Cumberland Community Safety Partnership

A Domestic Homicide Review of the death of Helen

March 2024

Report Author: Mike Cane

2nd June 2025

Family Tribute

Mam was born in December 1975. She was born in the year of the rabbit and a proud Sagittarius. She believed strongly about horoscopes and would often read ours to us. She was the 4th daughter born to her mother and father. Her mother went on to have a son and daughter later on in her life. Due to parental break ups she spent a lot of her childhood in and out of foster care and with people who didn't treat her well. Even though she had been through so much abuse at such a young age, I believe that was what made her into the strong Independent loving mother she became.
Mam was an incredibly strong human being. She always fought to make sure that all her family was safe and felt loved. She always thrived to give her children everything she never had. Times must have been so hard for her, two children under the age of three by 19, but me and my brother would never have known it growing up.. She had her flaws, but everyone does. She had a good support system at this time.. her sisters, who we had a very close relationship with and always went on family trips out with our cousins, and our neighbours who knew payday was on a Monday so would drop treats off for us after a Sunday car boot. Growing up we never knew about any of the turmoil she suffered. Our younger sister was born when she was 30 and our family was complete. The relationship with my sister's father didn't last, ending turbulently, but she was so strong and independent she took it in her stride and tried to do the best for her children. She always worked hard to provide for us all, and when she got a job helping homeless people in 2017 she really took to it.

Anyone who had ever met her would say her cackle would fill up the room and she was genuinely loved by anyone who met her. Her love for helping people shone and she would do anything to try stop somebody hurting. Her father and her stepmam would say she was the one who troubled them the most as a teenager, but she was always there. Her sister's adored her as the baby of the family and they all knew she would always be there to support them for whatever needed doing. After having some trouble with her mental health, she met the man she thought she would spend the rest of her live with. She seemed happy. He spoiled her. They were there for each other in times of darkness. Little did we know he was truly a monster.

Now she is gone there is a hole in our lives, that was once filled with love and laughter, is now a deep chasm of loss and sadness. 48 years was not enough time on this earth for her. She had so many plans, so many concerts she wanted to go to and so many gigs she had booked. Her son's wedding , her youngest daughter turning 18, her oldest grandchild starting secondary school. Her three children and four grandchildren will not get to feel her embrace or her wise (or not so wise) words of advice. Her youngest daughter, barely leaving childhood , will have to go forward in life without the touch of her mother and her grandchildren will never again have the opportunity to hug nana. Her loss is felt everyday by so many. Not a day goes by where I don't think about calling her, only to feel the grief hit harder. Knowing I'll never hear her voice again is the hardest part.

Section 1: Introduction

1.1 This Domestic Homicide Review (DHR) examines agency responses and support given to Helen, a resident of Cumberland, prior to her tragic death in March 2024. It also reviews the contact agencies had with the man who murdered Helen; her partner Colin.
The DHR panel extend their deepest condolences to Helen's family.

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 In addition to agency involvement, the review will also examine the past, to identify any relevant background or indicators of harm or of potential abuse before her death. It will consider if support was accessed and whether there were any barriers to accessing support. By taking a holistic approach, the review seeks to identify lessons that can be learned from this tragic incident.

1.4 The circumstances of the death were initially provided by West Yorkshire Police to the Cumberland Community Safety Partnership on 2nd April 2024.

1.5 To protect the identity of those involved, pseudonyms have been used for both 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.

1.6 The review will consider all agencies' contact and involvement with Helen and Colin from March 2021 through to the date of Helen's murder. This three year period was agreed as appropriate in order to give a full picture of Helen's life and experiences and those of the perpetrator. However, to fully understand this case, the Domestic Homicide Review Panel agreed to consider any significant event or pattern of events before those dates. These are also documented within the review.

1.7 The key purpose for undertaking a Domestic Homicide Review is to enable lessons to be learned where a person is killed as a result of domestic violence and abuse. In order for these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand what happened and most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future.

Section 2: Timescales

2.1 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.

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

Section 3: Confidentiality

3.1 The content and findings of this review will be 'confidential', with information available only to those participating officers and professionals and where appropriate their organisational management. It will remain confidential until the review has been approved for publication by the Home Office Quality Assurance Panel.

3.2 The victim, Helen, was 48 years old at the time of her death. The perpetrator, Colin, was 53 years old at that time. All subjects of this review are British citizens who reside or did reside permanently in the UK. Their ethnicity is white / British.

Section 4: Terms of Reference

4.1 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?'

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

Section 5: Methodology

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

5.2 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.

5.3 An Independent Chair for the DHR was appointed in May 2024.

5.4 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 or death 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 she was related or with whom she was or had been in an intimate personal relationship, or
b) A member of the same household as herself."

5.5 For this review, the term domestic abuse is in accordance with the statutory definition of domestic abuse contained within the Domestic Abuse Act 2021:

Definition of domestic abuse

(1) This section defines 'domestic abuse' for the purposes of this Act.

(2) Behaviour of a person (A) towards another person (B) is 'domestic abuse' if:

(a) A and B are each aged 16 or over and are personally connected to each other, and

(b) the behaviour is abusive.

(3) Behaviour is 'abusive' if it consists of any of the following:

(a) physical or sexual abuse;

(b) violent or threatening behaviour;

(c) controlling or coercive behaviour;

(d) economic abuse (see subsection (4));

(e) psychological, emotional or other abuse;

and it does not matter whether the behaviour consists of a single incident or a course of conduct.

(4) 'Economic abuse' means any behaviour that has a substantial adverse effect on B's ability to:

(a) acquire, use or maintain money or other property, or

(b) obtain goods or services.

(5) For the purposes of this Act A's behaviour may be behaviour 'towards' B despite the fact that it consists of conduct directed at another person (for example, B's child).

(6) References in this Act to being abusive towards another person are to be read in accordance with this section.

(7) For the meaning of 'personally connected', see section 2.

2 Definition of 'personally connected'

(1) For the purposes of this Act, two people are 'personally connected' to each other if any of the following applies:

(a) they are, or have been, married to each other;

(b) they are, or have been, civil partners of each other;

(c) they have agreed to marry one another (whether or not the agreement has been terminated);

(d) they have entered into a civil partnership agreement (whether or not the agreement has been terminated);

(e) they are, or have been, in an intimate personal relationship with each other;

(f) they each have, or there has been a time when they each have had, a parental relationship in relation to the same child (see subsection (2);

(g) they are relatives.

(2) For the purposes of subsection (1)(f) a person has a parental relationship in relation to a child if:

(a) the person is a parent of the child, or

(b) the person has parental responsibility for the child.

(3) In this section:

- *'child' means a person under the age of 18 years;*
- *'parental responsibility' has the same meaning as in the Children Act 1989 (see section 3 of that Act);*

5.6 The overarching reason for the commission of this review is to identify what lessons can be learned regarding the way local professionals and organisations work individually and collectively to safeguard victims.

5.7 The Cumberland Community Safety Partnership identified that in this case the death met the criteria of the Domestic Violence, Crime and Victims Act 2004 and commissioned a Domestic Homicide Review.

5.8 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.

5.9 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.

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

Section 6: Involvement of family, friends, neighbours and wider community

6.1 Helen's family were approached at the start of the Domestic Homicide Review. After introductions via the police Family Liaison Officer, the Independent Chair telephoned Helen's eldest daughter and explained how the DHR would be conducted and progressed. The family had a specialist advocate appointed to support them from the Homicide Service of Victim Support.

6.2 The Chair then wrote formally to Helen's family to set out the process and that the family were invited to take part. This was followed by further telephone calls to clarify a timetable. The family were thanked for their agreement to take part during this difficult time.

6.3 Further periodic calls took place and then the Independent Chair met Helen's family face to face in January 2025. The meeting lasted several hours and discussions included Helen's family life together with her relationship history, the involvement of services and a review of each individual incident recorded by agencies. The family assisted by providing valuable clarification of events and also their own personal views on the circumstances that led to their mum's murder. They were supported throughout the meeting by their advocate from Victim Support.

6.4 Helen's (adult) son and two (adult) daughters were aware that the nature of the relationship with Colin was abusive. They had seen her injuries following him assaulting her in November 2023. Her younger daughter lived with her and saw her mum 'limping' as she came back to her home following a few days away with Colin. She challenged her mum about what happened and knew that she was telling lies about how her injuries had been caused. Her daughter described how she 'backed off' a little when her mum told her to stop 'nagging'. She subsequently saw several texts from Colin to her mum saying how sorry he was and how he should never have done it. During a telephone call, her daughter overheard Helen saying to Colin 'Why have you done this to me?' Eventually, her mum did say that Colin had assaulted her. However, she also said he was really sorry and that he loved her.

6.5 Colleagues of Helen were also approached during the review process. They were able to share their own memories of Helen. They described Helen as upbeat and with a great sense of humour.

They were aware Helen had started using an online dating site and they told her to be careful. One friend did actually meet Colin once. He seemed 'okay' but the friend quickly identified that the relationship between Helen and Colin had alcohol at the heart of it. They would both drink heavily together while socialising . However, even Helen's closest friend at work

did not know that the relationship was violent. They were aware she had phoned in sick on one occasion but Helen had insisted she had fallen off a table while decorating.

Helen came across as confident, but one close friend stated to the DHR Chair that they believed Helen was a lot less confident than she portrayed. The same friend recalled that Helen would sometimes ring them at home on an evening crying and talking about her childhood or other experiences (though not about domestic violence).

Helen's colleagues and friends remember her as a popular and effective member of their team. The team supported many vulnerable people and colleagues realised Helen was able to use her own life experiences to communicate with their clients. She really did mean it when she spoke with people and told them she understood what they were going through.

Following Helen's death, there was a big void in her team. It was felt by everyone as they were such a tight knitted team and her colleagues really did think so highly of her.

When asked to describe their memory of Helen, one close friend said "She was a tough cookie but vulnerable underneath. We all miss her so much. There is now a Helen-sized hole in the workplace."

6.6 Helen's family remember their mum as loving, kind and with a great sense of humour. They believe she was far too trusting of Colin. She had such a difficult childhood and unhealthy adult relationships that they are certain she wanted to be loved for who she was. They describe that Colin 'gave her validation' that she could be who she wanted to be. They said that he 'glued' her to him. He showered her with gifts and they enjoyed each other's company. After he had badly assaulted her, she was willing to forgive him as she wanted to believe the best in people.

6.7 The DHR Panel and the Cumberland Community Safety Partnership extend their deepest condolences to Helen's family at this very difficult time. A full pen portrait with family memories of their mum is contained on the first page of the Domestic Homicide Review.

Section 7: Contributors to the Review

7.1 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.

7.2 The following organisations were required to produce an Individual Management Review:

- 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).

7.3 Other agencies provided scoping, summaries and chronologies:

- 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)

Section 8: The Review Panel Members

8.1 The Independent Chair of the Review Panel is Mr Mike Cane. He is also the appointed Independent Author for the review.

8.2 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

8.3 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.

8.4 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.

Section 9: Author of the overview report

9.1 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.

Section 10: Parallel Reviews

10.1 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.

10.2 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.

10.3 There were no children in the relationship and so no requirement for a Child Safeguarding Practice Review.

10.4 Due to some of the vulnerabilities of the victim, a copy of the DHR will also be shared with the Cumbria Safeguarding Adults Board.

Section 11: Equality and Diversity

11.1 The protected characteristics named under the Equality Act 2010 are age, sex, gender reassignment, marital status, race, religion/belief, pregnancy, sexual orientation and disability.

11.2 The victim and the perpetrator were not married at the time of her death. Their marital status did not affect any of the services provided.

For the year ending March 2024, the Crime Survey for England and Wales (CSEW) showed that a significantly larger proportion of adults who were separated or divorced experienced domestic abuse in the previous year than those who were married, in civil partnership, co-habiting or widowed.[1]

11.3 No issues were identified during this review applicable to gender reassignment, sexual orientation, race or religion/belief. The victim was not pregnant at the time of her death.

11.4 The victim was not registered with any disability, however she had experienced Adverse Childhood Experiences (ACE) which caused her to seek support from mental health services.

11.5 The perpetrator was not registered with any disability.

11.6 Mental health is a factor affecting many victims of domestic homicide.[2]

[1] *Domestic abuse victim characteristics, England and Wales - Office for National Statistics*

[2] *Key findings from analysis of domestic homicide reviews: October 2019 to September 2020 (Updated 12 April 2023)*

Mental health issues were recorded for 48% of the victims. The mental health issues do not differentiate between those which existed prior to their experiences of domestic abuse and those which are directly related to the experience of being abused. Of the mental health issues noted, depression is most often found (26% of the issues recorded). 16% of victims had suicidal thoughts and 14% had attempted to take their own life. Low mood / anxiety was also a mental health issue impacting on 14% of victims. The other mental health issues noted include anxiety, dementia or Alzheimer's, panic attacks, psychosis, Post Traumatic Stress Disorder (PTSD) and self-harm. Helen suffered from low mood and panic attacks.

When considering the vulnerabilities of perpetrators, 71% had been recorded with at least one vulnerability (which is a larger proportion than the 61% of victims). In examining the type of vulnerability, illicit drug use, problematic alcohol use and mental ill-health were the largest proportions (30% to 33%). Colin was known for consuming excessive quantities of alcohol.

11.7 Women are much more likely to be the victim of domestic abuse.

The Crime Survey for England and Wales (CSEW)[3] stated the victim was female in 72.5% of domestic abuse-related crimes in year ending March 2024. The Crime Survey for England and Wales estimated that 1.6 million women and 712,000 men aged 16 years and over experienced domestic abuse in year ending March 2024. This equates to approximately 7 in 100 women and 3 in 100 men.

As in previous years, women were disproportionately represented among victims of domestic abuse-related crimes. 65.4% of victims of domestic homicide were female compared with 12.3% of victims of non-domestic homicide between year ending March 2021 and March 2023. Women are most likely to be killed by a partner or ex-partner.

The CSEW also explains that Homicide Index data shows that 65.4% of the victims of domestic homicide were female, for March 2021 to March 2023. This contrasts with non-domestic homicides where the majority of victims over the same time period were male (87.7%). Of the 231 female domestic homicide victims, the suspect was male in the majority of cases (224). For male domestic homicide victims, the suspect was female in 39 cases out of 122. In the majority of female domestic homicides, the suspect was a male partner or ex-partner (74.9%), whereas in the majority of male domestic homicides, the suspect was a male family member (62.3%).

[3] *Office for National Statistics (ONS),released 27 November 2024, ONS website, article, https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/domesticabusevictimcharacteristicsenglandandwales/yearendingmarch2024*

This data shows the over representation of victims who are women in domestic homicide cases.

11.8 With regard to age, the Crime Survey for England and Wales (2024) estimates that the percentage of women who experienced domestic abuse in the last year was significantly higher than men for the majority of age groups. The exceptions were those aged 24 years and under and those aged 55 to 59 years, where there was no statistically significant differences in the prevalence of domestic abuse between women and men.

11.9 The Domestic Homicide Project states[4]:

'*Across the two-year period 1 April 2020 to 31 March 2022 there were 470 deaths in total which took place in a domestic setting or following domestic abuse, including 43% intimate partner homicide'*
'The proportion of all suspects previously known to police for domestic abuse rose to 66%, from 55% in year one. However, fewer suspects in adult family homicide cases were previously known to police for domestic abuse.'
'Across the two-year findings, only 10% of perpetrators were recorded as previously having been managed by police or probation.'

Colin was known for perpetrating previous domestic abuse against former partners.

Section 12: Dissemination

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

- Helen's family
- All organisations within the Cumberland Community Safety Partnership
- Safer Leeds Community Safety Partnership
- DHR Panel members
- Office of Police and Crime Commissioner for Cumbria
- Cumbria Safeguarding Adults Board
- Home Office DHR team
- The Domestic Abuse Commissioner for England & Wales
- HM Coroner

[4] *The Domestic Homicide Project is a Home Office funded research project led by the National Police Chiefs' Council (NPCC), delivered by the Vulnerability Knowledge and Practice Programme (VKPP) in collaboration with the College of Policing.*

Section 13: Background information

Case specific background

13.1 The victim, Helen, experienced a difficult childhood. Her mother left the family home when Helen was only 3 years and 11 months old. Helen and her three older sisters remained with her father for a period but he was unable to care for them and the girls were placed into the care of the Local Authority. Her mother then requested custody of the girls and all four sisters joined her in the North East of England. There was no stability, the girls lived with their mum and several different step fathers. Children's Social Care had involvement with the family. Further details are provided in section 15 of this review.

13.2 While still a teenager, Helen began a relationship with a male and they had two children together. This male was abusive to Helen, but she did not report any incidents to the police or any other agency.

13.3 Several years after the relationship ended, Helen met another male. This male was also violent and abusive to Helen. They had a child together. Helen ended the relationship due to the abuse.

13.4 Colin was born in Scotland. He lived in various locations in England before settling in Leeds where he lived for many years. He had been violent and abusive to several of his former partners.

13.5 Helen and Colin met via an online dating site in 2023 and began a relationship.

13.6 Although police were never called, the DHR panel have confirmed the relationship involved significant violence perpetrated against Helen by Colin.

13.7 In March 2024, Helen went to Colin's home in Leeds (Colin collected her in his car). Colin violently assaulted Helen. Colin called the police who attended, as did the ambulance service. They found Helen's lifeless body. Attempts were made to resuscitate her but she was pronounced dead at the scene. Colin was arrested on suspicion of Helen's murder. He was charged the next day. Helen had died from compression to the neck.

13.8 Colin appeared at Leeds Crown Court in October 2024 where he pleaded guilty of the murder of Helen and was sentenced to life imprisonment with a minimum term of 17 years and six months. He was also sentenced to two years to run concurrently, for assaulting Helen and causing her actual bodily harm in November 2023.

Section 14: Chronology

14.1 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.

14.2 Colin was convicted in August 1995 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.

14.3 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.

14.4 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.

14.5 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.

14.6 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.

14.7 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.'

14.8 In October 2010, a bus driver telephoned police; two females were arguing and so were asked to get off the bus. Colin was the partner of one of the women and he grabbed hold of the bus driver. Colin was subsequently

interviewed at the police station but denied any allegations. CCTV showed minimal contact between Colin and the bus driver. No further action was taken.

14.9 In May 2013, a child protection incident was reported to West Yorkshire Police. Colin was the child's stepfather. An allegation was made that he kicked the child with his bare feet, after he believed the child had stolen £12.00 from his bag. No injury was caused. A referral was made to social services by the police. A core assessment was initiated and a family support worker was allocated to work with the family.

14.10 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.

14.11 In February 2017 Helen began working for Cumberland Council. She was appointed to a part-time post within one of the council departments.

14.12 In July 2017 a local school called the police to report Colin engaging in threatening and abusive words towards a member of their staff. The member of school staff was a female teaching assistant and Colin appeared to be blaming her regarding issues with his son. He was reported to have been only a foot away from her and pointing his finger causing her to feel alarmed and distressed. The teaching assistant did not want to prosecute Colin. Colin was warned by police concerning his future conduct.

14.13 In March 2018 Helen self-referred into the North Cumbria Talking Therapies service (NCTT) regarding her anxiety and suffering a recent panic attack. Her initial assessment took place in April and she had further appointments in the following months. Helen made disclosures of Adverse Childhood Experiences including emotional and physical abuse by her step-mother and also disclosed that she and her siblings had been taken into care.

Following several missed appointments Helen was discharged from the service in July 2018.

14.14 In August 2020, Helen contacted Cumbria Police to report a malicious communication from a male. She had connected with the male through a dating website and although they had never met, they had regularly messaged each other. When Helen told him she no longer wanted any contact he began sending abusive and derogatory messages to her. He also sent a semi naked photo of Helen to her school-age child. Helen did

not wish to make a statement. An officer spoke to the male and he agreed not to message Helen or her family again.

Safeguarding advice was given to Helen to block all his numbers/devices and report to the police if he attempted to contact her again.

No Vulnerable Adult Form (VAF) or Vulnerable Child Form (VCF) were completed. A domestic abuse form was deemed not required as Helen was not in a relationship with the male.

14.15 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'.

14.16 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.

14.17 In July 2022, Helen had an appointment with her GP. The consultation was regarding anxiety following an assault. This was not domestic abuse related but had occurred when Helen was assaulted by a female while on holiday.

14.18 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 then 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.

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

14.20 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.

14.21 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.'

14.22 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.

14.23 On 6th December 2023 Colin engaged in a verbal outburst whilst attending his GP practice. This incident was directly attributed to a mix up with his medication. It was dealt with appropriately by sending a standard GP communication via text message to Colin regarding zero tolerance to violence and aggression. There were no warning letters issued to Colin prior to, or after this incident.

14.24 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.

14.25 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.

14.26 On 10th January 2024 Colin had a face-to -face consultation with his GP linked to urinary tract symptoms. He attended subsequently for blood tests.

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

14.28 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.

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

14.30 On 20th February 2024 Helen was sent a 'behaviour warning letter' by her GP practice regarding aggressive behaviour towards a staff member. This related to an outburst in frustration at waiting times.

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

14.32 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.

Section 15: Victim Adverse Childhood Experiences

15.1 This section has been included to illustrate the childhood experiences of Helen. These events may have framed her views and thoughts and affected how she lived her life. It is likely they affected her future experiences and decision-making.

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.

15.2 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.

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

15.4 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.

15.5 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.

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.

15.6 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.

15.7 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.

15.8 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.

15.9 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.

15.10 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.

15.11 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.

15.12 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.

15.13 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.

15.14 When Helen was aged 15 years, Children's Social Care discharged the supervision order in place.

15.15 Helen had a child the following year 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.

15.16 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.

15.17 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.

15.18 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.

15.19 These range of experiences; abuse and neglect in childhood, constantly moving home, different adults involved in her life and then subsequently suffering domestic abuse in her adult years, impacted upon Helen to the extent she sought help from mental health and counselling services.

15.20 It was important that the Domestic Homicide Review panel understood these experiences and circumstances when considering Helen's relationship with the male who went on to murder her. Her choices and decision-making were unique to Helen as an individual. This is all part of Helen's intersectionality. Professionals must not sub consciously insert their own path through life in their considerations and analysis. Every person is different and their experiences and circumstances are likely to have been significantly different to Helen's.

Section 16: Overview

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

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

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

16.4 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.

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

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

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

16.8 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.

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

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

16.11 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.

16.12 Colin was convicted of Helen's murder and was sentenced to life imprisonment.

Section 17: Analysis

17.1 Robust analysis has been carried out as part of the review process. Each specific agreed 'term of reference' has been considered, discussed by the DHR panel and addressed according to the circumstances, history and context of the case.

Although fifteen organisations were involved in the DHR; providing information, data, records and making contributions at panel meetings, no single agency had dealings with both the victim and perpetrator prior to Helen's tragic death.

17.2 Were practitioners sensitive to the needs or vulnerabilities of the victim?

17.2.1 Nine agencies were Identified as having contact with Helen.

17.2.2 Cumbria Police had four contacts with Helen from 2016 to 2024. One of these related to domestic abuse.

The domestic abuse incident (reported in 2016) related to her ex-partner (not Colin). Police were initially called to a 'verbal argument'. However, when they attended an assault was also reported. A 'DASH' risk assessment was carried out (a national recognised domestic abuse risk assessment process). The assessment determined this was a 'standard' risk incident. The circumstances recorded on the crime report were that the assault included the male 'putting his hands on Helen's neck and pushing her backwards'. An independent witness also reported that the male had hit Helen in the face. Arrangements were made to obtain a statement from Helen but she was unavailable. Further attempts were made but eventually Helen told officers she did not feel able to support a prosecution. The ex-partner was traced and attended the police station as a voluntary attendee. He did not deny the offence but stated he could not remember the incident as he had taken illicit substances. He did say the incident 'probably happened'.

Officers did recognise Helen as a vulnerable victim of domestic abuse and she was offered a referral to the Victim Support Service but she declined as she stated she was no longer in a relationship with the male. With Helen's reluctance to assist a prosecution, a supervising officer determined a caution would be the most suitable conclusion to the case. But police then had difficulty re-tracing the male and they missed the statutory time limit for summary offences. This meant the case was finalised as 'No Further Action'. Although Helen's wishes were respected, this was not a satisfactory outcome as the opportunity to record a formal caution against the male was missed.

17.2.3 The second incident involving Cumbria Police occurred in August 2020 when Helen reported receiving abusive messages from a male she had met on a dating site. They had never met and Helen had ended the contact before they ever met. Following that, the male had become abusive and this included him sending a semi-naked photograph of Helen to her teenage child. Helen did not want a formal prosecution. The male had deleted the image and Helen requested he was warned regarding his conduct. This action was carried out. Officers did recognise her vulnerability by advising her to 'block' the male from all forms of social media (which was in line with national police practice at that time) and advising her to call '101' if there was any further contact. Helen was happy with these actions.

17.2.4 In January 2022 Helen was threatened in the workplace. A male in a flat near to where she was working with a colleague had shouted threats of violence towards her. Police attended the scene immediately and the male was arrested. He was later interviewed and charged with a public order offence. It is unclear if this matter was recorded by Helen's employer as such records are only retained for 12 months. Nevertheless, police action was swift and positive.

17.2.5 The final contact between Helen and Cumbria Police was in March 2023 when she was attacked by a male. She had been pulled to the ground by a male unknown to her and sexually assaulted. The male was traced, arrested, interviewed and later charged with attempt rape. Helen's vulnerability was recognised. She was referred to the Independent Sexual Violence Advocacy (ISVA) service. In line with national best practice, Helen provided a Video Recorded Interview (VRI) with specially trained police officers as her eligibility for special measures was noted as a vulnerable witness in a sexual offence investigation. This case was still outstanding when Helen was murdered by Colin.

17.2.6 Victim Support provides a number of services across Cumbria. These include a victim advocate team for all crimes plus specialist staff who can support domestic abuse cases (Independent Domestic Abuse Advocates) and Independent Sexual Violence Advocates for cases of rape and sexual assault.

The domestic abuse case reported by Helen to police in 2016 was several years before Victim Support Services (VSS) were commissioned to provide support within that field. VSS did receive two other referrals from the police; the public order offence in 2022 and the attempt rape offence in 2023.

Following the police referral about the public order offence (when a male in a flat near to where Helen was working had threatened her), a member of the VSS team contacted Helen by telephone. Helen told the professional she was not concerned nor affected by the incident and that its 'in the hands of the police'. Helen stated she didn't need any support as her job provides therapy, counsellors and special leave in such circumstances if required.

17.2.7 Victim Support made contact with Helen by telephone within two days of the attempt rape offence in March 2023. The professional noted within the referral that a male unknown to Helen had tried to engage her in conversation when she was on her way home before grabbing her, pulling her to the ground and trying to force his hand down her waistband while attempting to kiss her.

During the contact it was noted Helen stated she was 'on auto-pilot at the moment'. She asked for a call back in a few weeks when she had taken the time to process what had happened. The ISVA advised Helen that there was a current waiting list for clients and Helen was happy with that. She told the VSS professional she 'was not in a rush'.

As there was no further contact with Helen, it was not possible for a full needs assessment to be carried out to assess her vulnerabilities.

17.2.8 Helen was employed by the local council from 2017. She worked within the homeless section and as part of her recruitment and selection process, Helen disclosed she had experienced homelessness herself and that she had lived within the care system when she was younger. These vulnerabilities were recorded and noted. Additional supervisory support on a 1:1 basis and internal training was provided to enable Helen to build her confidence in her new role.

During one such support session in 2017, Helen disclosed she suffered with anxiety at times due to historic personal issues (the exact details were not disclosed). Contact numbers were given directly to Helen so she could access counselling through the Employee Assistance Programme (EAP), which she later advised managers that she was engaging with (for full details and analysis see paragraph 17.12).

17.2.9 Helen had a period of sickness logged with the council, for four weeks from November to December 2023 and was signed off from work by her GP. The fit note provided stated the reason she was unfit for work was due to a `head injury and bruised ribs'.

In line with the council's sickness policy, regular contact was maintained throughout the absence period and at the conclusion of the sickness period, a return-to-work (RTW) interview was held with the duty manager. The RTW interviews are held in confidence and explore the reasons for absence and any wider support factors needed to support the employee to return to work including whether any adjustments are required, reduced hours, risk assessments, referrals for additional support etc. The first part of the RTW form is to be completed by the employee and the second part by the person undertaking the meeting with the employee.

The RTW form does not explicitly ask managers to consider domestic abuse, but as the reason for absence noted was a head injury and Helen advised this was due to a fall, the duty manager did ask her around whether there were any wider issues she needed support with including domestic

abuse. Helen advised she had fallen off a table whilst decorating and banged her head and ribs and this was the reason stated on the form. As part of the DHR process, staff were interviewed and confirmed that it was known within the team that Helen was decorating at that time, as she was discussing this pre-absence, and she had posted pictures of her decorating on social media.

Helen also stated at the RTW discussion that she was getting new glasses and awaiting an appointment for a CT scan as she was having some blurred vision following this fall. The details of the Employee Assistance Programme were again shared with Helen along with wider contact information for support (which included the National Domestic Abuse Helpline information). The manager shared the completed RTW form with HR as part of the reporting process in line with the policy and RTW submission process. Helen was advised to speak to management if she needed any extra support or adjustments. Following this, there were no other periods of absence, and no issues noted within subsequent one to one discussions.

17.2.10 In April 2018, Helen self-referred into NHS North Cumbria Talking Therapies (NCTT) service (at the time known as the 'First Step' service). NCTT is commissioned to provide brief, short term, evidence based psychological therapies for people with 'mild to moderate' mental health problems. Clients can self-refer or be referred by another health care profession.

17.2.11 Helen's self-referral followed her experiencing a panic attack (for full details see analysis at paragraph 17.12).

17.2.12 Helen cancelled her first planned appointment but at the next session discussed the principles of Cognitive Behaviour Therapy (CBT) and guided self-help and information was given relating to anxiety. Helen engaged well. At her second session, reductions in the level of her anxiety were recorded. She attended a third session and again engaged well. But Helen rang to cancel her fourth session. A new date was arranged and a letter sent to confirm the date and time of her appointment. However, Helen did not attend that session either. A letter was sent advising Helen that non-attendance could have a negative impact on the benefits of therapy and encouraged Helen to call and discuss if there were any problems with maintaining her regular appointments. Helen did not get back in touch and so, in line with Trust policy, a discharge letter was sent to her and a copy sent to her GP. (For further details of the content of Helen's three therapy sessions, see paragraph 17.12).

17.2.13 Helen attended the Cumberland Infirmary, Carlisle (part of North Cumbria Integrated Care NHS Foundation Trust – NCIC) in November 2023 with multiple injuries. Staff quickly identified Helen's vulnerabilities and raised concerns with her over her safety and well-being. Helen did not feel able to share the details of the incident which had resulted in her injuries. However, there is evidence that staff did display professional curiosity and asked

further questions of Helen. Helen's account did not match the presenting injuries, and so staff completed a nationally recognised DASH (Domestic Abuse Stalking and Harassment) risk assessment. This was good practice. However, Helen would not consent to the sharing of her personal information with other organisations. This meant there was a missed opportunity for further action and intervention. This is fully analysed at paragraph 17.7.

17.2.14 Helen's GP practice rang her after they had received the letter confirming Helen's attendance at the Emergency Department. Although Helen did confirm she had been assaulted, she did not want any further action taken. Again, this issue is explored at paragraph 17.7.

17.3 Were professionals knowledgeable about potential indicators of domestic violence and abuse and aware of what to do if they had concerns about a victim?

17.3.1 There was only one incident of domestic abuse reported to Cumbria Police (this did not involve Colin and was seven years before Helen's murder). This was correctly identified as such and positive action taken.

17.3.2 An incident of domestic abuse perpetrated by Colin against Helen occurred in November 2023. She attended the Cumbria Infirmary at Carlisle and also contacted her GP. The actions of professionals in relation to this incident are analysed at paragraph 17.7

17.3.3 Victim Support Services did not receive any referrals relating to Helen that were linked to domestic abuse. However, their workforce includes specially trained and accredited Independent Domestic Violence Advocates (IDVAs) who are experienced professionals that work closely to support victims of domestic abuse.

17.3.4 Cumberland Council staff within Helen's team are trained in conducting domestic abuse risk assessments (using the national DASH model). Levels of training in the team ranges from mandatory core safeguarding and domestic abuse training up to specialist IDVA trained officers.

17.3.5 Leeds Teaching Hospital NHS Foundation Trust (LTHT) only briefly had contact with Helen when she accompanied Colin at his hospital appointment. There were no concerns noted regarding their relationship. The patient was Colin who was receiving treatment for a serious (potentially terminal) illness and Helen was there to support him. The Trust does have domestic abuse training programmes in place for their staff and their Adult and Children's Safeguarding Team are also available to provide advice.

17.3.6 West Yorkshire Police, the Leeds GP and the Yorkshire Ambulance Service did not have any contact with the victim. All have domestic abuse training programmes in place within their organisations.

17.4 What knowledge did your agency have about the relationship between the victim and perpetrator?

17.4.1 Other than the brief unconnected hospital appointment referred to in paragraph 17.3.5, no agency had knowledge of the relationship between Helen and Colin. Even when partial disclosures were made by Helen to NCIC and Helen's GP, the identity of Colin was not known or divulged.

17.5 Did the agency have policies and procedures in place relating to domestic abuse? Were these policies complied with?

17.5.1 Cumberland Council has a Domestic Abuse Policy in place which was reviewed in 2024. The contact with Helen following her sickness absence in 2023 showed clearly that managers did consider domestic abuse as a potential cause of Helen's absence. Helen maintained that she had fallen, but the manager still actively considered other factors and documented their rationale.

17.5.2 Cumbria Police's Domestic Abuse Policy was revised and updated in 2023 following the introduction of new initiatives within the Domestic Abuse Act 2021. The only incident of domestic abuse involving Helen was reported in 2016 and actions (including risk assessments) were in compliance with domestic abuse policies in place at that time.

17.5.3 Victim Support Services (VSS) reviewed their Domestic Abuse Policy in August 2024. The previous version was published in 2020. VSS within Cumberland also hold the contract for delivery of specialised domestic abuse services (including IDVA and ISVA professionals). Therefore, they also have national IDVA operating procedures in place (these were also reviewed in August 2024).

Victim Support also has an internal Domestic Abuse Policy with reference to procedures for their own employees.

17.5.4 West Yorkshire Integrated Care Board (WYICB) has extensive references to domestic abuse within its Safeguarding Policy. The ICB provides support and guidance and training to GP practices in Leeds and this includes Colin's GP Practice. In addition, Safer Leeds (Community Safety Partnership) offers a comprehensive city-wide domestic abuse training

programme. There were no incidents or suspected incidents of domestic abuse reported to the GP Practice in Leeds.

17.5.5 At the time of Helen's death, Yorkshire Ambulance Service (YAS) had no Domestic Abuse Policy in place. YAS did have management guidance in relation to domestic abuse. This guidance was due for review in July 2024. However, in November 2024 the newly drafted YAS Domestic Abuse Policy and Management Guidance was approved and is now live. This is next due for review in November 2025.

YAS paramedics can also utilise the Joint Royal College Ambulance Liaison Committee (JRCALC) guidance in relation to domestic abuse. JRCALC guidance is reviewed and updated on a rolling basis and provides specialist guidelines for UK NHS Ambulance staff. There were no issues of domestic abuse reported to any YAS staff relating to Colin or Helen.

17.5.6 North Cumbria Integrated Care (NCIC) is an integrated care trust covering both adult, children's and maternity care. The Trust works from over 70 sites across Cumbria and includes main hospital acute services as well as community services. The Trust has domestic abuse guidance in place which is part of their wider Safeguarding Policy.

The guidance aims to support staff to recognise and respond to those people accessing its services who may be experiencing domestic abuse. Staff have access to the Trust's internet site which has a page dedicated to domestic abuse. Within this system are contained relevant forms such as DASH risk assessments and MARAC referral links (Multi-Agency Risk Assessment Conference) as well as details of third sector agencies that can provide support.

17.5.7 Primary Care within the North East North Cumbria ICB area (Helen's GP) have reassured the ICB that they have safeguarding policies in place, that the policy is up to date and that there is specific reference and guidance within the policy relating to domestic abuse.

17.5.8 Leeds Teaching Hospitals NHS Trust (LTHT) have a Safeguarding Adults at Risk Policy. Safeguarding adults is integral to complying with legislation, regulations and delivering cost effective care (Care Act 2014), providing additional measures for those least able to protect themselves from harm or abuse. This policy outlines the duties and responsibilities of all LTHT staff to safeguard adults at risk, whether patients, patients' family members, carers, or staff, and the actions to be taken where there are concerns for an adult's safety or welfare. Allegations of abuse may occur both in the community and within LTHT services. Staff have a responsibility to recognise and respond to these eventualities and this policy defines the processes involved in both cases. This policy is supplementary to the Leeds Safeguarding Adults Board Multi-Agency Safeguarding Adults Policy & Procedures. Although Helen was present at one of Colin's hospital appointments, this was entirely to support Colin in his treatment. There

were no disclosures or any concerns expressed relating to domestic abuse, nor did staff observe any behaviour that caused them concern. The patient was Colin, who resided in Leeds.

17.5.9 West Yorkshire Police have a comprehensive Domestic Abuse Policy in place. This was last reviewed in February 2023. All actions relating to Colin were in compliance with the policy in place. West Yorkshire Police had no contact with Helen until after her tragic death.

17.6 Were risk assessment and risk management processes for domestic abuse victims or perpetrators correctly used in this case?

17.6.1 There were two Domestic Abuse Stalking & Harassment (DASH) domestic abuse risk assessments completed during the time frame of this review. Both related to the victim Helen, but neither involved Colin.

17.6.2 Cumbria Police completed a DASH risk assessment when Helen was assaulted by her ex-partner in 2016. The circumstances of the offence were correctly assessed. There were three positive responses to the 27 questions on the risk assessment and the incident was graded as a 'standard' risk, i.e. *'Current evidence does not indicate likelihood of causing serious harm.'*[5]

17.6.3 Staff at the Cumberland Infirmary, Carlisle completed a DASH risk assessment during Helen's attendance in November 2023. Unfortunately, despite extensive enquiries, the DASH form could not be located. There is no electronic record and the paper form cannot be found (see recommendations).

17.7 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?

17.7.1 There was a missed opportunity for intervention to safeguard Helen in November 2023. It is now known that Colin committed a violent and sustained assault on Helen while they were staying in an Airbnb. Helen received significant injuries. These included multiple bruises to her face and head, two black eyes and bruising to her hip.

[5] Safe Lives national risk assessment criteria

17.7.2 Helen's initial contact with her GP practice was from a telephone call to a paramedic practitioner based at the practice. She said she had fallen off a table. Without face to face contact, there was little further opportunity for intervention at that stage, though it appears the practitioner advised Helen to seek treatment if she was in pain.

17.7.3 The following day, Helen attended Cumbria Infirmary, Carlisle. Practitioners noted her multiple injuries. They also recorded that Helen was providing conflicting accounts about what had actually happened. She informed staff at the hospital that she had fallen from a table and hit her head. Staff were concerned and applied professional curiosity (i.e. selective enquiry) to the incident. This was good practice. This led to a partial disclosure from Helen that she had been assaulted by her partner. However, she would not give professionals Colin's details.

17.7.4 Following Helen's partial disclosure, hospital practitioners completed a 'Domestic Abuse, Stalking and Harassment (DASH) risk assessment' which is in line with Trust policy. As the actual form cannot be found, it is not possible to scrutinise the responses to questions within the risk assessment. The DHR panel has been unable to confirm how many positive responses were made by Helen, or if the incident was assessed as high, medium or standard risk. However, we can say that with the level of injuries sustained during what was clearly a prolonged assault, together with Helen's minimising of the incident and her initial account of a 'fall', it is likely the incident was assessed as 'high risk'. Plus, the completion of a MARAC referral form also suggests this was deemed a high risk incident by the professionals involved.

17.7.5 Due to their significant concerns about Helen's injuries, staff considered a referral to the Multi-Agency Risk Assessment Conference (MARAC) which convenes to exchange information and formulate plans to safeguard the victim in the highest risk domestic abuse cases. However, Helen would not consent to the sharing of her personal information with other agencies. Staff sought advice from a consultant managing the Emergency Department but the feedback was that the hospital could not share the details of Helen's case without her consent.

17.7.6 Professionals did not need consent from the patient in this case. In likelihood, the incident was assessed as 'high risk':

'*There are identifiable indicators of risk of serious harm. The potential event could happen at any time and the impact would be serious.'* [6]

[6] *Safe lives DASH risk assessment criteria*

Local protocols within Cumberland (and across all localities in England & Wales) are that consent may be overridden in high risk domestic abuse cases as the victim is at risk of serious harm or death.

The NHS has a duty relating to patient confidentiality. It is recognised that any sharing of personal and sensitive data must be strictly controlled. However, Article 2 of the European Convention on Human Rights (ECHR) outlines the 'right to life'. The Human Rights Act 1988 enshrined this fundamental right into law. There is a duty on all professionals to save life:

Everyone's right to life shall be protected by law. No one shall be deprived of their life intentionally.

Public officials must take reasonable steps to protect life when they know (or should know) that a person's life is at real and immediate risk. This risk could be from another person or the person themselves. [7]

17.7.7 As staff were unaware that consent was not required, no information about Helen was shared with the police, specialist support groups or any other agency. Although we cannot know what the outcome of such an exchange of information (and probable MARAC meeting) would have been, this still represents a significant omission.

17.7.8 Staff were sensitive to the patient. Indeed, when the DHR Chair met with Helen's family, they outlined how their mum told them a nurse at the hospital spent a considerable amount of time with her, explaining protocols and conducting a risk assessment. But Helen did not want any further action taken. Nevertheless, this represents a missed opportunity to have intervened.

17.7.9 A copy of the hospital appointment details was sent to Helen's GP. A GP from the practice then rang Helen to discuss the incident. This was good practice. However, once again, the details were not shared with other agencies. The GP did not know the identity of the offender. They did not carry out a formal recognised 'risk assessment', though it is clear from the medical notes that the practitioner did consider the risks involved. This is evidenced by noting that Helen told them she had been seeing someone and 'it got out of hand'. Helen stated she didn't want the police involved, that the offender did not live nearby, that they didn't know her address and that they would not be seeing each other again. The GP could have demonstrated more professional curiosity.

17.7.10 These were difficult circumstances for clinicians at both the hospital and GP practice to navigate. Helen had significant, multiple injuries. But she

[7] *Article 2 Human Rights Act 1998. See Equality & Human Rights Commission web page..*

was adamant she did not consent for her details to be shared with other agencies, specifically the police. Her wishes were respected. However, the nature of the injuries, together with Helen minimising the incident and giving different accounts of what had happened suggests this was a 'high risk' incident that needed a multi-agency response (via existing systems such as the MARAC).

Recommendations made from this review include actions to give staff greater confidence within such scenarios.

17.8 How did misuse of alcohol or other substances impact on this case?

17.8.1 There were no specialist alcohol support agencies involved with either the victim or perpetrator in this case.

17.8.2 There were no major concerns recorded by any professional of the victim's alcohol intake. This included during several therapy sessions with a dedicated mental health service provider.

17.8.3 During a police investigation in 2023, Helen disclosed that she had consumed a full bottle of wine at home before leaving the house where she was later assaulted.

17.8.4 Within the scoping period of this Domestic Homicide Review, there are two references recorded by Helen's GP practice relating to her alcohol intake. In February 2023 she disclosed drinking 18 units of alcohol per week. In March 2024 she reported consuming 40 units of alcohol per week. There is no discussion recorded as to why her alcohol intake had doubled in 12 months. This could be a missed opportunity.

17.8.5 There are several references in various agency records of Colin being intoxicated. These include West Yorkshire Police, Yorkshire Ambulance Service and Leeds Teaching Hospital Trust.

17.8.6 Yorkshire Ambulance Service (YAS) attended a call in 2021 when Colin had been drinking excessively and had fallen and hit his head. The crew noted they did not believe he had capacity to make decisions and so conveyed him to the Emergency Department at Leeds Hospital both for treatment for his injury and also as a place of safety. YAS have access to alcohol misuse referral pathways but as Colin was assessed as not having capacity at the time of his conveyance, no consent could be sought. He was treated at the Emergency Department. No referral was made to Leeds Drug & Alcohol Support Service but a copy of the circumstances of his attendance was forwarded to Colin's GP. There are no further references to alcohol referrals via his GP. The head injury was recorded and the letter to the GP confirmed Colin had drank 15 pints of beer prior to the ambulance

being called. But the letter does not raise alcohol consumption as a concern in itself.

17.8.7 West Yorkshire Police records note a history of alcohol abuse relating to Colin:

In 2000 he was recorded as being drunk on his custody record risk assessment.

In 2001 Colin was convicted of being drunk and disorderly. He received a conditional discharge.

In 2004, his then partner stated she was afraid of him when he had been drinking.

17.8.8 Following his arrest for the murder of Helen, Colin stated in interview that he blamed his alcohol misuse for his history of perpetrating domestic abuse. He said that he and Helen had been consuming alcohol on the night prior to Helen's death and that he could not recollect all events before her death. Toxicology tests showed a low alcohol level within Colin's blood (though this is probably due to the time lapse from the incident to his arrest, detention and taking of samples). At the post mortem of Helen, tests showed she had a relatively high level of alcohol in her body (twice the legal drink drive limit).

17.8.9 No records in any agency relating to either Helen or Colin suggest they were alcohol dependent (see recommendations).

17.8.10 The issue of alcohol abuse was discussed at length with Helen's family during a meeting with the DHR Chair. They knew their mum and Colin were both heavy drinkers. They enjoyed socialising together. However, the family are also aware that both of them attempted to reduce their alcohol consumption by taking part in initiatives such as 'Dry January' and 'Stoptober'.

17.8.11 One of Helen's work colleagues also referred to alcohol use when speaking to the DHR Chair. They described (through their conversations with Helen) that excessive alcohol consumption was at the heart of the relationship between Helen and Colin.

17.8.12 The view of Helen's daughters is that their mum was not physically dependent on alcohol but that she did turn to drinking for emotional reasons. They cite 'triggers' from both her childhood experiences and from incidents during her adult life that would prompt Helen to start drinking heavily. They see this as her way of trying to cope with her memories and experienced trauma.

17.9 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.

17.9.1 The protected characteristics named under the Equality Act 2010 are age, sex, gender reassignment, marital status, race, religion/belief, pregnancy, sexual orientation and disability.

17.9.2 The victim and the perpetrator were not married at the time of her death. Their marital status did not affect any of the services provided. No agency was aware of the relationship and so marital status could not be a factor in services offered or provided.

17.9.3 The victim was a white female. The perpetrator was a white male. Their ethnicity, religion/ belief, sexual orientation or gender reassignment were not factors in the provision of services.

17.9.4 The victim was not pregnant at the time of the incident.

17.9.5 For a full review of domestic abuse crimes and incidents linked to gender see full details at section 11 of this DHR overview report. National data is provided.

17.9.6 In terms of the victim's own intersectionality (i.e. where protected characteristics intersect), Helen was a 48 year old white female who had lived all of her life within the UK. She was not diagnosed with any disability or mental illness through she did experience low mood, depression and panic attacks. These mental health concerns were documented by services.

Helen was not recorded as being alcohol dependent but her heavy drinking was noted on occasion by agencies (e.g. she had drunk a full bottle of wine one evening before she left her house). Helen's family believe she did use alcohol to cope with life pressures and memories of past experiences, but that she had not sought help with this. There is very little in agency records that suggest practitioners would have sufficient concerns to have referred Helen into specialist substance support services.

Section 15 of this review outlines the significant trauma experienced by Helen both as a child and an adult. This is highly likely to have affected how and when she contacted services.

Helen did seek help from mental health services ('Talking Therapies') following a panic attack, but after three appointments she disengaged from the service.

She also agreed to a referral to an Independent Sexual Violence Advocate from Victim Support following being attacked. This was good practice.

Although there was initial successful contact with Helen, she asked that the practitioner ring her back in a few weeks when she had the time to process what had happened to her. Helen's wishes were respected. The ISVA left their contact details and subsequently followed up with four attempts to re-contact Helen. Each time there was no answer on her phone. The ISVA then also got in touch with the Officer In the Case (OIC) from Cumbria Police to confirm they had the most up to date contact numbers. The OIC stated that they were also having difficulty contacting Helen. After the four attempts, the ISVA spoke with their manager and it was agreed to close the case in line with the Victim Support non-engagement policy.

Although agency policies on non-engagement were followed in both instances, the DHR panel recognises that more could be done to highlight the importance of trauma informed practice to professionals and this is reflected within the recommendations of the review.

17.9.7 The perpetrator was a 53 year old white male who had lived in various locations across the UK. He had contact with the criminal justice agencies but in his later life this contact was infrequent. He was known to drink heavily (previous arrests for being drunk and disorderly and an ambulance being called by his family when he had fallen over after drinking 15 pints of beer). However, these instances were not frequent and no referrals were deemed necessary by professionals involved. There is no record of signposting to specialist alcohol support services and this forms part of the recommendations within this review.

17.10 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?

17.10.1 During Cumbria Police's involvement with Helen for a domestic abuse incident in 2016, Helen's wishes were noted by officers. Her former partner (not Colin) had assaulted her. The male was interviewed under caution. The incident was assessed as 'standard' risk, with Helen answering the questions within the risk assessment document.

Helen did not feel she wanted to support a prosecution and did not provide a written statement. As the risk level had been assessed as standard, officers respected her decision but they did attempt to issue a caution to the male.

17.10.2 Victim Support Services received two police referrals for Helen in 2023. Neither of these crimes were related to domestic abuse. All options were outlined to Helen but she declined further support.

17.10.3 NCIC contact with Helen following a hospital attendance with multiple injuries in 2023 is fully documented at paragraph 17.7. Although errors were made, it is clear that clinicians spent a considerable time talking through options with Helen and staff were empathetic and respected her decisions.

17.10.4 Helen's GP practice rang her following her hospital attendance. She stated that although she had been assaulted, the relationship was over and the perpetrator did not know where she lived. She did not want the police involved. Her wishes were respected.

17.11 Were there any barriers to reporting abuse or violence?

17.11.1 Helen had a traumatic childhood and suffered abuse from intimate partners in her adult life. The emotional abuse, physical abuse, neglect and lack of stability and affection had a significant impact on her life. This was clearly outlined by her family during the DHR process.

Helen's family and professionals on the DHR panel are in agreement that Helen's thoughts and decisions were framed by what happened to her as a child and subsequently as an adult. The trauma she experienced was significant. When police were called regarding Helen being assaulted by her ex-partner in 2016, it was a third party which made the call, not Helen. By the time she met Colin, her children had grown up. Her daughters expressed how Helen now felt this was 'her time'. Colin gave her gifts, he took her away for weekend breaks, took her to music concerts and restaurants. These were experiences she had not had all of her life. He also repeatedly told her he loved her. She received the attention and affection she had not had in the past. It is highly likely that this contributed to her reluctance to report the serious assault by him in November 2023 to the police.

17.11.2 Another barrier to Helen reporting abuse was discussed by the DHR panel. The team in which Helen worked within Cumberland Council supported many clients with vulnerabilities. Therefore, Helen's colleagues and managers were trained and experienced in supporting and referring victims of domestic abuse. It is possible that Helen had a sense of embarrassment at reporting any domestic abuse. We cannot be certain of this, but it is an issue that Helen's family agree may have been a factor.

Helen's managers were supportive to her. When she was on long term sickness absence they discussed potential domestic abuse. But Helen did not disclose anything and stated she had fallen over. This is a difficult

process to manage as the balance is to protect their staff but also support them and respect their wishes (see recommendations).

17.12 Was mental health a factor in this case?

17.12.1 There are no agency records suggesting Colin had any mental health issues. He was not referred to any mental health support organisation. After his arrest for Helen's murder he self-disclosed that over 20 years previously, 'someone' told him he may be bipolar. However, he ignored this and did not seek any help regarding any mental health condition. There were no recent entries on his medical records.

17.12.2 Helen suffered from low mood, anxiety and depression. Her childhood experiences are documented at section 15 of the DHR. She had been prescribed fluoxetine (an anti-depressant) by her GP since 2006.

17.12.3 Helen disclosed her anxiety and depression at her initial job interview with Cumberland Council in 2017. Additional support was provided via one to one meetings with her manager. This included signposting to a specialist counselling service through the council's Employee Assistance Programme (EAP). Helen later advised her manager that she was accessing the EAP.

17.12.4 As part of this Domestic Homicide Review, the DHR Chair contacted the counselling provider; 'Health Assured'. Confidential counselling notes were shared. These confirmed Helen's long standing issues with her anxiety. The notes record that several coping mechanisms were explored.

17.12.5 In April 2018, Helen self-referred into NHS North Cumbria Talking Therapies (NCTT formerly known as 'First Step'). Since then, due to NHS re-organisation, this had amalgamated and is now part of Cumbria, Northumberland, Tyne & Wear NHS Foundation Trust (CNTW).

17.12.6 Helen's self-referral was due to her experiencing a panic attack. NCTT was commissioned to provide brief, short term, evidence-based psychological therapies. Clients can self-refer or be referred by another health care profession.

17.12.7 NCTT has a stepped care approach. Stepped care has two principles:

- Treatment should always have the best chance of delivering positive outcomes while burdening the patient as little as possible.
- A system of scheduled review that detects and acts on non-improvement must be in place to enable stepping up to more intensive treatments (or stepping down where a less intensive treatment becomes appropriate and stepping out when an alternative treatment or no treatment becomes appropriate).

Treatment within the team is provided by:

- Step two: Psychological Wellbeing Practitioners: low intensity guided self-help.
- Step three: high intensity Cognitive Behavioural Therapy therapist.
- Step two and step three: Counsellors

The service is commissioned to provide psychological interventions for the following mild to moderate conditions, including:

- agoraphobia
- depression
- generalised anxiety disorder
- health anxiety (hypochondriasis)
- mixed depression and anxiety (the term for sub-syndromal depression and anxiety, rather than both depression and anxiety)
- obsessive-compulsive disorder (OCD)
- panic disorder
- Post-traumatic stress disorder (PTSD)
- social anxiety disorder

17.12.8 Helen reported being emotionally and physically abused when seven years old by her father's partner and had experienced a poor relationship with her eldest children's father. No immediate/current risks were identified at the time of assessment.

Helen identified other possible triggers to her panic. Helen described how her youngest child had started secondary school and was being picked on. Her sister was having difficulties, and she was supporting her too but had to cut contact as she was finding this hard. Helen reported her and her sister had a difficult childhood and were in care due to an abusive parent. Helen reported that she felt she had dealt with that aspect of her life but that it could be a cause of her anxiety. Helen stated she had an adult daughter and son.

Helen described that her boss at work was supportive and that she was able to talk to and confide in her eldest daughter.

She self-reported she had commenced taking fluoxetine (20mg) six weeks ago. Helen reported she had been on this before but stopped taking it approximately 18 months ago. Her GP prescribed diazepam following a panic attack, but Helen declined to take it.

The goals identified by Helen and which she agreed to focus on, were for her to feel more confident about going out, not overthinking or worrying as much and to regain the ability to deal with situations as they arise.

A plan was agreed: Helen to was to read the booklet and ‘worry sheet’ linked to anxiety, as well as complete a ‘worry diary’. Her next appointment was scheduled for May 2018.

17.12.9 Helen’s case was taken to and discussed in supervision by Helen’s allocated Psychological Well-being Practitioner (PWP). The supervision session included that Helen was always worried, but this had increased over the last few months. Advice from the supervisor was that at the next therapy session, Helen and the PWP were to cover five areas; how humans experience thoughts, emotions, physical sensations, behaviour and interconnect, plus to start the ‘worry work’. This was implemented in the next therapy session and focused on Helen’s worry and anxiety within her work situation.

17.12.10 At session two, Helen reported she was going to her GP to review her medication as she had been taking it for two months and was unsure if it was having any therapeutic effect. Helen stated she had been worried about work and did not attend a First Aid course as she knew it would be hands on and a lot of people attending. Helen had completed her worry diary; mentioned stress about having to go into work and face people and worried that they would see she was anxious. Physically she was experiencing palpitations at the thought of going out and worried in case she passed out. She continued to dread going to work but stated it was the best job she had ever had, and her colleagues were great. She mentioned that a colleague was in a bad mood and Helen thought it was due to her and also found a conversation with her boss overwhelming so went into another room to calm down. She had called her daughter and after some time had managed to compose herself. Once home, Helen wrote up her worry diary and described how something ‘clicked’ and instead of panicking she ‘snapped out’ of that way of thinking and told herself that it's not other people and that she had to help herself. She reported that the next couple of mornings her anxiety had decreased in relation to her attending the workplace.

17.12.11 At her third session, Helen reported she’d had a good two weeks since the last therapy session. She reported she had not felt the dread of going to work and an increase in the feeling of being in control. She reported having more of a perspective on things and wasn't overthinking and catastrophising as much. There were no risk concerns identified during this session. Helen reported no recent panic attacks. Helen and the therapist looked at the Worry Tree. Helen reported she had tried to implement this when worrying about her sister and felt there was nothing further she could do to help her sister. She reported an increase in her wanting to carry out physical activities and had achieved a 10 mile walk with the dog and her daughter. She described how the next goal would be to resume seeing friends and they had told her to call around anytime. The agreed plan: Helen to use the ‘panic diary’ when needed and to use the ‘worry tree’.

17.12.12 Helen's next appointment was booked for June. There had been a positive reduction in her PHQ and GAD 'scores'. (PHQ is Patient Health Questionnaire and GAD is Generalized Anxiety Disorder. Both are used to measure the severity of anxiety and depression).

17.12.13 Helen later called to cancel her appointment in June. A new appointment was made for July and a letter sent to confirm the date, but again Helen did not attend. A letter was therefore sent advising her that she would be discharged from the NCTT service. A copy of the letter was sent to her GP.

17.12.14 During a meeting with the DHR Chair, Helen's (adult) daughters stated they believed their mum was bi-polar but would never agree to get herself 'checked out'.

17.13 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).

17.13.1 Neither Helen nor Colin was ever listed at a MARAC meeting. There were no incidents of domestic abuse recorded by West Yorkshire Police or by Cumbria Police that resulted in a 'high risk' assessment of harm. Hence, there would not be a MARAC referral.

17.13.2 There was a DASH risk assessment conducted at the Cumberland Infirmary, Carlisle in November 2023. However, staff did not make the MARAC referral as Helen would not consent to the sharing of her personal details.

17.14 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.

17.14.1 Colin was born in Scotland. His first conviction recorded on the Police National Computer (PNC) was for 'Wilful Fire Raising' committed in Scotland (similar to Arson in England). He was convicted of this offence in 1995 and sentenced to two years imprisonment. His PNC conviction history confirms he has resided in multiple areas of the UK.

17.14.2 Colin is recorded on West Yorkshire Police's local systems. He has five crime offender records between 2000 and 2024 for offences of drunk and disorderly, assault and threatening/abusive behaviour.

He has not been subject to MAPPA, MATAC or any other perpetrator programme. At the time of Helen's murder, Colin was not subject to any injunctions or other court orders.

17.14.3 Colin does have a previous history of violence against women and girls both domestic and non-domestic related. Several of his convictions are for domestic abuse related offences and assaults against previous partners. These included incidents of non-fatal strangulation by way of choking or grabbing his partner by the throat.

17.14.4 He was convicted in August 1995 at Nottingham Magistrates of a common assault perpetrated against his then girlfriend. He had attended his girlfriend's house whilst drunk. Upon being asked to leave, he refused to do so. He grabbed his girlfriend around the throat without warning, causing her to choke. He was sentenced to a Community Order of 80 hours and to pay his victim compensation.

17.14.5 He was 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.

17.14.6 In October 1997, he was convicted at Lincoln Crown Court of Assault Occasioning Actual Bodily Harm and Common Assault against a 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.

17.14.7 In January 2001, Colin was convicted of being drunk and disorderly at Leeds Magistrates Court and sentenced to a Conditional Discharge for 12 months. He had struck a female on the head whilst drunk and became abusive to police officers. The female did not want to pursue a complaint against him.

17.14.8 In September 2004, Colin's then girlfriend contacted West Yorkshire Police to request help. She reported that she was scared of Colin and wanted to leave him. She disclosed suffering verbal and mental abuse from Colin. She said when he was in drink she was scared of him and feared for her safety. The girlfriend was provided temporary accommodation in a refuge. No offences were recorded and he was not charged with any offences at the time.

17.14.9 Colin was also involved in other incidents including assaulting a male bus driver and using threatening behaviour towards a female teaching assistant. These incidents took place in 2010 and 2017 respectively.

17.14.10 Colin's criminal behaviour including his domestic abuse offences were not known to his GP, to Leeds Teaching Hospital or to the Yorkshire Ambulance Service. Although his background included serious offending, there was no contact with the police since 2017. This infrequency and non-recency means that Colin was not discussed at a MARAC meeting nor was he applicable to a MAPPA or MATAC intervention. Hence, there were no grounds to share his details with partner agencies.

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

17.15.1 Clare's Law[8] (also known as the Domestic Violence Disclosure Scheme - DVDS) is a useful tool in making disclosures to vulnerable people to protect them from abusive partners.

17.15.2 Clare's Law was introduced across England and Wales in March 2014. It followed the case of the murder of Clare Wood. Clare was a 36 year old woman with a 10 year old daughter. She had met a male named Colin Appleton on 'Facebook' and they had formed a relationship. Unknown to Clare, Appleton had a long history of violence towards women which included harassment and kidnapping a former partner and holding her at knifepoint for several hours. When Clare had ended the relationship with Appleton, he had threatened to kill her. These threats were not taken seriously by the police and no officer warned Clare about Appleton's background. In February 2009, Clare was murdered by Appleton. He had raped and strangled her, then set her body on fire. A subsequent campaign by Clare's family and friends resulted in the introduction of 'Clare's Law'. The Domestic Violence Disclosure Scheme is an option for professionals to consider, to protect victims of domestic abuse.

[8] *National Domestic Violence Disclosure Scheme roll-out 2014 (Police common law powers). Placed on a statutory footing section 77 of the Domestic Abuse Act 2021.*

17.15.3 The DVDS has two distinct processes. (the 'right to ask' and the 'right to know'). The first process is triggered by a member of the public applying to the police for a disclosure. The second is triggered by professionals making a proactive decision to disclose information to protect a potential victim. Although the police are the lead agency, both processes can involve a multi-agency decision-making panel when deemed appropriate. Police initially assess the risk and consider all salient points linked to necessity, legal compliance and proportionality. They take into account the nature of offending, the sensitivity of the information they may disclose, any risks associated with making the disclosure (for example potential harm to perpetrators or their families), the risks of not disclosing and who they may disclose the information to.

Until 2024, there was a multi-agency panel involved in most cases in Cumberland. However, following review, it was clear that the panel was in itself creating delays and thus potentially placing victims at increased risk of harm. So locally, most disclosures are 'police only' decisions. The option of convening a multi-agency panel in complex cases remains in place.

17.15.4 In this case, there were no professionals aware of the relationship between Helen and Colin. Therefore, there were no opportunities for a proactive 'Right to Know' disclosure under Clare's Law.

17.15.5 Although Helen suffered a brutal and sustained attack by Colin in November 2023, it is unlikely she would have been aware of his previous abuse and violence towards partners. If she had concerns, then a Clare's Law application under 'Right to Ask' provisions (either by Helen or by her family) would have been justified. The DHR panel cannot be sure if Helen was aware of Clare's Law and the opportunity for her to make an application to find out more about Colin's background (this forms part of the recommendations for the review).

17.16 How effective was record keeping?

17.16.1 A significant number of records were accessed across many agencies during the review process. These included many different electronic databases across policing, the NHS and local authorities. There were also a number of paper based records.

17.16.2 In some cases (e.g. mental health and social services) the records dated back several decades. Documents were clear, accurate and consistent with agency policies at that time. All documentation was accessed and the content supported the DHR.

17.16.3 There was an issue with one of the health records relating to Helen's hospital attendance. The risk assessment form could not be located by the DHR panel representative. This forms part of the learning from the review.

17.17 How effective was management oversight?

17.17.1 In many cases, there were no concerns of domestic abuse taking place and so management oversight or guidance was not required.

17.17.2 All Cumbria Police interactions with the victim and West Yorkshire Police contacts with the perpetrator appear positive. Management oversight and adherence to Force policies were in place.

17.17.3 The perpetrator's involvement with Leeds Teaching Hospital or the GP practice in Leeds did not require any escalation and appointments or contacts were dealt with appropriately.

17.17.4 Victim Support had only minimal contact with the victim. Professionals did seek management advice when following their disengagement policy.

17.17.5 There is evidence within personnel records at Cumberland Council that management oversight in relation to Helen's welfare and sickness absence was good and effective.

17.17.6 NCIC had contact with Helen when she attended the Cumberland Infirmary in 2023. Errors were made in relation to the sharing of information without Helen's consent. NCIC have a specialist safeguarding team who can provide support and advice to frontline staff. However, in this instance, such advice was not sought and the opportunity to refer the matter to multi-agency colleagues was missed (see recommendations).

17.17.7 Helen's GP practice did not encounter circumstances that suggested escalation was necessary. However, they could have sought advice on conducting a risk assessment from the Integrated Care Board (ICB) when Helen made disclosures regarding domestic abuse.

17.18 Did resource issues impact upon services offered?

17.18.1 No resource implications were identified by any agency.

17.19 Did the Covid-19 pandemic impact upon agencies' responses?

17.19.1 Police, hospital and ambulance services continued with their emergency responses throughout the covid pandemic.

17.19.2 Although other services needed to alter their methods of operation during that time (e.g. a move to telephone contact rather than face to face appointments), there does not appear to have been any adverse effects or shortfalls in the quality of service provided, either to the victim or the perpetrator.

Section 18: Conclusions and Lessons Learned

18.1 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.

18.2 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.

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

18.4 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.

18.5 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.

18.6 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.

18.7 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.

18.8 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.

18.9 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.

18.10 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.

18.11 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.

Section 19: Recommendations

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.

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).

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.

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.

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.

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.

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.

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[9]. 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/. 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.

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

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

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

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

Glossary of Acronyms

AAFDA	Advocacy After Fatal Domestic Abuse
ACE	Adverse Childhood Experience
ACN	Adult Concern Notice
ASC	Adult Social Care
CIN	Child in Need (section 17 Children Act 1989)
CNTW	Cumbria, Northumberland, Tyne and Wear NHS Trust
CPS	Crown Prosecution Service
CSP	Community Safety Partnership
CSEW	Crime Survey for England & Wales
CTT	Community Treatment Team
DASH	Domestic Abuse, Stalking and Harassment This is a nationally recognised risk assessment model to assess the level of risk relating to an incident of domestic abuse. The professional carrying out the risk assessment may then determine if the incident is assessed as 'standard', 'medium' or 'high' risk: *Standard risk* – current evidence does not indicate a likelihood of serious harm. *Medium risk* - there are identifiable factors of risk of serious harm. The offender has the potential to cause serious harm but is unlikely to do so unless there are a change of circumstances *High risk* – there are identifiable indicators of risk of serious harm or death. The potential event could happen at any time and the impact would be serious. A high risk case may be taken to a MARAC meeting and the victim supported by an IDVA.
DVDS	Domestic Violence Disclosure Scheme or Clare's Law. See paragraph 17.15
DWP	Department for Work and Pensions
EAP	Employee Assistance Programme
EIP	Early Intervention in Psychosis
FLO	Family Liaison Officer
GAD	Generalised Anxiety Order
IAPT	Improving Access to Psychological Therapy
IDVA	Independent Domestic Violence Advocate
ISVA	Independent Sexual Violence Advocate
IMR	Individual Management Review
LTHT	Leeds Teaching Hospitals NHS Foundation Trust
MAPPA	Multi-Agency Public Protection Arrangements This is a statutory process used to manage Registered Sex Offenders (RSOs) or the most violent offenders. The police,

	HM Prisons and the Probation Service are the three 'Responsible Authorities' within the MAPPA process. MAPPA has different categories of offender and different 'levels' which determine the level of resources required to manage that dangerous individual. In addition to the three 'Responsible Authorities', other agencies (for example GPs, hospitals, local authorities or registered social landlords) may also be invited to participate within MAPPA.
MARAC	Multi-Agency Risk Assessment Conference These are meetings attended by several agencies who share information and formulate a plan to protect those victims of domestic abuse assessed at the highest risk of harm.
MASH	Multi-Agency Safeguarding Hub
MATAC	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.
MCA	Mental Capacity Act 2005
NCIC	North Cumbria Integrated Care NHS Foundation Trust
NCTT	North Cumbria Talking Therapies
NMO	Non Molestation Order This is an order granted by the courts to protect a victim for further abuse by a named individual. It can restrict the movements of an offender and prevent a named individual from contacting a victim.
NENC ICB	North East, North Cumbria Integrated Care Board
NPS	National Probation Service
OEL	Occurrence Enquiry Log
PDP	Potentially Dangerous Person
PHQ	Patient Health Questionnaire
PLT	Psychiatric Liaison Team
PNC	Police National Computer
PND	Police National Database
RTW	Return to Work interview
SARC	Sexual Assault Referral Centre
VAWG	Violence against women and girls
VSS	Victim Support Services
YAS	Yorkshire Ambulance Service

References

Multi-agency statutory guidance for the conduct of domestic homicide reviews (Home office 2016)

Domestic Homicide Reviews 'Key findings from analysis of domestic homicide reviews' (Home Office 2016)

'The Social Worker's Guide to The Care Act 2014.' (Pete Feldon 2017)

'A Practical Guide to the Mental Capacity Act 2005.' (Matthew Graham and Jakki Cowley 2015).

'Working together to safeguard children' (HM Government 2015, revised 2018)

PEEL Inspections into domestic abuse (HMICFRS November 2017)

Vulnerability, Knowledge and Practice programme (Home Office, National Police Chief's Council, College of Policing 2020-2024)

Untangling the concept of coercive control (Sylvia Walby & Jude Towers 2018)

Crown Prosecution Service policy on domestic abuse cases and the VAWG strategy (2017)

Office for National Statistics (2021-4)

https://www.gov.uk/government/publications/tackling-violence-against-women-and-girls-strategy

Working definition of trauma-informed practice - GOV.UK (www.gov.uk)

National statutory guidance for the Domestic Violence Disclosure Scheme (Home Office April 2023).

e-Harmony and the Imperial College Business School