DASH qualify for MARAC. This is not in line with Safelives guidance which recommends 14 and above. That is not to say it can not be heard at MARAC on professional judgement. The DASH completed with Len in November therefore was not referred to MARAC. Had it been, it would have been with Len as the primary victim. It will remain unknown what impact this would have had on service responses, but it would have provided an opportunity for multi-agency discussion, with a domestic abuse lens, in a high risk forum.

The police have reflected on their high-risk assessment on 3rd October 2023. This assessment was downgraded to medium by a supervisory officer on the same day. This was not appropriate and showed a lack of understanding of the risk posed to Ava. This was evidenced by Len breaching his bail soon afterwards. Further context as to why this downgrading occurred is as below from the supervisory officer:

“I confirm I have reviewed the risk assessment in conjunction with the investigation record and disagree with the risk assessment recorded. New assessment - medium risk. The current allegation relates to an alleged common assault and non-fatal strangulation (reported by Ava) and Len (pseudonyms used) has already made allegations Ava was the aggressor, and he is in a controlling relationship. It is noted across the crime reports the pair consume alcohol and drugs and this appears to be the main trigger within their relationship. Both frequently make allegations and counter allegations against the other. Their relationship is an unhealthy one which appears to focus on substance abuse and the consequences of said usage. Both are prone to violence: Ava accepted a conditional caution for assaulting Len and Len was found guilty at Mags court for assaulting Ava. There are indicators of serious harm occurring with the trigger for these being linked to their alcohol and substance misuse.

Previous risk assessments – including incidents clearly shown on CCTV – have been graded as medium or standard risk. From the above, I would suggest this is reclassified to medium risk.”

The supervising officer appears to reference counter allegations as one reason the risk should be downgraded. They state it is an “unhealthy relationship” which “appears to focus on substance misuse”. The use of both terms, perhaps unwittingly, minimises the harm and apparent increase in risk. The officer states both parties are prone to violence whilst also acknowledging “indicators of serious harm” which appears to contradict the decision to downgrade. It could be argued if both are “prone to violence” as put by the officer, there is just as much reason to keep them at high risk status. The officer also mentioned previous risk assessments being graded as medium or standard. This risk grading of previous domestic abuse allegations is irrelevant to this grading decision.

Significant context and detail has been lost from this summary and the interpretation of all available information appears to be more about the supervising officer’s subjective stance. For example, the allegation of non-fatal strangulation which is a high risk indicator³⁹, Ava’s willingness to provide information having been so reluctant to do so previously and Len’s recent conviction 3 weeks earlier for physical abuse, the recent timing of which is not mentioned.

Ava should have stayed as high risk. The MASH (multi agency safeguarding hub) upgraded the risk back to high before sharing with partners, but this was not until 13th October 2023 when Ava was already in the coma. The subsequent MARAC referral should have been made much earlier although sadly it would have had no bearing on the eventual outcome.

Mutli Agency Collaboration / MA Forums

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

Within the scoping period there was a MARAC held in January 2019 in relation to Ava and Len. The recorded minutes of this appear thorough and detailed. Considered at this meeting were:

- Exclusion / banning orders for Len.
- DVDS consideration for Ava (though this was not agreed)
- Increased links with education with regards to Kyron
- Clarification of whether Ava was pregnant (she wasn’t)

³⁹ [Non-fatal strangulation is an important risk factor for homicide of women - PMC](#)

The list of agencies within the 2019 MARAC minutes incorporates all services involved within this DARDR, indicating they are signed up to information sharing processes. However, there are no notes from CGL or Probation who were involved with the couple at that time. It would be beneficial to include a list of attendees in future MARAC minutes. It is unclear if they were in attendance or contributed. Regardless, the information shared does not appear to have been factored into later agency responses for the couple. It is highly likely services were not aware of this MARAC involvement, or they did not analyse what this meant if so. Len spent periods in custody between this MARAC and latterly encountered services such as Social Care and so there was limited evidence of the couple being together with no domestic abuse related concerns. Where one individual is known to have been in custody it can be especially useful to use chronologies to illustrate differences in concerns / presentations.

The next time the couple were heard at MARAC Ava was in a coma and it was too late to effectively intervene.

As has previously been addressed, the score of 17 on the DASH being the minimum score for MARAC referral is unusually high and in contrast to the Safelives guidance of 14. This would limit opportunities for cases to be heard at this forum. The panel wished to make clear the DARA is now the main tool used by the police when assessing risk. This has been seen to increase referrals to MARAC locally and, anecdotally, this tool appears to be better placed to identify high risk familial abuse. There appears to be pros and cons to this. Conversely it was felt two different domestic abuse risk assessments (DARA⁴⁰ and DASH) being used within one area can increase the risk of miscommunication and differing analyses. The panel representative for Impakt⁴¹ reported some medium risk graded DARA's becoming high risk once a DASH is used.

4.15 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.

As this ToR indicates, there were multiple issues present. There were significant drug and alcohol concerns for both parents, housing instability, the birth of a child, previous child removal, a backdrop of Covid limiting in-person contact amongst others. When child protection planning commenced, and especially when midwifery and health visiting became involved, there appeared to be enhanced engagement from all services with attendance at core groups. Professionals acknowledged the presence of mental health, drug, alcohol and domestic abuse concerns which were impacting on the parent's ability to care for Julian. Midwifery detailed their positive relationship with both Len and Ava during this time which appeared to be at odds with the couple's engagement with drug

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⁴⁰ [Domestic Abuse Risk Assessment \(DARA\): Rationale for development, structure and content](#)

⁴¹ [Domestic Abuse Support in Cambridgeshire & Peterborough | IMPAKT Housing & Support](#)

and alcohol services, although reduction in their use of substances was noted. A referral to perinatal mental health was considered for Ava during this time but on one occasion she declined stating her emotional wellbeing was stable.

In early February 2022 the statutory child protection plan was stepped down to child in need, a voluntary agreement with parents and one with a lower level of monitoring and intensity, in recognition “of ongoing positive progress”. The conference was held earlier than usual due to the parent’s “positive progress” and their “abstinence from illicit substances and alcohol since December 2020”. As noted within the chronology, Ava had been seen consuming alcohol in June 21 by CGL. This was an overly optimistic assessment and did not adequately consider the domestic abuse, the entrenched nature of the drug and alcohol concerns nor their root causes. Therefore, the answer to this ToR is no, risk was not effectively understood or addressed, not just domestic abuse risk but the risk of child removal. The history was there, Len’s dishonesty with services, Ava’s previous child removal, the couple’s long term battles with drug and alcohol use, Ava’s multiple previous contacts with MARAC, Len’s continued criminal activity and potential fraud re benefit claims. All of this was not going to dissipate in the limited time the couple had been open on a child protection plan. More evidence of change was required as was meaningful trauma informed intervention in relation to domestic abuse, mental health and drug and alcohol use. It is noted how on the occasions support was offered, it was often declined by Ava but this in itself highlighted a concern.

The only occasion known to this review where any agency conducted relationship based content with either Len or Ava was on 24th June 2022. This was via social care and was recorded as ‘healthy relationship work’ (para 3.62). It was conducted with both together. The power & control wheel was utilised together with the equality wheel⁴². It was noted how both said they were happy in their relationship and did not want further sessions. Joint sessions within a domestic abuse dynamic are highly likely to be inappropriate and even dangerous. If there is a power and control dynamic one can feel compromised to speak openly and may fear consequences if they do so. Furthermore, joint sessions can actually increase risk; for example, one discloses information the other did not wish to be disclosed. Given the long term history of both, it was unrealistic to think this would adequately address domestic abuse concerns. Additionally, Ava was asked to complete an online course for female perpetrators of domestic abuse. This was not an appropriate request. It would have indicated to Ava she was entirely at fault for the abusive behaviour in the relationship and may well have increased the anxiety of Julian being removed from her care. If Len was aware of this ask of Ava, it may have indicated to him he had no behaviour related issues to work on himself, which was inaccurate.

Mental Health Support

⁴² [Wheels - Domestic Abuse Intervention Programs](#)

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

Referrals to mental health support were offered at various points throughout the scoping period by services such as the GP, Health Visiting and Social Care. At times Ava declined these stating she felt more settled, such as at the Initial Child Protection Conference on 8th April 2021 and on 18th August 2021 where both Ava and Len were asked. There can often be misgivings from individuals regarding accepting mental health support or acknowledging such difficulties. This can be due to feeling acceptance of such a concern is a weakness, or worrying services may look unfavourably on one’s capacity to care for a child. There is no direct evidence to suggest Ava had these specific worries but the timing of her acceptance or reluctance to accept such services is of note. Where evidence indicates life was settling, Ava appeared more reluctant to take mental health support stating emotionally she felt she did not require it. For example, at a review child protection conference in 2022, the GP said they continued to call Ava to check on her wellbeing. Ava found this supportive and said her GP was “brilliant”. She said her GP did not think she was experiencing anxiety at that time. If it was the case Ava was feeling more settled, this could have been the right time to engage her in appropriate mental health support rather than taking a more reactionary approach which appears to have been the case at times. She frequently presented to the CPFT (services including LADS, Dual Diagnosis Team) throughout the scoping period, but she was never assessed as having any diagnosis other than depression. This ToR is designed to consider whether domestic abuse experiences were considered within mental health support but in exploring this, the panel has also considered whether there were opportunities for longer term mental health support. This is relevant as often victim / survivors space for action can be limited by those perpetrating domestic abuse, preventing them from gaining the necessary support. The review has found specialised, longer term mental health support was rarely accessed, other than depression medication.

On 11th May 2021, it was reported by the GP within their IMR (Individual Management Review) they had referred Ava to the perinatal mental health team⁴³ (PNMHT), a service for “Women across Cambridgeshire and Peterborough with moderate to severe mental health conditions who are planning a pregnancy, currently pregnant, or have a child under 12 months”. Alongside the support for the eligible woman, this service offers therapeutic support, group intervention and bi-weekly online support and information for partners, Dad’s, extended family and family by choice in recognition that supporting those closest to the mother and baby will improve outcomes for everyone. This, with hindsight, would appear to have been a helpful service within this context as it would have provided increased support and greater insight into Ava’s mental health. Upon deeper exploration of this point, the GP did indeed submit a “PCMHS (*primary care mental health service*)

⁴³ [Perinatal Service | CPFT NHS Trust](#)

Request for service involvement” referral form and ticked the perinatal box. However, the process at the time meant this referral did not go straight to the PNMHT for assessment but to the primary care mental health service triage team to establish the severity of her mental health needs. They attempted to contact Ava on her mobile phone to assess her mental health needs but were unsuccessful. Three weeks after proactively seeking support, Ava was spoken to by this team after a male had initially picked up her phone. Ava then declined mental health input saying she had told her GP she no longer needed this phone call.

There has been learning from this review, and recognition that where there is a Child Protection Plan, CPFT should have ensured the child/unborn’s social worker was informed that consent for perinatal mental health service had been withdrawn. This is a training matter which is being addressed within CPFT.

Clearly there were complex issues for Ava at the time involving drugs / alcohol, social care involvement, mood swings and a long history of depression and overdosing. There was also current domestic abuse although this was not clearly stated on the referral. Nevertheless, the known issues would have indicated a need to be flexible with engaging Ava in the triage process which did not occur on this occasion. This could have involved liaising with her CGL or Social Worker to support her engagement in the triage which would have been covered under information sharing processes as her unborn child was already on a child protection plan. Her referral was closed following this final phone call. The process has changed since Ava’s experience with the CPFT developing pathways to ensure ease of access and to avoid eligible women having numerous assessments. Where an individual is clearly eligible for perinatal services, the referrals are received by primary care mental health, and sent straight through to perinatal services. These referrals are then considered by the perinatal team. Routine referrals are discussed at the weekly multidisciplinary referral meeting and urgent cases are dealt with on the day by the perinatal duty worker. This is a significant improvement in practice. However, following learning from this review, CPFT have committed to improving the process further so that in the future all perinatal referrals will go directly to the perinatal service for triage.

It is believed, should a similar scenario happen again, the same outcome is likely as the CPFT do not feel the information provided by the GP indicated Ava had a moderate or severe mental health difficulty. In considering this, they gave further information about the criteria for secondary mental health⁴⁴ care:

⁴⁴ Secondary Mental Health care provides services for those with moderate to severe mental health conditions. These may include Schizophrenia, Emotional Unstable Personality Disorder for example.

“Mild to moderate Mental Health cases are treated in primary care and moderate to severe are treated in secondary care.

In mental health care, particularly for depression, NICE (National Institute for Health and Care Excellence) guidelines define severity levels (mild, moderate, and severe) based on the number and intensity of symptoms, as well as the impact on daily functioning.⁴⁵

NICE often uses validated scales like the PHQ-9 to quantify this, with scores below 16 indicating less severe depression and 16 or more indicating more severe depression. However a note of caution in Ava’s case as she also had substance misuse which needs to be considered.”

It has not been possible to clarify thresholds during the course of this review as such clarity does not exist. Assessing whether someone has mild, moderate or severe mental health needs requires assessment and medical multi-disciplinary professional judgement. Typically, these assessments will consider the impact of one’s mental health needs on their daily functioning and social interactions. Their history will also be considered. There are several rating scales tools for measuring severity of mental health concerns each with its own focus and structure. Some common examples include the Global Assessment of Functioning (GAF) scale – a very common tool, the Hamilton Rating Scale for Depression (HAM-D), and the Brief Psychiatric Rating Scale (BPRS).

The CPFT and DARDR chair considered Ava’s circumstances. Together they reflected more generally on how drug and alcohol use might mask mental health needs. There were periods where Ava reported reduced use of drugs and alcohol, such as making concerted efforts to retain care of Julian, which may have been an ideal time to fully assess her mental health needs. When this opportunity presented itself, the health visiting and midwifery service, based on contributions to this review, did not deem it necessary for Ava to have longer term CPFT therapeutic support.

To ensure collaborative working between drug and alcohol and mental health there are a range of provisions including training to CGL by perinatal services and access to a perinatal duty worker. In addition, CGL employ specialist nurses and have access to a doctor who was also aware of Ava’s situation.

Consideration was also given to Ava’s background, childhood experiences (which were not known to services whilst Ava was alive) and the chronology of events. Whilst, based on the health records, Ava did not have a diagnosis of EUPD (Emotional Unstable Personality Disorder), the CPFT REDS (Relational, Emotional, Difficulties Services)⁴⁶ is

⁴⁵ [Recommendations | Depression in adults: treatment and management | Guidance | NICE](#)

⁴⁶ [How Are You Cambridge? | NHS CPFT Relational, Emotional Difficulties Services \(REDS\)](#)

relevant to consider. REDS is a treatment programme aimed at helping people aged 18+ improve their social functioning, interpersonal relationships, emotional regulation and reduce unhelpful and self-destructive behaviours. It seems helpful for services such as CGL and Social Care to have knowledge of such a service for future consideration. Knowledge of their eligibility criteria and appropriateness could then present further opportunities for longer term support. Close working with drug / alcohol services and mental health teams would still be required to prevent individuals falling through gaps.

Further to the above GP referral, in late March 2022 the Social Worker sought a referral to “perinatal mental health service or other service” to support Ava with “anxiety related to previous domestic abuse relationships and support to manage anxiety and depression”. This was done via liaising with the health visitor but again, no referral made its way to the PNMHT. It was good practice for the Social Worker to seek this but again highlights an issue with gaining longer term mental health support which at least two professionals (GP and Social Worker) felt Ava could benefit from.

On reflection within their IMR, Cambridge Access Surgery (CAS) felt it highly likely any referrals for Ava to the Primary Care Mental Health Services (PCMHS) would have been rejected with advice for the patient to engage with CGL for drug and alcohol needs. They state rejection letters are common locally. Should this be the case, this may impact services willingness to spend time referring if they feel the likely outcome is a rejection. This viewpoint is recorded here to ensure this apparent scepticism is noted and efforts are made to ensure referral pathways are clear. There is no evidence to say referrals were rejected due to this, more the triage process at the time did not adapt to someone with Ava’s needs and she did not have a diagnosis which would have gained her access to secondary services. However, should it be the case locally that mental health services decline where there are drug and alcohol needs, this would be at odds with the clear guidance from NICE (National Institute for Clinical Excellence) which states:

People aged 14 and over are not excluded from mental health services because of coexisting substance misuse or from substance misuse services because of coexisting severe mental illness.⁴⁷

Furthermore, good practice guidance from the Royal College of Psychiatrists in 2021 made some pertinent recommendations. Two relevant ones are selected below. The full report can be found here and has relevance for similar situations to Ava: [Perinatal mental health services: Recommendations for the provision of services for childbearing women](#)

⁴⁷ [Quality statement 2: Exclusion from services | Coexisting severe mental illness and substance misuse | Quality standards | NICE](#)

“Mental health and drug and alcohol services should be mindful that co-occurring mental health and alcohol and/or drug use conditions are common. Rather than solely focusing on a ‘primary problem’, both conditions must be treated to achieve the best possible outcomes. This will often require help across multiple agencies”

“Services should have specific funding and access to appropriate residential rehabilitation placements. During pregnancy, withdrawal from dependent use of alcohol and some drugs (such as benzodiazepines, opioids and gabapentoids) is likely to require specialist in-patient management, with input from a suitably qualified addictions practitioner. In cases where there is coexisting severe perinatal mental illness and substance use, admission to a mother and baby unit should be considered with in-reach from addiction services.”

There is no evidence to suggest a mother and baby unit was considered at any point but this would be due to the criteria for a severe mental illness never being met.

The GP acknowledged a lack of documenting domestic abuse concerns. Either domestic abuse was not asked or not documented. They suggested safety netting advice and crisis planning could have been improved. Improvements have been suggested within the single agency recommendations for this service.

There is evidence of depression screening questionnaires⁴⁸ being used with one scoring 27 out of a possible 27 just after Julian was taken into foster care (15th December 2022). This questionnaire has a rating system as below:

<i>Not at all</i>	<i>Several days</i>	<i>More than half the days</i>	<i>Nearly every day</i>
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It includes questions such as:

- Feeling bad about yourself - or that you are a failure or have let yourself or your family down?
- Thoughts that you would be better off dead, or of hurting yourself in some way?

To score 27 Ava would have needed to answer ‘Nearly every day’ for the majority of questions. A week later the same assessment was used via health visiting with Ava declining medication and saying she was happy with the GP supporting her mental health. This is a concern in itself and one which required focus within the multi agency intervention planning.

⁴⁸ [Patient Health Questionnaire \(PHQ-9\)](#)

In May 2023 Ava requested mental health input (para 3.95) to “*gain a diagnosis to prove she was taking agency’s concerns seriously*”. She was referred to primary care mental health services who assessed counselling services would be appropriate. It was noted in Ava’s GP visit on 18th September 2023 she remained on a waiting list for this but in the same appointment GP notes detailed her “hyperventilating and tearful”. This was post Julian’s removal. Len, who was seen as a support to Ava by the GP, was brought into the appointment at her request. She wanted him to help her with the breathing techniques she was being advised to follow. Having been part of the multi-agency network and with safeguarding flags on the system, CAS were aware of domestic abuse concerns at this point. It is appreciated how challenging this meeting would have been but the appropriateness of asking the partner, where domestic abuse is known, to support with breathing techniques is not advisable practice. As is now known, two weeks later Len was arrested for non-fatal strangulation towards Ava.

It is of little surprise Ava did not attend her first counselling session on 21st September 2023 as there was clearly a lot going on for her at this time.

In answer to this ToR, there were consistent concerns for Ava’s mental health but no longer term therapeutic input engaged with. There were various medications provided for low mood, depression and anxiety throughout the scoping period. There are mentions of the historic domestic abuse impacting on Ava and the need for this to be addressed but then a lack of adequately addressing it. Had appropriate support been forthcoming, it may well have been impacted by Ava’s capacity to engage due to drug and alcohol needs but this was not tested as no in-depth therapeutic intervention was accessed. An adaptable approach is needed to engage someone in mental health support, especially where they have previously had a child removed, there are concerns for their mental health and drug and alcohol issues.

4.17 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?

Ava had a known and significant mental health history. In October 2015, her mental health and alcohol use escalated triggering episodes of aggressive behaviours. She reported hearing voices and experiencing severe anxiety, which contributed to multiple A&E visits. Her mental health issues were compounded by use of substances including crack cocaine and heroin. In September 2019 it was recorded Ava told the Psychiatric Liaison Team she had a ‘passive death wish’ but had “*no active plans to end her life*”.

There were multiple instances of suicidal ideation and self-harm in her history but, importantly for this ToR and review, there were no specific mental health services directly

involved with her during the scoping period. The extensive trauma she experienced in relationships would have been highly impactful and there is an absence of targeted trauma informed support in this regard. The two specialist services who could have assisted, IDVA and mental health teams, were consistently declined by Ava or, with regards to the latter, may have declined referrals themselves. In their absence, there is limited evidence the increased risk of overdose or suicide led to domestic abuse informed suicide prevention plans being implemented by the services involved. For clarity, within these plans, they often include consideration of who one can speak to if feeling distressed. The following is taken from an example [Safety Plan from the Samaritans](#):

What I will tell myself (as alternatives to the dark thoughts):	
What would I say to a close friend who was feeling this way?	
What could others do that would help?	
Who can I call:	
• Friend or relative:	Another?
• Health professional:	Other?
• Telephone helpline:	Other?
A safe place I can go to:	
If I still feel suicidal and out of control:	
• I will go to the A& E department	
• If I can't get there safely, I will call 999 (112, 911 etc)	

The circled section requires services to consider who is safe to support the individual and what is realistic. We know Ava requested Len support her with breathing techniques in a GP visit in September 23 (ToR 4.16). It would be unrealistic to assume that merely by writing alternative support mechanisms on a plan Ava would not seek Len's support. But by including him in her care where there were significant concerns there is a risk of collusion. This is where mental health advice and domestic abuse knowledge must coalesce. Len would not have had the capacity to support, especially in the aftermath of Julian being taken into care and with an increase in severity of alleged violence.

Ava was hospitalized a number of times before and during the scoping period after overdosing. When she had sobered, she was asked, as part of suicide screening efforts, whether she was considering ending her life. Ava would say no every time. Sadly, as we now know, Ava was at increased risk of dying via overdose, not necessarily an intent to end her life. One of the DARDR panel members attended a Survivors of Bereavement by

Suicide conference <https://uksobs.com/> where a speaker raised this very subject. They said the question often asked, “are you considering ending your life by suicide?” or words to that effect, would usually be met with a negative response as there may not be an intention when asked. They felt they would have responded affirmatively to – “are you trying to find an escape?” Or “Do you ever think about trying to find an escape from your current circumstances?”. This is significant learning and highlights the importance of wording and subtleties. This is to be factored into the local suicide prevention strategy review taking place in 2025. This team was met by the chair as part of this review.

Given the number of agencies involved at various points, any suicide prevention / safety plans which were conducted needed to be shared amongst the network to enable a consistency of advice and understanding of risk. This is not apparent from the management reviews received.

Removal of child

In the short time Julian was in Len and Ava’s care he experienced housing instability, domestic abuse and he sustained bruising. The Domestic Abuse Act 2021⁴⁹ now clearly states children are victims of domestic abuse even if the abuse is not directed at them. The panel reflected whether this legislative change impacted intervention in any way. The law places an emphasis on recognising the seriousness and impact of domestic abuse on children. Ultimately this contributed to Julian being removed from his parent’s care to safeguard him and child safeguarding efforts reflected this change.

4.18 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?

There were only a matter of weeks between the court’s decision relating to Julian’s longer term removal and Ava entering a coma. This serves to highlight the importance of the time pre and post court decision. It is clear Ava and Len both maintained hopes of turning the situation around. They were having weekly contact with Julian prior to this decision and this would have significantly reduced afterwards.

At time of this DARDR, Cambridgeshire were in the process of reviewing their suicide prevention strategy. Several key points raised during panel discussions, relevant to this ToR, have been fed into the suicide prevention review. They are:

- *Reduction in agency support* - When children are removed the risk of a parent ending their life by overdose increases. At the same time, the co-ordination of

⁴⁹ [Domestic Abuse Act 2021](#)

multi agency intervention from social care reduces / ceases once court proceedings are concluded. This court decision is extremely significant for parents and can often signify the end of hope to turn the situation around and return the child to their care. It does not appear this risk was sufficiently factored into the child protection process or conversations pre and post court decision. Social Care are well placed to bring all services together at this point to co-ordinate safety planning and risk reduction plans.

- *Tolerance for alcohol and drugs reduces* - Additionally, there are often increased efforts from parents using drugs and / or alcohol to reduce and stop their usage. Therefore, tolerance for alcohol and drugs is lowered in the days post court decision. The line between suicide and overdose is thin and safety planning considering the tolerance level is beneficial. The continuity of care for the parents in these circumstances is a key learning point of this review.
- *Domestic abuse risk increase* - On the same day the court decision occurred, Len assaulted Ava and an evidence lead prosecution led to him receiving a fine for common assault a day later. As well as overdose / suicide risk, this indicates domestic abuse risk also increased.
- *Engagement with services who were part of the process can reduce* - CGL reflected how, once the court decision was made, both parents reduced their contact with CGL staff meaning no safety plans were completed in the days post court decision. It is likely any service associated with the child removal decision would have their engagement with the parents impacted. This indicates a need to consider these plans and associated conversations prior to the final court decision being made. Ava did present to her GP a week later who tried to support her when she was in an extremely distressed state but the advice would have been difficult for her to absorb.

There is no evidence of safeguarding referrals being made to adult services at this juncture, although it is unclear as to whether these referrals would have been accepted.

The panel discussed what support / resources are available locally for adults, particularly mothers who have had children removed from their care in circumstances similar to this DARD. There is support for those who have experienced a bereavement but there is a lack of wraparound support for someone in Ava's circumstance. This is a local authority decision as there appears to be greater provision in other areas of the country. The chronology showed a reduction in contact with CGL post court decision whom Ava had had a long term positive relationship with. There was the opportunity for counselling which Ava did not attend. So, it is questionable as to whether Ava would have accepted

specific support had it been available. The panel discussed whether changes to systems and / or multi-agency working could be made prior to the final court decision. Where removal is highly possible, and in Ava's case there were strong indicators it was, an openness and transparency about the process on a consistent basis is required from all services involved. Final decisions do not come as a surprise as final court dates can and should be communicated to the network. This can in turn ensure agencies connected to BOTH individuals are aware of increased risk, which in this case is highly evident. The importance of including the fathers in this is just as important. They too are likely to be grieving and in Len's case he was also struggling with drug and alcohol use. Given the domestic abuse between them, it is not difficult to foresee the blame which could occur between a couple leading to further domestic abuse.

Training / Policy / Procedures

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

Within each IMR (Individual Management Review) services were asked to consider their internal training requirements. Reflections and commitments can be seen within their single agency recommendations at the end of this report.

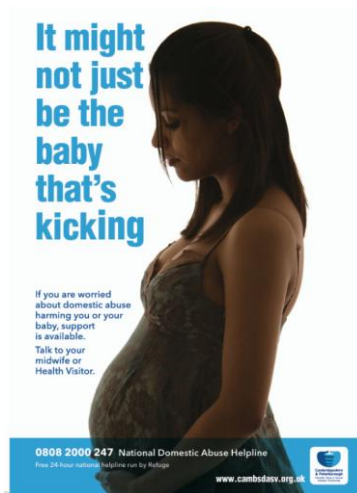
As the above analysis indicates, training on domestic abuse generally differs amongst workforces. This DARDR recommends domestic abuse training includes good practice guidance with how to navigate and assess counter allegations, a thorough understanding of coercive control and how to best use domestic abuse related chronologies. Joint multi-agency training is recommended as a way to increase knowledge and understanding of each agencies roles and ability to reduce risk. This would also assist in building relationships and encourage joint working which this review has identified as important.

4.20 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.

There are several gaps and missed opportunities across the multi agency network as detailed above. Individual agency reviews have been open to this and have acknowledged improvements which will be made going forward (see single agency recommendations). In summary, there was a lack of domestic abuse risk assessment and a fragmented understanding of Len and Ava's relationship. Services have recommended updates to guidance and policies in response.

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

Flyers and leaflets promoting local services are placed in public spaces such as libraries. The [Cambridgeshire County Council DASV Partnership - Home](#) website contains resources, posters, Clare's Law advice, links for other national and local services and guidance and advice for friends and family. Advice highlights the signs of domestic abuse and how to support a loved one who may be experiencing it. There are also translations available in Polish, Romanian, Lithuanian, Uru and Arabic. It is unclear if this is having a positive impact on self-referrals but it is recommended this is monitored as literature is created and promoted.



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

One review in particular was flagged locally with relevance to this DARDR. It is important for recommendations arising from this review not to be a repeat of previous conclusions. The relevant review is [Sarah DHR](#). Pertinent recommendations from this review are for:

- CSC to consider what support parents might need in the event of a child being removed (either through court proceedings or by a parent with care exercising their PR) and for families when a parent takes their life.

- CSC to refresh practice guidance around assessments, ensuring workers gather evidence and exercise professional curiosity around parental self-reporting.
- Ensure frontline professionals responding to incidents involving vulnerable people are aware of the continuing risk of suicide in those who have previously attempted suicide, self-harmed, or spoken of suicide.

The latter should now consider the risk of overdose as Ava's review has demonstrated. Ava's story is not an isolated one and during discussions panel members had knowledge of several others. The senior public health manager for drugs and alcohol raised several cases across Cambridge and Peterborough where mothers had died soon after child removal. These were not just drug and alcohol related but one very sad example was of a mother walking into the road in front of a vehicle. There are known drug and alcohol related deaths following child removal which would not have met the criteria for a domestic abuse related death review. But the lessons to be learned appear to be mounting and require urgent consideration to prevent future deaths.

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

Staff turnover within services was one theme which had significance. Similarly to Social Care, CGL reflected on staff turnover impacting a consistency of service. To improve their response, they have implemented a review of service users key safeguarding and risk issues such as domestic abuse, contact with children, carers status, relationship status, mental health, trauma. These are to be reviewed with all new service users within the first 3 appointments with their allocated recovery coordinator and subsequently they should be reviewed at minimum at every 6 months and during all medical reviews.

Section Five

Conclusions

- 5.1 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.
- 5.2 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 led 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 as well 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 lens. 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:

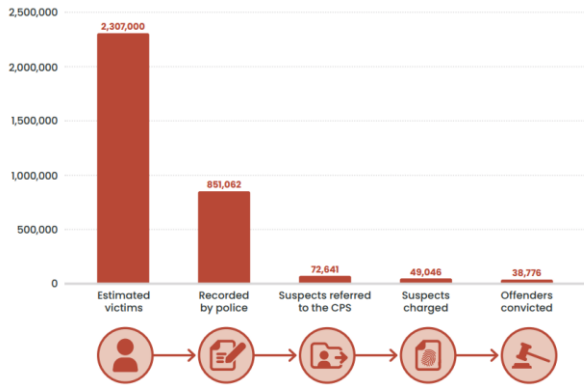
- Ava offered an IDVA and heard at MARAC as primary victim - January 2019.
- Ava recommended to attend an online female perpetrators of domestic abuse course - August 2022.
- A social worker conducting a one off healthy relationship session with both Len and Ava – June 2022

5.3 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 (para 3.81) 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 wheel⁵⁰, 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 have known to have occurred without thorough assessment, analysis, prior intervention and agreement from partner services.

5.4 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 and it would have impacted her want and the speed at which she could build trust with each new social worker. 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.

⁵⁰ [Understanding the Power and Control Wheel - Domestic Abuse Intervention Programs](#)

5.5 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 culpability 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 legislative protection for Ava. This did not occur as has been analysed.

5.6 A key element of this review is the child removal process and maintaining a consideration for both parent’s wellbeing. 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 crucial. 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 having an in depth understanding of the relationship dynamic and be in agreement of what support should be prioritised. The ToR has highlighted several deaths following child removal. It is vital these lessons are taken on board to improve the care and safety planning for those having children removed. Charities do exist to support mother’s with child removal such as [Pause – Creating Space for Change](#). However, none were commissioned locally at the time of this review.

5.7 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 escapism 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 abuse, suicide and overdose in future.

Section Six - 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. A domestic abuse specialist involved in this process is recommended.

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 when 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 breached this upon release by attending Ava's address. If someone has breached police bail, it's a sign of escalating behaviour and a disregard for 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 markers⁵¹. 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 pose 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.

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

⁵¹ 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.

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 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.

Section Seven – Recommendations

National

Social Work Training

Recommendation 1

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, promote the use of domestic abuse chronologies and other relevant learning from this review.

Local

Suicide Prevention

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.

Child Removal

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.

Multi Agency Domestic Abuse Risk Assessment

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.

Domestic Abuse Courts

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.

Police

Recommendation 7

National policy guidance for PNC⁵² 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.

⁵² 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)

GP – Single Agency Recommendations						
Recommendation Learning Theme	Scope of Recommendation ie local or regional	Action to Take	Lead Agency/ Partnership	Key milestones achieved in enacting recommendation	Target Date	Date of completion and Outcome
Documentation in patient records needs to include the “important negative” of there being no current domestic abuse concerns, particularly in mental health consultations and/or where safeguarding is relevant.	Local	Case to be discussed in clinical meeting. Email to be sent around to all clinicians, highlighting this event. Use of inbuilt consultation templates to be encouraged	CAS	Email sent, case discussed	28.2.2025	
All locum GPs to sign on arrival that they have read and understood the safeguarding policies	Local	To be added to locum pack and locum induction policy	CAS	Actioned	28.2.2025	

DNA policy to be authored and distributed, with focus on active follow up of vulnerable patients.	Local	Policy draft and sign-off	CAS	Policy authored and communicated	28.3.2025	
Reinstatement of mortality meetings	Local	Reschedule meetings - done	CAS	Next meeting planned 4/2/25	First meeting 4.2.2025	

CGL Single Agency Recommendations						
Recommendation Learning Theme	Scope of Recommendation ie local or regional	Action to Take	Lead Agency/ Partnership	Key milestones achieved in enacting recommendation	Target Date	Date of completion and Outcome
Key safeguarding and risk issues (domestic abuse, contact with children, carers status, relationship status, mental health, trauma etc) are to be reviewed with all new service users within the first 3 appointments with their allocated recovery coordinator and subsequently they should be reviewed at minimum at every 6	Local	CGL Quality lead and team leaders	CGL		01/12/2024 for initial review, then every 4 months	

months (or if risk/s changes during all medical reviews.						
Ensure case notes are added in a timely manner and notes for any appointments are detailed	Local	Team leaders	CGL		31/01/2025 for initial review, then every 6-8 weeks in line with caseload management/supervision sessions	
Ensure motivational interviewing (MI) skills training is embedded in practice across all Cambridgeshire CGL teams	Local	CGL Quality lead and team leaders	CGL		Ongoing	
All staff to be offered additional training in domestic abuse and working with perpetrators	Local	CGL social work team	CGL		Ongoing – 1 session has been completed and 3 further sessions pending	

Probation Single Agency recommendations						
Recommendation Learning Theme	Scope of Recommendation ie local or regional	Action to Take	Lead Agency/ Partnership	Key milestones achieved in enacting recommendation	Target Date	Date of completion and Outcome
Quality of Risk Assessment	Cambridgeshire and Peterborough	Robust quality assurance activity to	Probation	Ongoing	March 2026	

	Probation Delivery Unit	ensure that OASYS risk assessments address factors likely to cause risk of serious harm, (Regional Quality Assurance Tool)				
Quality of Risk Assessment	As above	Where evidence of Domestic Abuse exists, a Spousal Risk Assessment is undertaken in all circumstances.	Probation	Ongoing	March 2026	
Risk Management/Sentence Plan	As above	That objectives within Risk Management and Sentence Plan address all identified risks and that activity is undertaken to address these.	Probation	Ongoing	March 2026	

Recording	As above	That process is in place to reduce instances of missing contacts and that records are maintained according to policy	Probation	Ongoing	March 2025	
Sentence Delivery	As above	That sentence plan activity is being delivered including referrals to partnership agencies, interventions being delivered by Probation Practitioners or others involved with the delivery of the sentence and this is clearly recorded in Ndelius.	Probation	Ongoing	March 2026	

IDVA – Single Agency Recommendation						
Recommendation Learning Theme	Scope of Recommendation ie local or regional	Action to Take	Lead Agency/ Partnership	Key milestones achieved in enacting recommendation	Target Date	Date of completion and Outcome
Establishing client contact	Local	1.Update IDVA Policy & Procedure to state that creativity should be used when attempting contact with a client. Utilising different methods of contact and partner agencies. 2.Management to audit different methods in staff Supervisions.	IDVA service	Policy Updated Audit undertaken	March 2025	

Cambridgeshire Community Services – Single Agency Recommendation (Health Visiting)						
Recommendation Learning Theme	Scope of Recommendation ie local or regional	Action to Take	Lead Agency/ Partnership	Key milestones achieved in enacting recommendation	Target Date	Date of completion and Outcome
Quality of holistic assessment - All vulnerabilities and risks should be brought forwards into the supervision and oversight mechanisms available to staff which enable them to have holistic oversight and appropriate action plans to safeguard.	Local (Trust wide)	Review of effectiveness of safeguarding supervision peer review thematic learning which focuses on family history and functioning.	CCS	Report to be produced with a focus on the quality of the holistic assessment.	March 2026	
Domestic abuse training package - Revisiting domestic abuse training package to ensure that this is utilised as a case learning	Local (Trust wide)	Review the internal level 3 training package for domestic abuse and include this case as part of the learning.	CCS	Review the package of training and include this as a case review.	March 2026	

<p>discussion, including the need to have difficult conversations and ways to try and facilitate discussions about domestic abuse are undertaken with individuals when they are unaccompanied by others who may or may not be perpetrators.</p>						
<p>Audit of MARAC/MASH interface - Consider need for a MASH/MARAC audit of practice which evidences how this means of information sharing interfaces and supports decision</p>	<p>Local (Trust wide)</p>	<p>Develop an audit tool to support understanding about the interface between the two services which focuses on effectiveness.</p>	<p>CCS</p>	<p>Audit tool developed and completed.</p>	<p>December 2025</p>	

making about levels of risk.						
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Children's Social Care – Single Agency Recommendations						
Recommendation Learning Theme	Scope of Recommendation ie local or regional	Action to Take	Lead Agency/ Partnership	Key milestones achieved in enacting recommendation	Target Date	Date of completion and Outcome
Domestic abuse tools to be embedded as part of a child & family assessment or parenting assessment to support the identification of domestic abuse and offer appropriate intervention	local	Ensure that social care practitioner are aware of the tools to assess domestic abuse	CCC Children Education and Families	Evidence based decision making in assessing domestic abuse	Nov 25	

Training and awareness support to be offered regarding assessing coercive controlling behaviour including use of legal orders to disrupt domestic abuse	local	Ensuring that practitioner across the partnership are effective in assess and safety plan	Safeguarding board	Evidence based partnership working	Via annual audit timescales	
Liaison between Children and Adult Social Care where there is a vulnerable parent	local	Strengthen working together between practitioner ensuring they adhere to consent and where necessary refer under s.42 Care Act for safegaurding	CCC Children Education and Families	Evidence of working together within assessments. Think Family approach.	Nov 25	

Raise awareness of the joint Cambridgeshire and Peterborough Suicide Prevention Strategy	local	Training to be considered to promote said strategy aswell as other promotional activities (intranet promotion, bitesize learning packages, alerts to management – as deemed feasible)	CCC Children Education and Families	The suicide Prevention Strategy will reach it's intended audience. Ways to monitor engagement (e.g training attendance) to be confirmed	TBC	
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CPFT – Single Agency Recommendations						
Recommendation Learning Theme	Scope of Recommendation ie local or regional	Action to Take	Lead Agency/ Partnership	Key milestones achieved in enacting recommendation	Target Date	Date of completion and Outcome
There will be a change in process for the triage of CPFT perinatal referrals. Currently all referrals to CPFT secondary MH	Local	There has already been a pilot to test the new proposed process. Comms and Training are being	CPFT	Pilot to test new process (COMPLETED Aug 25) Training to be updated to include new pathway.	Completion date estimated within the next 12 months (Aug 2026)	

services are triaged by CPFT primary care MH. All referrals for perinatal service will be moved to the perinatal services for triage.

planned currently.

Comms required to alert practitioners to new process.

Appendix A

Explanation of different children's social care thresholds /tiers

[Cambridgeshire Threshold Document: Continuum of Help and Support | Cambridgeshire and Peterborough Safeguarding Partnership Board](#)

Level 1: No additional needs

These are children with no additional needs; all their health and developmental needs will be met by universal services. *These are children who consistently receive child focused care giving from their parents or carers.* The majority of children living in each local authority area require support from universal services alone.

Level 2: Early help

These are children with additional needs, who may be vulnerable and showing early signs of abuse and/or neglect; their needs are not clear, not known or not being met.

This is the threshold for a multi-agency early help assessment to begin. These are children who require a lead professional for a co-ordinated approach to the provision of additional services such as family support services, parenting programmes and children's centres. These will be provided within universal or targeted services provision and do not include services from children's social care.

Level 3: Children with complex multiple needs

These children require specialist services in order to achieve or maintain a satisfactory level of health or development or to prevent significant impairment of their health and development and/or who are disabled. They may require longer term intervention from specialist services. In some cases these children's needs may be secondary to the adults needs. This is the threshold for an assessment led by children's social care under Section 17, Children Act 1989 although the assessments and services required may come from a range of provision outside of children's social care that include targeted services

Level 4: Children in acute need

These children are suffering or are likely to suffer significant harm. This is the threshold for child protection. These children are likely to have already experienced adverse effects and to be suffering from poor outcomes. Their needs may not be considered by their parents/carers. This level also includes Level 4 health services which are very specialised services in residential, day patient or outpatient settings for children and adolescents with severe and /or complex health problems. This is likely to mean that they may be referred to children's social care under Section 20, 47 or 31 of the Children Act 1989.

This would also include those children remanded into custody or those with significant need who are known to youth justice services.

Appendix B

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 order⁵³ (RO) applied for?

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

⁵³ [Restraining Orders | The Crown Prosecution Service](#)

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?

Multi 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?

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.

¹ [Domestic abuse victim characteristics, England and Wales - Office for National Statistics \(ons.gov.uk\)](https://ons.gov.uk)

ⁱⁱ [999368 Law Domestic Violence MAIN Research Report Final FINAL PRE-PRINT.pdf \(aafda.org.uk\)](https://aafda.org.uk)