Cumberland Community Safety Partnership

A Domestic Homicide Review of the death of Helen

March 2024

EXECUTIVE SUMMARY

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Contents:

1. The Review Process

1.1 This is a review of the murder of a woman in Leeds in March 2024. This summary outlines the process undertaken by the Cumberland Community Safety Partnership Domestic Homicide Review Panel in reviewing the tragic death of Helen, who was resident in their area. This is a Domestic Homicide Review conducted under the mandatory requirements of the Domestic Violence, Crime and Victims Act 2004.

1.2 Of note, the UK government issued guidance in July 2024 which involved re-naming Domestic Homicide Reviews (DHRs) as Domestic Abuse Related Death Reviews (DARDRs). This was to ensure accuracy when many new reviews involved cases of suicide where there were concerns that there may have been domestic abuse or coercive control within a relationship prior to the tragic death. However, this case was a murder (homicide) and the process had commenced several months prior to the re-naming. In addition, the revised statutory guidance (issued for consultation in May 2024) had still not received royal assent (i.e. passed into English law) at the time this review was completed (in June 2025).

1.3 To protect the identity of those involved, pseudonyms were used for both adult subjects in the review. The victim will be referred to throughout as Helen. The perpetrator will be referred to throughout the review as Colin. Helen's family were consulted and agreed to the use of these pseudonyms.

Subjects of the Review:

- The victim; Helen, a female, aged 48 years old at the time of her death.
- Her partner, Colin, was 53 years old at that time.

Both subjects of this review are British citizens who reside or did reside permanently in the UK. Their ethnicity is white / British.

1.4 The criminal trial took place in October 2024. On the first day of the trial, Colin changed his plea and pleaded guilty to murdering Helen. Scoping and the first DHR panel meeting occurred before this, but it was agreed the IMRs would not be started until the trial and sentencing were completed.

The death has been registered with HM Coroner. The inquest was opened and adjourned. Contact has been maintained between the DHR panel and the Senior Coroner's officer.

1.5 The Cumberland Community Safety Partnership (CCSP) was formally notified of the circumstances of the death by West Yorkshire Police on 2nd April 2024.

1.6 The CCSP convened a meeting on 9th April and a collective decision was made that the circumstances of the death met the criteria for a Domestic Homicide Review. Multi-Agency partners were then informed to secure their records in preparation of a scoping process to determine their level of involvement with the victim or perpetrator in this case.

1.7 The review began in May 2024 with the appointment of an Independent Chair and Author. The first DHR panel meeting was held on 18th July 2024. Dates for the submission of chronologies and Individual Management Reviews (IMRs) were agreed. The panel met again on 6th November 2024 (immediately after the criminal trial had concluded), on 8th January 2025, and on 6th March 2025.

1.8 The DHR was concluded in June 2025 following presentation to the Cumberland Community Safety Partnership, who agreed with the conclusions, learning and recommendations.

1.9 A Community Safety Partnership (CSP) has a statutory duty to enquire about the death of a person where domestic abuse forms the background to the homicide and to determine whether a review is required. In accordance with the provisions of section 9 of the Domestic Violence, Crime and Victims Act 2004 (amended 2013), a Domestic Homicide Review should be:

"*A review of the circumstances in which the death of a person aged 16 years or over has, or appears to have, resulted from violence, abuse or neglect by-*

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

(b) A member of the same household as him/herself."

1.10 The statutory guidance states the purpose of the review is to:

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

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

- Apply those lessons to service responses including changes to policies and procedures as appropriate.

- Articulate life through the eyes of the victim, to understand the victim's reality; to identify any barriers the victim faced to reporting abuse and learning why interventions did not work for them.

- 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 violence and abuse.

- Identify any areas of good practice.

1.11 Initial scoping suggested that several agencies in Cumberland and Leeds had involvement with the subjects of the review. Further information gathering suggested a number of agencies in the Durham area also held some information about the victim and her family. Chronologies were requested and nine organisations were required to submit an Individual Management Review (IMR) of their agency's involvement. Other agencies submitted summary reports of their limited involvement.

1.12 The Independent Chair made enquiries and confirmed all IMR authors were independent of any actions or decision making in this case.

2. Contributors to the review

2.1 Fourteen agencies have contributed to the Domestic Homicide Review by the provision of summary reports or chronologies. Nine agencies then provided Individual Management Reviews (IMRs) to outline and analyse their own single agency actions, contacts and decision-making. The DHR Chair and Panel agreed that reports, chronologies, IMRs and other supplementary details would form the basis of the information provided for the overview author.

2.2 The following organisations were required to produce an IMR:

Agencies
North East and North Cumbria Integrated Care Board (NENC ICB) on behalf of General Practice for Helen
West Yorkshire Integrated Care Board on behalf of General Practice for Colin
North Cumbria Integrated Care NHS Foundation Trust (NCIC)
West Yorkshire Police
Cumbria Constabulary
Leeds Teaching Hospital NHS Foundation Trust
Yorkshire Ambulance Service
Victim Support Services
Cumberland Council (Helen's employer)

Other agencies provided scoping, summaries and chronologies:

Agencies
Leeds Children's Social Work Service
Cumbria, Northumberland, Tyne & Wear NHS Trust (CNTW)
Cumberland Council Children's Services
'Health Assured' (private counselling service commissioned by Carlisle City Council)
Department for Work and Pensions (DWP)

3. The Review Panel members

3.1 The Domestic Homicide Review panel comprised of the following people:

Name	Organisation/Job Title
Mike Cane	Independent Chair & Author
Louise Cavanagh	Domestic and Sexual Abuse Lead, Cumberland Safeguarding Hub, Children Social Care
Lindsey English	Specialist Domestic Abuse Practitioner Yorkshire Ambulance Service
Mary-Claire Telford	Strategic Lead for Domestic Abuse, Cumberland Council
Sarah Lambert	Detective Supt. Leeds District, West Yorkshire Police
Emma Winfield	Detective Superintendent - Senior Investigating Officer, West Yorkshire Police
Kathryn Smyth	Detective Inspector, Safeguarding, Cumbria Police
Sarah Edgar	Detective Constable Safeguarding, Cumbria Police
Jodie Openshaw	Domestic Abuse Team Leader, Victim Support
Gemma Qi	Specialist safeguarding practitioner & Domestic Abuse lead (Registered General Nurse) North Cumbria Integrated Care NHS Foundation Trust
Hayley Bishop	Area Planning Manager, Cumberland Council
Rashad Rasib	Specialist Advisor for Safeguarding Adults, Leeds Teaching Hospitals NHS Foundation Trust
Michelle Allsop	Designated Nurse, Safeguarding Children & Adults, NHS West Yorkshire Integrated Care Board
Leesa Stephenson	Designated Nurse, NHS North East and North Cumbria Integrated Care Board
Paul Latimer	Assistant Director of Housing, Quality and Resources, Cumberland Council
Donna Williams	Principal Social Worker, Leeds Children's Social Work Service, Leeds City Council
Georgina Ternent	Public Health Manager, Cumberland Council
Joanne Sharp	Named Nurse, Safeguarding & Public Protection, Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust (CNTW)
Carol Warren	Team Leader NHS North Cumbria Talking Therapies (previously First Steps), CNTW
Bharati Dwarampudi	Advanced Customer Support Senior Leader, DWP
Sarah Joyce	Adult Social Care Service Manager, Cumberland Council

The panel members were completely independent and had no direct dealings with the subjects of the review nor management responsibilities to any front line worker involved with any of the subjects of the review.

The Victim Support Service (VSS) are commissioned to provide the IDVA (Independent Domestic Violence Advocate) service and other specialist domestic abuse services in Cumberland. They also employ Independent Sexual Violence Advocates (ISVAs).VSS were an integral part of the DHR panel both as an agency with involvement with the victim and to provide scrutiny and expert advice to all panel members relating to domestic abuse or sexual violence matters.

4. Author of the overview report

4.1 The appointed Independent Author is Mike Cane. He is completely independent of the Cumberland Community Safety Partnership and has no connection to any of the organisations involved in the review. He is a former senior police officer where his responsibilities included homicide investigation, safeguarding and investigation of child abuse, rape & other serious sexual offences. He has extensive experience as a panel member for Domestic Homicide Reviews and is a former member of a Safeguarding Vulnerable Adult Board, several Domestic Abuse Strategic Partnerships and a number of Local Safeguarding Children Boards. During his police career he was Force lead for domestic abuse, child protection and vulnerable adults. He chaired the MARAC meetings across four Local Authority areas for several years, was Chair of the Sexual Assault Referral Centre (SARC) management board and a member of the Child Death Overview Panel (CDOP). He has previous experience of conducting Domestic Homicide Reviews, Safeguarding Adult Reviews, Child Safeguarding Practice Reviews and MAPPA Serious Case Reviews as an Independent Chair & Author.

Mike completed accredited DHR training for Chairs in 2010, refresher training in 2017 and the newly configured training for DHR Chairs (sponsored by the Home Office and delivered by AAFDA) in 2024. He is a member of the national ‘DHR network’ which meets to exchange ideas and best practice in coordinating Domestic Homicide Reviews.

He has designed and delivered domestic abuse training (identification, risk assessment & risk management) to staff across the public/voluntary sector.

5. Terms of Reference for the review

5.1 The terms of reference were agreed at the convening of the first DHR panel:

Were practitioners sensitive to the needs or vulnerabilities of the victim?
Were professionals knowledgeable about potential indicators of domestic violence and abuse and aware of what to do if they had concerns about a victim?
What knowledge did your agency have about the relationship between the victim and perpetrator?
Did the agency have policies and procedures in place relating to domestic abuse? Were these policies complied with?
Were risk assessment and risk management processes for domestic abuse victims or perpetrators correctly used in this case?
What were the key points or opportunities for assessment and decision making? Do assessments and decisions appear to have been reached in an informed and professional way?
How did misuse of alcohol or other substances impact on this case?
How did agencies recognise and respond to issues of equality and diversity for the individual? Please consider the nine protected characteristics and how these may have impacted on services or impacted on the perception of the individual. Was there any evidence of unconscious bias in assessments, decisions or actions taken? Consider any intersectionality issues.
How were the victim's wishes and feelings ascertained and considered? Is it reasonable to assume that the wishes of the victim should have been known? Was the victim informed of options/choices to make informed decisions? Were they signposted to other agencies?

Were there any barriers to reporting abuse or violence?
Was mental health a factor in this case?
Was the victim or perpetrator ever listed at the MARAC? *MARAC is a Multi-Agency Risk Assessment Conference. It is a meeting of professionals to share information and formulate plans to protect the victim and their children in the highest risk domestic abuse cases (those cases where the victim is assessed as at risk of significant harm).*
What information was known about the perpetrator? Was the perpetrator subject to MAPPA, MATAC or any other perpetrator intervention programme? Were there any injunctions or protection orders in place? *MAPPA is the Multi-Agency Public Protection Arrangements. These are statutory processes to manage sexual and violent offenders. The 'Responsible Authorities' (police, National Probation Service and HM Prison Service) all have statutory responsibilities to protect the public under national MAPPA guidelines).* *MATAC is Multi-Agency Tasking and Coordination. It is a scheme currently being rolled out in many areas across the UK to specifically manage serial and repeat perpetrators of domestic abuse*
How effective was record keeping?
How effective was management oversight?
Did resource issues impact upon services offered?
Did the Covid-19 pandemic impact upon agencies' responses?

As the Domestic Homicide Review made progress and further information was gathered, the DHR Chair made a decision to add a further term of reference. This was:

'Were there any opportunities for professionals to have intervened by way of a 'Clare's Law' disclosure in this case?'

5.2 These Terms of Reference were shared and agreed with Helen's family.

6. Summary chronology

6.1 The Domestic Homicide Review Panel agreed to review agency records going back three years before Helen's death. In some instances, earlier records were also checked as they could provide an insight into the life experiences of both Helen and Colin. These earlier experiences are also included in the chronology. Although this is a single chronology, the couple did not meet until the last year of Helen's life. Helen was residing in Cumbria. Colin was living in Leeds.

6.2 The chronology begins with a section detailing Helen's Adverse Childhood Experiences.

6.3 This is a summary chronology and does not contain all incidents, events or appointments relating to Helen and Colin. For the full chronology, please see the full DHR overview report.

Helen's Childhood

6.4 Helen had an unsettled childhood moving frequently between locations and those responsible for caring for her. From the age of four to sixteen years, she had moved repeatedly. This included to different areas of the UK. Custody of Helen changed between her mother, father and Children's Social Care. Over time, her parents had several different intimate partners. These individuals also had an impact on Helen's childhood. Helen and her siblings spent extended periods within the care system as what would now be referred to as 'Looked After Children'.

Each move to a different house, caravan site or children's care home meant Helen was uprooted from locations she was familiar with. This meant different schools, different professionals and Helen trying to make new friends. She had no stability in her life.

6.5 Helen was the youngest of four sisters and they lived in the family home with their parents. When she was only four years old their mother left the family home with Helen and her sisters. Mum tried to secure alternative accommodation but as her home was jointly owned she was unable to do so. Helen's mum then placed her four daughters (the eldest being just eleven) on a bus and sent them back to live with their father.

Helen's father was unable to care for his daughters and placed them into local authority care a few days later.

6.6 Helen's mother moved around a lot and eventually settled down with a man she was in a relationship with. She requested to have her girls returned. So

when Helen was five she and her sisters went back to live with their mum and her partner in a different part of the country.

6.7 Shortly afterwards, Helen's mum and her new partner had a baby together. After initially appearing that everything was going well, problems began. Helen's eldest sister clashed with mum's new partner. Helen and the other girls are reported to have repressed their feelings and became unresponsive. Records show their step father was authoritarian, possessive, rigid in his views and controlling.

6.8 As a result, Helen's eldest sister was placed back into care. Children's Social Care records note that carers found she was polite and well behaved.

6.9 A couple of months later, the eldest daughter was returned home (at the insistence of her mum). Soon Helen's mum's relationship with her current partner came to an end. Helen's mum and her four daughters moved out the next month but her son remained in the custody of his father.

6.10 Helen's mum and her daughters returned to this male shortly afterwards but then left again and found themselves living in a caravan. Whilst there Helen's mum began a new relationship.

6.11 Almost a year later concerns about Helen's mum (who was now pregnant) and her ability to care for her daughters, resulted in a statutory visit from a social worker. Conditions at the caravan site were very poor, with water having to be carried for drinking. The girls were not clean and they were hungry. Helen was seven at this time and said to be withdrawn, introverted and rarely smiled. The family continued to be supervised by social services. Other notes in Children's Social Care records made at that time stated the girl's mother was 'feckless with a poor developed sense of responsibility' and that the children's school found them to be hungry.

6.12 That summer all four daughters were taken on holiday by their father. They were not returned to their mum afterwards. Instead, he took them home and they moved in with their dad and his new partner. They were mainly cared for by their step mum as their dad worked away. She was not very caring towards them but they were clean and well fed.

6.13 In January the following year (when Helen had just turned nine) their father's relationship with their step mum ended and Helen and her sisters were returned once more to the care of social services.

6.14 When Helen was 13 years, the care home where she had been living was due for closure so Helen and two of her sisters were returned to their father's care.

Eight months later Helen, her dad and one sister moved in with dad's new partner. They remained in contact with their other sisters and their mother.

6.15 As part of this Domestic Homicide Review, the DHR Chair discussed Helen's childhood with Helen's (adult) daughters. They stated that she had suffered significant physical abuse as well as emotional abuse and neglect from her stepmother. Helen disclosed to her daughters that she was often beaten and covered in bruises. When she was attending school (in the North East of England) Helen described to her own children that she was 'crying out inside' for teachers to ask about her bruising. But no one ever did. There are no entries about this physical abuse on social care records. Therefore, it is likely professionals were unaware.

6.16 Helen had her own child the when she was aged just 16 years. Her partner (and father of the child) was violent and abusive to Helen. The family were supported by Children's Social Care.

Helen and the same male continued their relationship and Helen gave birth to a second child the following year. Her partner continued with his abusive behaviour. The male's own family were also abusive to Helen.

6.17 Helen and her sisters found out many years later that they had a brother. They traced where he was living, but by the time they did so the young man was dead. He had taken his own life (by an overdose) only six months before Helen had managed to find him. He was only 18 years old. This episode also caused Helen significant distress.

6.18 Helen began another long term relationship with a different male. They had a child together (Helen's youngest daughter who is now an adult). This male was also violent and abusive to Helen. Eventually the relationship ended.

6.19 In August 1995 Colin was convicted at Nottingham Magistrates, of a common assault perpetrated against his then girlfriend. He had attended his girlfriend's house whilst drunk and upon being asked to leave, refused to do so. He grabbed his girlfriend around the throat without warning, causing her to choke. He was sentenced to a Community Order.

6.20 He was further convicted in September 1997 at Skegness Magistrates Court of threatening to kill his then girlfriend repeatedly during a domestic dispute, his partner feared that he would carry out his threats.

6.21 In October 1997, Colin was convicted at Lincoln Crown Court of Assault Occasioning Actual Bodily Harm and Common Assault against his then girlfriend. He had squeezed his girlfriend's throat until she lost

consciousness, before throwing her at the bed and wardrobe causing bruising, concussion and vomiting. He was sentenced to a Probation Order for two years.

6.22 In June 2000 police were called to a public house in Leeds. This is the first record of him living in Leeds. Colin was drunk and being abusive to staff. Police officers removed him from the public house but he continued with his drunken and abusive behaviour and was arrested for being drunk and disorderly.

6.23 In October 2001 Colin was seen to strike a female on the head. The female did not wish to make any complaint, but due to his behaviour Colin was arrested for being drunk and disorderly.

6.24 In September 2004, police were called to a disturbance involving Colin and his girlfriend (not Helen). Both told officers they were in a relationship and the girlfriend stated she suffered verbal and mental abuse from Colin. Colin was drunk and the female was in fear for her safety. She stated the arguments had got progressively worse, which is why she had left their home and sought help. The police report states: 'No offences disclosed. No physical violence. No further action taken. Standard risk letters to both parties.'

6.25 In May 2016, a member of public called police to report a male had just assaulted a female. Helen had attended the address of her ex-partner and father of her child to speak about child contact arrangements. When Helen left, her ex-partner followed her, accusing her of being jealous of his new relationship and turning their child against him. He placed his hand on Helen's neck and pushed her backwards causing her to stumble. No injury was caused. The update on the police message states 'no injury caused, victim would not provide a statement, no power to arrest the suspect'. He was subsequently interviewed under caution at the police station.

6.26 In June 2021 Colin's step-son called '999' for an ambulance as Colin had fallen over whilst drunk. He was conveyed to Leeds Teaching Hospital where he was admitted to the Emergency Department.

A subsequent letter to Colin's GP practice stated Colin had drank approximately fifteen pints of beer before staggering and falling against a wall and hitting his head. The letter also stated that Colin had lost consciousness for three minutes and so his family had called '999'.

6.27 In January 2022 Helen and her colleague were cleaning a room in a hostel as part of her work duties. A male living in the room directly below began throwing items at the window of the room where Helen was working. He also shouted threats of violence which left Helen feeling distressed. Officers attended and the male was arrested for threatening behaviour. A referral was also made to the Victim Support Service.

6.28 In March 2023, Helen called police to report she had been stopped in the street by a male who had engaged her in conversation. The male had then pushed her to the ground and sexually assaulted her. Helen provided a statement to the police and forensic samples were taken. A referral was also made to Victim Support Services and an Independent Sexual Violence Advocate (ISVA). The male was subsequently identified, arrested and charged. The case was still ongoing when Helen was murdered.

6.29 In May 2023, Helen first 'met' Colin via an online dating site.

6.30 On 8th November 2023 Helen had a telephone consultation with a paramedic practitioner from her GP practice. She stated she had accidentally fallen from a low table, bumping her head and ribs.

6.31 On 9th November, Helen attended the hospital in Carlisle. She had extensive injuries which were noted by Emergency Department staff. The NCIC (hospital) entry notes recorded:

'Conflicting accounts given. Helen initially stated she had fallen from a table and hit her head. Multiple bruises noted to her face and head, black eye present and bruising to right hip. Helen not willing to disclose exactly what happened – was staying in a hotel – states she doesn't wish to discuss further. Staff were concerned she had been assaulted. DASH and MARAC. Noted lives with her daughter aged 18, this occurred outside the family home, perpetrator doesn't come to the family home. She feels safe and doesn't want to pursue any safeguarding. Does not give consent for MARAC. Discussed with consultant in charge and as she gives no consent we are unable to pursue this further.'

6.32 On 14th November 2023 Helen's GP practice contacted her after receiving the notes from her hospital attendance. Helen disclosed that she had been assaulted, but the perpetrator was not local, she would not be seeing them again and they did not know her address. Helen declined to involve the police or any other support agency.

6.33 On 8th December 2023 Helen returned to work following four weeks of sickness absence. She reported to her line manager that she had fallen whilst decorating at home. Helen was asked directly about wider issues including domestic abuse. She stated there were no issues.

6.34 On 3rd January 2024 Colin called the '111' service reporting health issues. During the call he stated he was 'sofa surfing following a relationship breakdown'. He said he was moving shortly to a new address. He said he had a new partner and it was she who had encouraged him to call '111'. The name of the partner was not provided. He rang his GP practice the following day.

6.35 On 15th January 2024 Colin's GP submitted an urgent referral regarding concern for a suspected cancer diagnosis.

6.36 On 24th January 2024 Colin had a telephone consultation with the Urology Consultant. He subsequently attended the hospital for scans and a biopsy. He was accompanied by his partner, Helen.

6.37 On 14th February 2024 Colin attended Leeds Teaching Hospital where he underwent surgery under local anaesthetic.

6.38 During February and March 2024 Colin continued treatment at Leeds Teaching Hospital relating to his diagnosis of prostate cancer.

6.39 At the end of March 2024 Colin rang West Yorkshire Police to say he had murdered his partner. Police attended Colin's home address where they found Helen's body. Colin was arrested for her murder. Helen had died following compression of the neck.

7. Key issues arising from the review

7.1 There were several emerging themes identified that affected Helen, Colin and their relationship.

7.2 Helen experienced significant trauma in her childhood, including physical abuse, emotional abuse and neglect.

7.3 Helen had suffered violence and abuse at the hands of former partners. One incident was reported to police. Other incidents were not.

7.4 Colin was a serial perpetrator of domestic abuse. He had perpetrated violence and exercised coercion and control over several former partners in a variety of localities in the UK.

7.5 Helen and Colin had been in a relationship for several months. They met via an online dating site.

7.6 Both Helen and Colin consumed alcohol to excess. Neither had a diagnosis of alcohol dependency.

7.7 Helen was in permanent part time employment. Colin was not working and was in receipt of benefits.

7.8 The couple lived a considerable distance apart. They did not share a home but did spend weekend breaks away together. They had no children together but Helen has three (adult) children from previous relationships.

7.9 Police were never called to any incident of domestic abuse between Helen and Colin.

7.10 Colin has a potentially life threatening/terminal illness. Helen supported Colin by attending hospital appointments with him.

17.11 Non-fatal strangulation (not reported to police at the time) was part of an earlier attack on Helen by Colin. Compression of the neck was the method by which he later murdered Helen.

7.12 Colin was convicted of Helen’s murder and was sentenced to life imprisonment.

8. Conclusions and Lessons Learned

8.1 Helen had a traumatic childhood which involved a number of Adverse Childhood Experiences. These are documented within the review and included separation from her mother and father, moving around various locations with no continuity linked to schools or friendship groups, suffering physical and emotional abuse, and being neglected through poor living conditions.

8.2 Colin was known to the police for drunkenness and violence. The violence included abuse perpetrated against several female intimate partners. There were incidents of strangulation. Enquiries conducted as part of this Domestic Homicide Review have confirmed that these incidents took place at several locations around the UK. However, there had been no domestic abuse incidents involving Colin recorded for the last 20 years. These incidents predated the introduction of DASH, IDVAs, MARAC and other recognised domestic abuse support processes.

8.3 Helen had experienced violence and abuse perpetrated by at least two of her former partners.

8.4 Helen and Colin did not live together. They had been in a relationship for less than a year having met via an ‘online dating site’. They went away for weekends together but lived over a hundred miles apart.

8.5 Helen had contact with primary mental health service providers. She suffered from low mood and anxiety but had no formal diagnosis of any mental illness. She had been prescribed anti-depressant medication for many years.

8.6 Helen’s family knew about the previous violent attack (in November 2023). They recall Colin showed Helen love and affection and showered her with gifts etc. Her family believe that previous abusive relationships and her traumatic childhood had desensitised Helen to this violence and clouded her view, making her believe this was a ‘normal relationship’.

She told her daughters ‘This is my time’ because she was going on trips out to hotels, concerts etc. As she had frequently moved around in her childhood, experiencing domestic abuse, and starting a family when still a teenager, this was something she had not had the opportunity to do in the past.

Helen’s daughters described how Colin gave their mum ‘validation’ by having an active social life and drinking together.

8.7 Helen was in part-time employment with her local council. She disclosed her history of low mood and anxiety during her initial interview. Helen’s employers put in support measures which included her manager signposting Helen to professional counselling services. This was good

supportive practice within the workplace. Helen did access the counselling service and confidential disclosures seen by the DHR Chair as part of this review process confirm that these measures helped Helen to maintain her employment.

Domestic abuse posters were displayed in the workplace signposting where to access support if it was needed. Helen was also given leaflets during her Return-to-Work interview.

She made no disclosures of domestic abuse to her close work colleagues.

Her employment records note that Helen was an exemplary member of staff.

8.8 In November 2023 Colin assaulted Helen whilst they were staying at an 'Airbnb'. It was a sustained attack with Helen receiving multiple injuries including bruising to her face and head, two black eyes and bruising to her hip. When she arrived home her daughter described that Helen was walking with a limp. Helen did not report the assault to the police, but due to the pain she was suffering, she attended the Emergency Department at her local hospital and also consulted her GP practice.

Helen initially informed clinicians that she had accidentally fallen. However, staff were concerned that she had been assaulted and challenged her account. This is good practice. Practitioners then completed a nationally recognised domestic abuse risk assessment (DASH) and also a Multi-Agency Risk Assessment (MARAC) referral. However, Helen would not consent to sharing her personal information with other agencies. After seeking advice from a senior manager, staff complied with Helen's wishes and the information was not shared with non-health organisations. Although Helen stated to staff that the assault occurred outside of her family home and that she was ending the relationship, this still represents a missed opportunity for intervention. The same male attacked and murdered Helen only four months later.

8.9 The perpetrator, Colin, was diagnosed with a serious (possibly terminal) illness in January 2024. Helen supported him, which included accompanying him to his hospital appointments.

8.10 Alcohol was a significant feature of Helen and Colin's relationship. Their heavy drinking has already been noted within this review. In relation to Colin, his misuse of alcohol was not regular, but did occasionally result in statutory agency intervention (notably being arrested for being drunk and disorderly or his family calling an ambulance when he had fallen over while drunk).

During his police interview following his arrest for Helen's murder, Colin told officers that their the relationship was pretty good but they did argue usually when they were both intoxicated with alcohol. He said that he had always

been a heavy drinker and that Helen was also a heavy drinker (Helen's family confirm this). He stated that they both had mental health problems and that he could be 'up and down' some days.

He went on to describe that on the night before the murder, they had both been drinking alcohol since around 10.45pm, consuming two crates of beer (20 bottles per crate) and a bottle of wine. He said Helen had consumed a bottle of wine prior to him collecting her from her home address.

Colin also said that he had assaulted Helen previously (in November 2023) and that he was intoxicated at the time. He told officers that he blamed his previous domestic abuse history on his excessive alcohol consumption.

8.11 At the time of Helen's murder, other than her accompanying Colin to his hospital appointments (where no concerns were ever raised), no agency or professional was aware Colin and Helen were in an intimate relationship.

9. Recommendations

9.1 Cumberland Community Safety Partnership coordinates awareness raising within the private sector relating to domestic abuse. This to include how to recognise potential abuse, how to offer support and what to do if they have concerns about the welfare of an employee or guest.

9.2 North Cumbria Integrated Care NHS Foundation Trust (NCIC) and the GP practices within Cumberland provide Cumberland Community Safety Partnership with assurances that practitioners are confident in sharing patient's personal details without their consent in domestic abuse cases that have been assessed as 'high risk' (i.e. those cases where the patient is at risk of significant harm or death).

9.3 NCIC ensure that all documentation relating to completed domestic abuse risk assessments, are scanned onto electronic databases and the hard copy is stored securely.

9.4 All agencies who are part of the Cumberland Community Safety Partnership, Cumbria Safeguarding Adults Board or the Safer Leeds Partnership, provide assurances that when professionals encounter vulnerable people that may be consuming alcohol to excess, they are aware of how to signpost or refer the individual to specialist alcohol & substance support services.

9.5 Cumberland Community Safety Partnership carries out a piece of work to gauge the level of knowledge within agencies relating to 'trauma informed practice'. The whole concept of 'trauma informed practice' should be explored and appropriate training accessed by front line staff to ensure a tailored response to vulnerable individuals who may be struggling with how to access support.

9.6 Cumberland Community Safety Partnership reviews current processes in place to raise awareness of 'Clare's Law' (the Domestic Violence Disclosure Scheme) with the general public. This is particularly important in relation to the 'Right to Ask' element of the scheme.

9.7 The victim may have been reluctant to make disclosures to her employer as her own team had specialist staff able to provide advice around domestic abuse to the public. Cumberland Council provided excellent care and offers of support to the victim, both on her initial appointment and when she returned from sickness absence. But the council should ensure alternative pathways are available to signpost employees to other departments to be able to speak in confidence outside their own management structures, if they so wish.

9.8 Cumberland Community Safety Partnership ensures enquiries are made with 'online dating site' providers linked to the safety of clients using their

sites. Many Domestic Homicide Reviews across the UK have made findings linked to vulnerable victims using these sites.

In this case, the victim and perpetrator met via a dating site (confirmed by the victim's family to be 'Plenty of Fish'). Academic research suggests that one in three relationships now start online[1]. The enquiries should satisfy the CSP that measures are in place within the site(s) that provide advice on keeping safe when chatting with people online and safety advice when meeting people in person. A specific section on 'Clare's Law' would be helpful to ensure clients are aware of what to do if they have concerns about someone they meet on line.

9.9 NCIC issues a reminder to all front line professionals that their specialist safeguarding team is available for advice and guidance if practitioners are unsure of what action to take in a case of suspected domestic abuse. This includes advice around multi-agency information sharing.

9.10 The Cumberland Community Safety Partnership hold a 'lessons learnt' event, highlighting the trajectory of this very sad case. Helen had been in a relationship with Colin for only 10 months before he killed her. The timeline closely follows the 8-stage homicide timeline developed by Professor Monckton-Smith, which would be an excellent resource to support multi-agency learning and awareness.

Single agency recommendations

9.11 Cumberland Primary Care to consider offering face to face appointments where there is a concern regarding a possible assault.

9.12 Leeds ICB safeguarding team to review the effectiveness of the communication of available domestic abuse training across the city within GP practices.

[1] *e-Harmony and the Imperial College Business School*