Overview report

Huntingdonshire CSP

HUNTINGDONSHIRE
COMMUNITY SAFETY
PARTNERSHIP

A Domestic Homicide Review (DHR) concerning the death of Chloe (pseudonym)

(February 2025)

Author – Jackie Dadd

Date completed – November 2025

The Domestic Homicide Review Panel and the members of the Huntingdonshire Community Safety Partnership would like to offer their sincere condolences to the family of Chloe, who have lost their loved one in tragic circumstances.

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Preface

The key purpose of any Domestic Homicide Review (DHR) is to examine agency responses and support given to a victim of domestic abuse prior to their death and to enable lessons to be learnt where there may be links with domestic abuse. For these lessons to be learnt as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each death, and most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future. The victim's death in this case met the criteria for conducting a DHR according to Statutory Guidance1 under Section 9 (3)(1) of the Domestic Violence, Crime, and Victims Act 2004. The Act states that there should be a "review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by-

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

(b) a member of the same household as himself, held with a view to identifying the lessons to be learnt from the death".

The Domestic Abuse Act 2021 and the Home Office define Domestic Abuse as:

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.

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

(e) Psychological, emotional or other abuse

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

"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.

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).

Controlling behaviour is:

A range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.

Coercive behaviour is:

An act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim. The term domestic abuse will be used throughout this review as it reflects the range of behaviours encapsulated within the above definition and avoids the inclination to view domestic abuse in terms of physical assault only.

Recommendations will be made at the end of this report, however, there has been an ongoing action plan introduced by the panel, parallel to this review to ensure that the areas that can be immediately addressed have not incurred unnecessary delay.

Glossary

ACEs – Adverse Childhood Experiences

ADHD – Attention Deficit Hyperactivity Disorder

AWOL – Absent Without Leave (missing)

CAMH – Child and Adolescent Mental Health Services

CSP – Community Safety Partnership

DARA – Domestic Abuse Risk Assessment

DASH – Domestic Abuse and Stalking and Harassment risk assessment.(inc so called Honour based abuse)

DHR – Domestic Homicide Review

DWP – Department of Work and Pensions

ED – Emergency Department

IOPC – Independent Office for Police Conduct

PNC – Police National Computer

UC – Universal Credit

Section 1 - Introduction

1.1 The commissioning of the review

1.1.1 This review examines agencies responses, provisions and support provided and/or available within Cambridgeshire to Chloe, a 35-year-old female, prior to the point of her death, having been murdered in her own home by her partner, Keith in February 2025. The cause of death was found to be strangulation. Keith was found a day a later hanging in the toilets of Hinchingbrooke hospital. A file has been submitted to the Coroner with the findings of Keith being responsible for the murder of Chloe, with him then taking his own life.

1.1.2 Cambridgeshire Police made a referral to Huntingdonshire Community Safety Partnership (CSP) in March 2025 for consideration for a Domestic Homicide Review (DHR) and following a meeting held the same day with representatives from local Authorities, a decision was made to undertake a Domestic Homicide Review as the definition in Section 9 of the Domestic Violence Crime and Victims Act (2004) had been met.

1.1.3 Contributors to the review

Agency	Contribution
NHS Cambridgeshire and Peterborough Integrated Care Board (ICB)	Panel member, IMR
Cambridgeshire Domestic Abuse and Sexual Violence Partnership (DASV)	Panel member, Oversight
North West Anglia NHS Foundation Trust	Panel member
Department of Work and Pensions (DWP)	Panel member, IMR
Cambridge Children's Social Care (CSC)	Panel member, Summary report
Cambridgeshire Police	Panel member, IMR
Cambridgeshire and Peterborough NHS Foundation Trust (CPFT)	Panel member, IMR
Refuge	Panel member
IDVA Service	Panel member
Adult Social Care	Panel member
Huntingdonshire District Council	Panel member

1.1.4 Adult Social Care only attended the second panel meeting at the request of the Chair in order to establish whether there were any areas identified that could or should have involved their service. This was due to Adult Social Care initially electing not to attend as they did not have any contact with the subjects of the report until the Chair insisted on their attendance. No learning in this area was identified.

Review Panel

1.1.5 The following agencies/organisations/voluntary bodies have contributed to the Domestic Homicide Review by the provision of reports and chronology. Individual Management Reviews (IMRs) have been requested and supplied by those who had relevant recorded information and/or recent contact with either Chloe or Keith.

1.1.6 The panel comprised of the following:

Name	Area of responsibility	Organisation
Liz Clarke	Service Director	Cambridge Children's Social Care (CSC)
Victoria Gant	Named Professional for Adult Safeguarding	North West Anglia NHS Foundation Trust
Jenny Thompson	Designated Nurse Safeguarding Adults	NHS Cambridgeshire and Peterborough Integrated Care Board (ICB)
Sarah Fines	Domestic Abuse Review Co-ordinator	Cambridgeshire Domestic Abuse and Sexual Violence Partnership (DASV)
Rachel Robertson	Advanced practitioner Safeguarding: Domestic Abuse	Cambridgeshire and Peterborough NHS Foundation Trust (CPFT)
Kayleigh Smith	Detective Inspector	Cambridgeshire Police
Julia Cullum	Head of Service	Cambridgeshire Domestic Abuse and Sexual Violence Partnership (DASV) & IDVA Service
Julie Rivett	Strategic Lead for Safeguarding	Adult Social Care
Pardip Barmi	Senior Operations Manager	Refuge
Lisa Barraclough	Senior Leader	Department of Work and Pensions (DWP)
Mandi George	Lead Officer for Domestic Abuse	Huntingdonshire District Council
Lesley Rich	Domestic Abuse and MARAC Manager	Cambridgeshire Domestic Abuse and Sexual Violence Partnership (DASV) & IDVA Service

1.1.7 All members of the panel and authors of the IMRs have complete independence from any subject in this review. The Review Chair and Panel gave due consideration for the content of the DHR and it was agreed that reports, chronologies, IMRs and other supplementary details would form the basis of the information provided. Thanks go to all who have assisted and contributed to this review with their valued time and cooperation.

Author of the Overview report

1.1.8 The chair of the review panel and author of this report is Mrs Jackie Dadd, an independent consultant who is independent of the organisation and agencies contributing to this report. She has no knowledge or association with any of the subjects in this report prior to the commissioning of this review. She is a retired Detective Chief Inspector with Bedfordshire Police with vast experience of safeguarding and domestic abuse related issues, having been the Force Lead for domestic abuse, stalking and harassment and serious sexual offences and has been involved in the DHR process since its inception in 2011.

1.1.9 She has completed several training courses including the Home Office online training, the Continuous Professional Development accredited AAFDA DHR Chair training, the domestic Abuse and suicide accredited course, and is a member of the AAFDA DHR network, regularly attending the monthly forums for CPD and discussion. Mrs Dadd has obtained the accredited Home Office qualification of a level three certificate ONC in Chairing a Domestic Homicide Review and is on the register of accredited DHR/DARDR Chairs for England and Wales.

1.1.10 Mrs Dadd has completed and published several DHRs.

1.2 Purpose of the review

The purposes of a DHR are to:

a) 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.

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

c) Apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate.

d) Prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity.

e) Contribute to a better understanding of the nature of domestic violence and abuse; and

f) Highlight good practice.

DHRs are not inquiries into how the victim died or into who is culpable; that is a matter for the Coroner and criminal courts, respectively, to determine as appropriate. DHRs are not part of any disciplinary inquiry or process. Part of the rationale for the review is to ensure that agencies are responding appropriately to victims of domestic abuse by offering and putting in place appropriate support mechanisms, procedures, resources and interventions with an aim to avoid future incidents of domestic homicide and domestic abuse. The review also assesses whether agencies have sufficient and effective procedures and protocols in place which were understood and adhered to by their staff.

This review will ascertain whether domestic abuse could have been the cause or a contributory factor to the death of Chloe. It is not to apportion blame, but to view the circumstances through her eyes.

1.3 Timescales

1.3.1 Following the commencement of the criminal investigation, Cambridgeshire Police made a referral for a consideration for a DHR to Huntingdonshire CSP due to the circumstances of the death and the relationship between Chloe and Keith.

The following day, Huntingdonshire CSP, in accordance with the December 2016 Multi-Agency Statutory Guidance for the conduct of Domestic Homicide Reviews commissioned this Review.

Mrs Jackie Dadd was commissioned to provide an independent chair and author for this DHR on the same day, along with the Home Office being notified. Three panel meetings took place to discuss and identify learning. The completed report was handed to the Huntingdonshire Community Safety Partnership on 31/12/2025.

1.3.2 Table outlining timeline of review

February 2025	Death of Chloe
03/03/25	Cambridgeshire Police make a referral for consideration of a DHR to Huntingdonshire CSP
04/03/25	Decision to commission a DHR by Huntingdonshire CSP
04/03/25	Home Office notified of decision to commission a DHR
04/03/25	Jackie Dadd commissioned as Chair and Author
12/05/25	First panel meeting
05/08/25	Second panel meeting
14/10/25	Third panel meeting
31/12/25	Completed report handed to Huntingdonshire CSP by Author

1.3.3 Home Office guidance states that the review should be completed within six months of the initial decision to establish one. Due to the death of the perpetrator, Keith, the Senior Investigating Officer (SIO) from the Police was content for the DHR to commence immediately when asked, as there would not be a Criminal Court case. A file has been submitted to the Coroner.

1.4 Confidentiality

This report has been treated as Official Sensitive and dissemination kept to those outlined at 1.9.

The pseudonyms used in this report were chosen by the Author and ratified by Becky to protect the identity of those referred to throughout the report. Full details are found at 1.6 of this report.

The Huntingdonshire CSP and Author have ensured that the collation of information and the information contained within this report complies with the Data Protection Act 2018 and the General Data Protection Regulation (GDPR).

1.5 Terms of Reference (ToR)

1.5.1 The Terms of Reference areas were discussed within the first panel meeting and ratified shortly afterwards. Chloe's sister, Becky agreed with the areas and had nothing further to add. The ToR was a working document throughout the review. The Full Terms of Reference can be found in Appendix A at the conclusion of this report.

1.5.2 The main areas for focus were agreed to be on the following:

a) The support and service availability and response to Chloe and what considerations were or should have been made by professionals in contact with her.

b) The holistic areas that require consideration in order to ascertain risk of a potential perpetrator of domestic abuse.

Methodology

1.5.3 The initial scoping was completed and it was ascertained that Chloe and Keith had previous contact with a number of agencies between them. During the first panel meeting, the Terms of Reference were established in which family agreement was sought and provided.

1.5.4 Contact was made with the family in order to establish any knowledge they may have of domestic abuse against Chloe; obtain background information on Chloe to ensure she is humanised within this report and ensure that they were centric to the review with communication and conversation being maintained with the Author throughout.

1.5.5 Panel meetings were held to provide discussion, debate and confirmation of actionable recommendations. All panel members and Becky were sent the report to read and have opportunity to comment and amend prior to submission to the Home Office.

1.6 Subjects of the review/Family and friends' involvement

1.6.1 In accordance with Home Office guidelines to ensure confidentiality, pseudonyms have been utilised throughout this report for the following: (All ages are recorded at the time of Chloe's death).

Chloe – The deceased. A white British female aged 35 years old.

Keith – Partner of Chloe. A white British male aged 28 years old.

Becky – Older sister of Chloe.

1.6.2 The family of Chloe were written to by Huntingdonshire CSP to inform them of the commissioning of the DHR. The Author spoke with Becky, Chloe's sister, who spoke on behalf of her family as her brother and mother did not feel able. They were contacted in person, via Microsoft Teams and on the phone as per the preferences of Becky. The family were provided details, a leaflet and knowledge of AAFDA and the services that they offer and Becky made contact with them. Becky agreed with the Terms of Reference and was offered the opportunity to attend a panel meeting but declined.

1.6.3 Becky was sent a copy of the report which she discussed with the author and was content that it was factually correct and that it identified the areas such as controlling and coercive behaviour that she felt was important.

1.7 Parallel reviews

Coroner

1.7.1 The Coroner's inquest has been opened and adjourned awaiting the completion of this review.

1.7.2 A post-mortem took place in which the cause of death was found to be:

- Compression of the neck.

1.7.3 Time to death in fatal strangulation is highly variable between individuals. In sustained compression of the neck structures, time to unconsciousness is stated to be around ten to fifteen seconds (or earlier if the carotid arteries are compressed). If the pressure is not relieved, petechial haemorrhages are said to arise at around ten to thirty seconds with death occurring in a small number of minutes although precise timing to death unattainable. It is agreed that application of pressure need not be maintained for the full length of time although time to irreversibility i.e. beyond the time for regaining consciousness spontaneously is still largely unknown.

1.7.4 Bruising was found on the neck along with linear marks from Chloe's choker necklace indicating it may have been used as a ligature. Bruising was also found on her upper arms consistent with gripping.

IOPC (Independent Office for Police Conduct)

1.7.5 Following the discovery of Chloe's murder, the Constabulary appointed an investigating officer from Professional Standards, and the force self-referred itself to the Independent Office of Police Complaints (IOPC) of the death following police contact, known as reporting of Death or Serious Injury (DSI) This accords with practice.

1.7.6 After the IOPC conducted an initial assessment, the matter was referred back to Cambridgeshire Police Professional Standards Department for local investigation as this was deemed the most appropriate course of action in these circumstances.

1.8 Equality and Diversity

1.8.1 The review gave due consideration to each of the protected characteristics under Section 149 of the Equality Act 2010. The relevant legislation that provided the context for the panel was The Equality Act 2010.

1.8.2 Throughout this review process the Panel has considered the issues of equality in particular the nine protective characteristics under the Equality Act 2010. These are:

- Age
- Disability
- Gender reassignment
- Marriage or civil partnership (in employment only)
- Pregnancy and maternity
- Race
- Religion or belief
- Sex
- Sexual orientation

1.8.3 The panel felt that the most relevant of these in regard to this review were the sex and age of Chloe but took into consideration disability due to the potential of undiagnosed neurodiverse traits.

1.8.4 Sex was relevant as eight women a month are killed by a current or former partner in England and Wales[1]. One in four women experience domestic abuse in their lifetime[2] and 2.5 years is the average time victims at high risk of serious harm or murder live with domestic abuse before getting help[3]. In the year ending March 2024, 83 of the 103 domestic homicides were women with 66 of these victims being killed by a partner or ex-partner.[4]

1.8.5 National statistics show that in the period of April 2023 to March 2024 there were 18 female victims of homicide by way of strangulation/asphyxiation.

1.8.6 Age was deemed relevant in relation to Chloe as statistics show that there were 29 female homicides in her age range between April 2022 and March 2023 which was the highest age range.

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[1] SafeLives Marac national dataset (2023)

[2] Domestic Abuse statistics UK – NCDV

[3] SafeLives Insights Idva Dataset 2021-2022

[4] Homicide in England and Wales - Office for National Statistics

1.8.7 Research[5] shows that people with autism are more likely to experience domestic abuse than neurotypical individuals due to their increased vulnerability and is often emotional abuse rather than physical violence. There is a dependence on others which was seen by Keith claiming he was Chloe's carer and she may have struggled with social understanding which provides opportunity for coercive and controlling behaviour in the form of gas lighting, manipulation which were all aspects of how Chloe was treated.

1.8.8 Equality is about ensuring everybody has an equal opportunity and is not treated differently or discriminated against because of their characteristics. Diversity is about taking account of the differences between people and groups of people and placing a positive value on those differences.

1.9 Dissemination

Recipients who received copies of this report prior to publication:

Relevant members of Huntingdonshire CSP

Cambridgeshire Police and Crime Commissioner

Chloe's sister

Domestic Abuse Commissioner

Panel members as at 1.1

The learning and findings from this review are published on the Huntingdonshire CSP website with an action plan to provide accountability of progress. Internal learning forums will take place within agencies and learning events held by Cambridgeshire County Council and the DASV will take place on specific learning areas.

Section 2 – The Facts

2.1 Background information

Chloe (The early years background was provided by her sister, Becky)

[5] Neurodiversity and domestic abuse: understanding the hidden risks

2.1.1 Chloe was the youngest of three children with her brother being the eldest and then her sister, Becky. Becky and Chloe were close, as Becky is ten years older than her and therefore spent a lot of time with her as an additional mother. They would confide in each other. Chloe was always full of high energy and they referred to her as the 'Tasmanian devil.'

2.1.2 Chloe lost her father through illness when she was ten years old which she took really badly and was soul destroyed. She always remained close to her mum. Chloe had her first boyfriend when she was 16 years old and had a relationship with him for about nine years. He was sweet and gentle. She then had boyfriends on and off, mostly who were nice. Chloe would live with her mum on and off between boyfriends.

2.1.3 During covid, Chloe lived with her Mum and suffered from depression as she could not go out. GP records reflect that depression and anxiety were something she had suffered with since initially presenting in July 2011 with panic attacks and again in 2015. On this occasion, she stated it was mainly work-related stress but also issues with her partner and mother. (no further details known). She continued her anti-depressants on and off with regular check-ups over the next few years.

2.1.4 The police recorded a Vulnerable Adult incident in November 2017 in which Chloe had been in a relationship with a male for the past 5-6 months who she found to be unsupportive and prone to arguments which led to an increase in her anxiety and depression. Notes state that her mother was concerned that she was in an abusive relationship.

2.1.5 The police forwarded notification to her GP practice with this information which also stated that she had terminated contact with her ex and blocked him across various media. However, police records show a further incident between Chloe and the same boyfriend in June 2018 in which the neighbour contacted the police reporting a loud argument. On attendance, a DASH risk assessment as standard was recorded and a community resolution was given for criminal damage with no further action for an assault alleged by her boyfriend that she had kicked him. Chloe admitted that she did not manage the situation well as she was upset, he was being verbally abusive towards her, and she snapped.

2.1.6 In 2019, there were a further two incidents recorded as verbal only domestic incidents. No offences were identified and Chloe was left at the address along with her boyfriend. Becky informed the author that this boyfriend had treated her badly and sold drugs. "He was not a nice man." One day, he grabbed hold of her round the throat in a rage and she immediately packed her bags and left him.

2.1.7 In 2020, Chloe was referred by her GP to the Psychological Wellbeing Service (PWS) which comes under CPFT. An assessment was completed by the PWS practitioner, during which Chloe disclosed having two previous consecutive mentally abusive relationships, also experiencing tensions at home with her mum and difficulties in the workplace. She reported her current relationship was supportive. Chloe was not offered the option of completing a DASH or signposted for support and advice on relationship problems with her mum or the previous relationship's domestic abuse.

2.1.8 Chloe stated she felt anxious and disliked being alone. She reported she was not on any medications. The practitioner discussed with Chloe the two different treatment approaches on offer; talking therapies and counselling, and Chloe opted for the latter and said she did not want to undertake both at the same time. A referral was made to an independent counselling service.

2.1.9 Chloe restarted anti-depressants in September 2020. She continued to have contact with the GP Practice for both mental health struggles and clinical reasons over the next few years with her receiving Cognitive Behaviour Therapy 2022 following a referral by PWS to the Group Therapy Centre. Over this period, the Department of Work and Pensions (DWP) record Chloe working for various employers on short term basis and following claims for benefits, was assessed due to health conditions of anxiety and depression and Asthma.

Keith

2.1.10 Keith was adopted by his parents at the age of two years old following his birth mother taking her own life with an overdose whilst in her twenties in 1999. He could not remain living with his birth father as he was a heavy drug user. There was history of alcohol, drugs and violence within the birth family home.

2.1.11 He was immediately referred to under his adoptive parents surname. Keith had a birth brother who he initially had a lot of contact with but this ceased as he found it too upsetting. Keith did not have a good relationship with his adoptive father and the police were first called in 2011 due to a verbal argument between them.

2.1.12 In 2012, his parent's requested support and referrals were made from the school to the Child and Adolescent Mental Health Services (CAMH) with which he refused to engage and refused to work in school, becoming aggressive and restraints having to be used by staff. Support was provided for the parents including a home visit and anger management was recommended for him. Keith was already known to the police for shoplifting and being involved in a fight at school with a weapon.

2.1.13 In 2014, there were reports of Keith 'sofa surfing' and alleged to children's services that his adoptive parents are calling him names like 'retard' and 'bastard' and threatening violence towards him. He was offered housing support and stated he wanted to live independently as he was now 17 years old. A Child and Family (CAF) referral recorded Keith is experiencing verbal abuse, mainly from his dad with threatening comments being made. Dad has called him a 'retard' and threatened violence. Mum has called Keith a "bastard" and "I don't know if it was worth adopting you." A recent incident, dad described as 'restraining' Keith which was witnessed. This followed Keith telling his mum to 'Fuck Off.' Keith described dad going to hit him, he ducked and then dad grabbed him and pinned him down by his face. Mum feels Keith and dad have, in the past, taken the mickey out of her a lot. There were two Early Help referrals during the summer of that year.

2.1.14 In December 2014, a number of disclosures were made by Keith to Children's Services in relation to drunkenness and violence towards him and his mother by his father. The police attended on one occasion that month and a DASH was completed.

2.1.15 In March 2015, Keith was living independently, supported by a keyworker and the case was closed to Children's Services. There is a long police history of domestic incidents involving Keith's parents dating back from 2015. Keith was the only child in the household and his father was reported to have been an alcoholic. By March the same year, Keith was eligible for adult mental health services and the GP made a referral, as he was having 'significant problems with anger control.' The GP stated that this has been a problem since the age of six, but it has got worse in the last two years particularly when things frustrate him; he gets angry and finds it very difficult not to get physically abusive, he has also been assaulted a few times, lost a lot of friends and police have been involved on multiple occasions. He was able to express some of his feelings to the GP and agreed that his anger did sometimes feel out of control and he himself said that he would like some help with this and his mood.

2.1.16 His mood had been getting worse in the last year. He had been feeling very low, not motivated to do anything, and he felt isolated. He was not sleeping well at night. He denied any visual or auditory hallucinations. However, he had felt that someone was constantly watching and following him. He denied any suicidal thoughts or thoughts of self-harm.

2.1.17 As a result of the referral, an assessment was completed, and he was referred to MIND[6] who provided the local anger management courses. He was also given advice on self-referral to YMCA temporary & supported housing and then referral was closed.

2.1.18 In 2016, he was seen in police custody by CPFT Liaison and Diversions Service (LaDS) where he made several disclosures about his current life including that he had self-harmed by cutting his wrist and chest previously with no intention of ending his life. A plan was agreed together with offers for assistance with housing and employment but he declined consent to sharing the screen information with other agencies outside of CPFT who may have been able to help him. The case was then closed.

2.1.19 Keith continued to struggle with his mental health throughout 2017 (as outlined at 2.3) and CPFT responded to these.

2.1.20 In July 2017, Keith's parents contacted the police stating that Keith had gone to their home having self-harmed with a knife blade. He had superficial injuries to both forearms and therefore, although s136 of the Mental Health Act was considered, it was not deemed applicable and he was encouraged to see his GP and the crisis team. He refused treatment to his wounds and it was recorded under Vulnerable Adult.

2.1.21 In March 2018, a previous partner reported to the police that following their separation, Keith was sending her a large number of threatening messages on social media, trying to coerce her to quit her job due to her working with other men. He had threatened to ruin her job by stating she was psychotic, implying mental health bias. A DASH was recorded as standard.

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[6] Mental health problems | Find support for anger - Mind - Mind.

2.1.22 In April 2018, Keith's parents called the police as he had gone to their home which was a breach of a restraining order. A DASH was raised as standard risk and recorded as a verbal only domestic incident but no action appears to have been taken in relation to the breach.

2.1.23 In 2020, DWP records show that Keith attended a Sector-led Work Academy Programme and swore at his tutor when asked to stop using his mobile phone. In 2021, notes state that he had been diagnosed with Anti-Social Personality Disorder (ASPD) and got bored easily.

2.1.24 In March 2022, Keith attended an appointment by phone with DWP for a work search interview and was noted as being agitated and defensive. After failing to make an appointment in the August of that year, he stated the reason was that he was suffering badly with his mental health and was currently being assessed for this.

2.1.25 Keith was only seen twice by his GP Practice during the Terms of Reference period. In September 2022, Keith was seen for his mental health and requested a sick note. Several consultations are on his medical records dating back to 2006 with ongoing depression since childhood when he was under the care of Children and Adolescent Mental Health Services (CAMH). Records also show several consultations in regard to anger issues between 2007-2016. The other appointment was for a clinical reason.

2.1.26 Keith first approached the housing department for help in October 2022 stating that he was living with his family but was being asked to leave. He remained at his parent's home over the next few months whilst enquiries were made in which his mum called on several occasions stating that things were getting difficult at home. Records show that it was not easy to engage with Keith directly.

2.1.27 Also in October 2022, the police began investigating Keith following his communication through social media with what he thought was a child under 16 years old, seeking sexual acts. A lengthy investigation then took place. He was arrested the following month and received a conditional caution for possession of class B controlled drug but failed to comply with the conditions and was summonsed to court. He was later fined in Court.

Combined Chronology

2.1.28 Chloe and Keith began their relationship in the early months of 2023.

2.1.29 In March 2023, Chloe attended a Universal Credit appointment at DWP where the agent noted that 'Chloe had major issues where she was working which has impacted upon her mental health so much that she has started therapy again. She also says that she needs to go to the police about what happened at her previous workplace but as yet, has not felt up to starting the process. No vulnerabilities were recorded or additional support noted.

2.1.30 Keith's homeless application was eventually closed at the end of March 2023 as contact had been lost with Keith but his mother then contacted several days later to inform them that Keith was now homeless and not living with them.

2.1.31 During the same month, Keith was arrested for attempting to incite a child for sexual activity and was interviewed and bailed.

2.1.32 During the summer of 2023, there were seven separate incidents recorded by the police where they were contacted over arguments and allegations involving Keith's dog who, as he was sofa surfing, he had left it with his parents to look after. The incidents were initially dealt with as a civil dispute but on the fourth occasion, a DASH was completed as standard risk and shared with Adult Social Care (ASC).

2.1.33 Keith signed the tenancy for his property in August 2023 as the sole tenant.

2.1.34 In October 2023, Chloe attended a video assessment with the Healthcare professional in which Keith attended for support. In December 2023, following a further appointment, Chloe's notes stated, 'No changes, Chloe is still struggling with her mental health but this is because of Christmas as this is a hard time of year for her'.

2.1.35 In November 2023, Keith made a claim for Carers Allowance for looking after Chloe which was awarded in the December. ASC records do not have any carers assessment or referral of any kind recorded. It does not appear they were living together at that time.

2.1.36 In December 2023, Keith was charged with attempting to incite a child to engage in sexual activity[7] and was bailed for a trial at Crown Court in February 2025.

2.1.37 In April 2024, Chloe's single person claim was closed with DWP as she had moved into Keith's address and they made a joint claim and both declared they were unemployed. Chloe declared she was caring for Keith but did not make a claim for carer's allowance.

2.1.38 In October 2024, Chloe attended her GP practice with Keith and informed her GP that her partner and friends had noticed traits of ADHD. She stated that her brain was always active and she would get fixated on things with having bursts of energy and then no energy at all as she was tired all the time. She was receiving long term therapy on a Zoom group. Chloe was given a self-assessment ADHD form which she completed and returned and the GP surgery referred for an ADHD assessment. This was referred to PCMH for triage and a conversation took place with Chloe on the phone and she was signposted to Right to Choose Right - ADHD UK due to long waiting list for CPFT adult ADHD service assessment. She was provided with crisis contact numbers should she need their support. In November 2024, the GP informed PCMH that Chloe preferred to wait for CPFT services rather than use another service in a different locality. Chloe was contacted by PCMH on the phone to arrange an appointment to complete the Childhood Screening forms to facilitate onward referral to CPFT Adult ADHD Clinic. Chloe agreed to an online appointment in December 2024 but did not attend and was not offered another appointment. There is no reason recorded for this in the notes. The referral was closed, and the GP was informed.

[7] Sentencing guidelines - Community order to 10 years' custody. The determination of seriousness in sentencing is made regardless of whether activity was caused/incited in person or remotely and regardless of whether harm was caused to a victim or intended victim (attempt).

2.1.39 Chloe stated to DWP that she would like to get into care work and was doing a course as part of her Universal Credit.

2.1.40 Chloe had an appointment booked with the GP practice for her mental health in September 2024 but did not attend and there is no record of this being followed up. She had regularly attended her appointments at DWP for a few years but did not attend the August 2024 appointment and went on to miss appointments in January and February 2025, having not done so previously.

2.1.41 In January 2025, Becky saw her sister around their mothers as she had a new puppy and they were playing with it. Becky said that Chloe was good and upbeat. She spoke of getting a new job as working support for autistic children and was excited about it but told them that Keith was not happy about it and had told her, "I need you to stay here." She only stayed a while and then left as he was expecting her home.

2.1.42 The days leading up to Keith's trial and on the actual day, several Google searches were made by Keith on his phone with key word searches for kill, death, suicide, overdose, painkiller, hospital, murder, strangle, choke, throat, neck, self-harm and cut. There were searches in relation to his upcoming court trial of what happens if you do not attend court and whether the hospital would know you have a warrant along with how to get sectioned? And the issuing of warrants. There were also further searches asking:

- What causes CO2 poisoning in houses
- What is lethal to human's in rat poison
- How to snap someone's neck
- Stukeley Meadows murder (x2 searches)

Some of these searches were made the day he was due to attend court.

2.2 Circumstances of the death of Chloe

2.2.1 In February 2025, on the day that Keith's trial was due to begin, he did not attend Court and an arrest warrant was issued for his arrest by the Judge. He was not circulated on the Police National Computer (PNC) at that time.

2.2.2 Early evening of the same day, Chloe's mother contacted the police reporting concern for the well-being of her daughter as she had not heard from her since a phone call the previous day and there had been no social media activity of which both were out of character. She stated that Chloe's current partner was a former drug user and dealer, but she did not indicate that there was any domestic abuse in the relationship. The contact she made did not mention him by name, although she was not asked. It transpired that she had fallen out with Chloe earlier that day concerning the ashes of her pet cat.

2.2.3 An active enquiry to arrest Keith was already being conducted by investigating officers in relation to the warrant but the two were not connected. The following day, police officers attended his parent's address to try and locate him, arrest him and take him straight to

Crown Court. Keith's mother indicated that she had no idea of his whereabouts but thought he was still in the Huntingdonshire area.

2.2.4 Officers attended Keith's home address and had no reply with neighbours stating that they had not seen the occupants for several days. Officers then visited Chloe's mother who informed them that she did not like Keith, felt he was controlling and that he had not been there for her daughter. She had an argument with Chloe the previous day on the phone over her cat and had then gone by taxi to her house as she had not heard from her since. There was no reply and the dog didn't bark which was unusual and that is why she had contacted the police.

2.2.5 It was at this point that the lead officer declared Chloe a missing person as her behaviour was out of character and she could not be located and may have been at risk from Keith. Further rationale was recorded and the priority was to locate and safeguard Chloe. Enquiries were made with neighbours who understood both Keith and Chloe to be heavy drinkers and there had been occasions when one of them had gone to them for support at various times with Chloe being particularly distressed on one occasion following an argument with Keith.

2.2.6 Officers had recontacted Keith's parents and went to see them later that day when they informed them as to the circumstances of his court case to which his father reacted angrily as they were not aware. His mother informed them that Keith had come to her house late the previous day with the dog having not had contact for some time and asked them to look after the dog for a week without giving an explanation. He had stayed until 2am in the morning when he left.

2.2.7 Keith's mother then shared two emails with the police from lunchtime that day where he asked them to take care of his dog and stated he loved them and was sorry for being a 'shit son.'

2.2.8 "Please look after honey I'm sorry for everything I have put you through I have always loved you both but please take good care of honey she is a very special girl she will be happy with you both as I know she will get all the love she needs. I'm so sorry."

2.2.9 Having now exhausted all reasonable lines of enquiry; officers returned to Keith's flat and forcibly entered the flat that afternoon. They discovered Chloe, covered in a blanket and lying face down on the floor, apparently deceased. It appeared she had been dead for many hours. Although there was blood at the scene, it appeared to be inconsistent with Chloe as she had no obvious visible injuries. Officers determined that the blood had possibly originated from a third-party and that the source of the blood had either sustained an injury or had self-harmed. The assumption was that the blood was attributed to Keith and that he was the primary suspect in her death. The on-duty senior detective attended the scene and declared a murder investigation, nominating Keith as the suspect. Light fittings appeared to have been pulled from the ceilings, which may be indicative of an effort that a person had attempted to self-harm by hanging.

2.2.10 Although declared as a suspect, Keith does not appear to have been circulated as a wanted person for murder at that time.

2.2.11 Early on the following morning, Keith was found hanging in the public toilets of the local hospital. An investigation took place and a file has been submitted to the coroner in

relation to the murder of Chloe and the suicide of Keith as his death was not linked to a third-party and appeared to have been self-inflicted.

2.2.12 Section 70 Domestic Abuse Act 2021[8] (DA Act 2021) introduced the offence of non-fatal strangulation or suffocation which came into force in 2022. Data in relation to this offence is only partially accessible but the Ministry of Justice Criminal Court statistics show that the police use of the offence is increasing each year and the CPS is reviewing charging decisions to ensure strangulation is charged instead of common assault where evidence supports it.

2.3 Individual management reviews (IMRs)

GP Surgery

2.3.1 Chloe's GP surgery provided information from their records from 2020 until her death as per the Terms of Reference.

2.3.2 Chloe had 27 contacts with the GP practice between those times with seven of them being face to face and the remainder by other methods of phone and technological communication. Much of this time the GP Practice, as all NHS services in following nationally mandated guidance during the COVID-19 pandemic were, operating on a system to reduce face to face contact to reduce the risk of infection transmission. A large number of appointments were for clinical reasons.

2.3.3 There is no mention of domestic abuse within the consultations and no record of whether she was asked about this in the consultations. The practice takes the issue of domestic abuse seriously, and ensure all staff are trained in the recognition of abuse and how to manage this. The practice displays information within all surgeries on notice boards, and have a changing display in multiple areas, including in the patient toilets. The practice website has links to support for domestic abuse, however on review these would benefit from being updated.

2.3.4 Chloe's records do not indicate any self-neglect or thoughts of suicide or self-harm. There was no recognition that she was vulnerable within the practice and only one mention of domestic abuse from the police information in 2017 and therefore no attempt to access support was made. Chloe had a total of 43 medical certificates issued since July 2015 with a large portion of these relating to her mental health.

2.3.5 Chloe was signposted to appropriate Mental Health support and was able to access this herself with self-referral, as per the Cambridgeshire pathway. There is nothing in her notes to suggest she did not have mental capacity. She never received an appointment to assess for ADHD as the current NHS wait for adult ADHD assessment is several years. This is the situation for the whole country and not a localised issue.

[8] https://www.legislation.gov.uk/ukpga/2021/17/section/70

2.3.6 The appointment for Keith in September 2022 was at his previous practice but taken from his medical records. Notes mention that he had not found anger management courses helpful. There was no evidence of self-neglect or self-harm.

2.3.7 There is nothing in Keith's recent records apart from one consultation about mental health. No referrals were made; however, he was signposted to support appropriately. There is nothing in his notes to suggest that Keith did not have mental capacity.

2.3.8 All clinical staff undergo regular safeguarding training which can include ACES. No concerns were raised by either Chloe or Keith about domestic abuse so the effect cannot be assessed in regard to this.

Department of Work and Pensions (DWP)

2.3.9 Records dating from 2020 show that Keith was unemployed throughout the period, frequently missing appointments and was constantly seeking avenues for differing claims. Throughout the period of claims, there is no evidence of either Chloe or Keith disclosing domestic abuse.

2.3.10 Benefit entitlement is calculated on a person's eligibility according to the criteria for claiming the specific benefit, this does not include the consideration of protected characteristics.

2.3.11 The Department is committed to providing services which embrace diversity and promote equality of opportunity. This means we need to ensure that our customers have access to reasonable adjustments or additional support, to enable them to access benefits and our services.

2.3.12 The Department is legally obliged to make reasonable adjustments for disabled customers. Where customers need assistance to access our services and information, we will make reasonable adjustments to meet their individual needs.

Cambridgeshire Police

2.3.13 There were no recorded incidents of domestic abuse between Chloe and Keith on police records. There are no police referrals to other agencies concerning noise or partnership responses to anti-social behaviour.

2.3.14 Keith's file name (conviction and PNC record) was in his adoptive surname. When spoken to during the investigation, his father appears to have firmly laid the blame for his son leaving the household as a teenager with Keith, suggesting that they did not get on. When he was informed about the reason for Keith's trial, his contempt for his son became apparent and he wished to distance himself further from him.

2.3.15 Keith's parent's viewpoint in communication with the family liaison team contact officer, was that they disliked Chloe and did not warm to her company as she did little and expected that Keith would wait on her and provide for her, despite his limited income. They

would frequently subsidise them both and provide them with food, but that as a couple they were seemingly '*loved up'* and were of the opinion that it was Chloe who controlled the relationship, and that Keith acceded to her demands. There was no suggestion or indication of domestic violence on the part of Keith or Chloe.

2.3.16 Becky indicated in conversation with the family liaison officers that Keith would constantly text Chloe when she was out, and she was not allowed to speak to some of her friends. To her, it felt very unhealthy, but she had not reported this to any services or sought advice independently. Becky explained that Chloe was naïve and would trust people easily. She would believe things people said and had entire trust in Keith. Becky described Chloe as being "not very well",' believing that she had an undiagnosed neurodiversity and was prescribed antidepressants, but she did not act her age, seemingly acting and behaving like a teenager and was vulnerable as a consequence of this. She "always saw the good in people," was kind-hearted and was susceptible to doing things other people wanted.

2.3.17 Becky said that Chloe was about to start the pathway to see if she had ADHD, which she believed was the root cause of her sister's psychological health issues.

2.3.18 Becky stated that Chloe found it difficult to hold down jobs as she was "always falling out with someone," but she had worked regularly including time within retail and in clubs and bars. Chloe had recently completed the training to become a carer and was about to start but did not have a starting date and at the time of her death she remained on Universal Credit and PIP payment due to not being able to work through her mental health. It was rumoured that Keith was unhappy that she was about to become a care worker.

2.3.19 The review of the body worn video of the officers making enquiries to locate Keith, indicates that one resident reported there had been times Chloe had fled to a nearby flat following domestic arguments. Following these incidents, they had avoided those neighbours when they had seen them in the town centre. Those neighbours also reported that Keith drank a lot of whisky.[9]

2.3.20 Following their deaths, police downloaded both Chloe's and Keith's mobile phones. Chloe's last verified footprint on social media was at 15.55hrs on the day that Keith was due in court. Evidence indicates that Keith had possession of Chloe's phone at this time. The last interaction on Chloe's phone was at 22.00hrs the same day.

2.3.21 Keith's device was sent the warrant issued for his arrest after failing to attend court by a defence Solicitor, which was accessed at 1517 hours the day after he was due in court. There are numerous images and videos on the device which would indicate that Keith was on social media and interacting with Facebook after the time that Chloe was killed. There is also an image from a webpage source showing a naked woman with a banner saying "censored" edited over her breasts, being 'strangled' from behind by a person with a horror mask on; this was accessed at 1710 hours the same day.

See appendix B at the end of this report which outlines 'Right Care, Right Person.'

CPFT

[9] The IMR author has reviewed the homicide file and there was no witness statement obtained from the neighbours referenced.

2.3.22 Chloe first had contact with CPFT Psychological Wellbeing Service (PWS) in 2010. PWS is part of CPFT Primary Care Mental Health (PCMH). PWS is also known as Talking Therapies (TT). Chloe was referred by her GP due to experiencing anxiety symptoms in 2010.

2.3.23 Keith attended the Emergency Department (ED) in November 2016. The ED practitioner telephoned FRS service for advice as the CPFT Liaison Psychiatry Service (LPS) at this acute hospital is not commissioned to provide out-of-hours mental health services. Health staff in the ED deemed Keith to be medically fit and he was given the phone to speak to FRS. The FRS notes state he sounded 'groggy' as he had taken ten Co-codamol.

2.3.24 He told FRS he was 'fed up' but no specific triggers were identified. When asked about suicidality he said, 'a little…not as much as earlier.' He felt safe but sleepy. He said he was homeless and staying with a friend and not in contact with his parents as the relationship had broken down and that his dad was abusive. He felt he could talk to his friend and would normally go for a walk to manage his emotions. He was not offered a DASH assessment or signposting for DA support due to his disclosure of abuse by his dad.

2.3.25 Together FRS and Keith made an individualised safety plan and agreed if he felt suicidal again to call FRS and he said he would do this. He was signposted to PWS and counselling. Keith said his brother was supportive and was due to collect him from hospital. They discussed distracting activities and emotional regulation, and Keith stated he would draw/sketch and go for walks and sleep. This Individual Suicide Reduction Plan demonstrates good practice.

2.3.26 In February 2017, the GP made a routine referral to CPFT. The GP referral stated Keith was experiencing depression, anxiety and agoraphobia that were making his life difficult and making it hard for him to work. He also reported hearing a voice in his head regularly that tells him how useless he is but no other psychotic symptoms. There was a history of self-harm, and he experienced regular thoughts about wanting to hurt himself but not strong enough to act on.

2.3.27 In response to the referral, Keith was sent a letter advising him he had been placed on the waiting list for the Community Mental Health Team (CMHT) for assessment and potential treatment and support. He was offered an appointment at the assessment clinic but failed to attend the initial appointment but attended in April 2017, where a psychiatrist saw him.

2.3.28 The Psychiatrist's report states Keith was struggling with depression and anxiety since he was 15 years old. His depression was characterized by months of low mood, poor motivation, poor appetite, weight loss, and poor sleep. Keith said he frequently felt he was a nuisance and a burden to others, he felt hopeless and tearful. He also mentioned episodes of anger and irritability also driven by his poor self-esteem and hopelessness. Keith described symptoms of anxiety and panic attacks which also started in his teenage years. Keith stated he had unusual visual experiences and sees a "black figure" watching him. The figure was mostly present when he was under pressure or anxious and he was afraid of it, it made deprecatory remarks about him and told him to hit or hurt his friends, but Keith said he was not obeying.

2.3.29 Keith shared his personal childhood history which is already covered more accurately by other DHR IMRs. At the time of the assessment there were no current or imminent risks to self or others. Keith agreed to a plan to refer him to the Personality Disorder Community Services for psychological interventions, and he was offered an appointment with their service for 13th July 2017.

2.3.30 The following month (May 2017) there was a phone call to FRS by Keith's mother. She said Keith was 'in a state' and 'ignoring her' and she asked for FRS to come out for a home visit. Keith refused to speak to FRS on the phone. It was explained to his mother that FRS would need to establish if a home visit was required through phone triage with Keith first. His mother asked to speak to another MH practitioner and during the conversation she stated she needed an ambulance and so the call was transferred to 999. Subsequently FRS have developed a Non-Consenting Pathway, which helps FRS staff consider their options if a person of concern is not consenting or engaging with FRS and the risk is high.

2.3.31 In June 2017 there were two further calls to FRS from Keith's mother and he agreed to a triage over the phone. He said he had self-harmed a couple of days previous and had attended the ED for treatment, requiring 17 and 12 stitches for lacerations along his left and right arm and chest. He said the ED doctors had wanted him to wait to be seen by CPFT LPS when the service was available, however, he left the ED once he had been given medical treatment as he did not want to wait. Due to the limited operating hours of LPS commissioned-at this acute hospital, this was a missed opportunity for a mental health assessment

2.3.32 Keith stated to the FRS practitioner that he felt safe and well with no thoughts of self-harm at that time. Although he found it difficult to verbalise his feelings, he said he would let his mum or FRS know if he was in crisis.

2.3.33 They agreed a plan and for longer term support Keith would remain on the waiting list for PDCS interventions. The notes state his mum was unhappy he was not being offered an admission to hospital for mental health support, but this was not felt to be required. His mum was also unhappy Keith was still on the waiting list for PDCS interventions. The FRS practitioner assessed Keith as having no imminent risks to self and a crisis plan was agreed to call FRS if he was experiencing thoughts of self-harm. There is no recorded evidence to demonstrate professional curiosity into the risks to others.

2.3.34 Keith was taken to custody the same month (June 2017), and while in custody Keith was referred again to the LaDS team for a Vulnerability Screen because the custody staff had concerns about his mental health. Keith had recently self-harmed which required sutures to the wounds and while in custody he had reopened his wounds and removed the sutures. He had his wounds assessed by custody health staff for this. Keith gave the LaDS practitioner both verbal and written consent for all information to be shared with professionals. The practitioner reviewed his CPFT records and could see he was on the waiting list for an appointment with PDCS.

2.3.35 The notes show Keith engaged well with LaDS. He expressed no suicidal thoughts and was happy to engage in conversation about his history of self-harm. He stated that self-harming made him feel relaxed and released his frustrations. He stated he had self-harmed since he was 10 yrs old. Although there is no record of what 'frustrations' he had or the triggers for self-harm.

2.3.36 Keith stated, at that time he had been drinking about three to four bottles of vodka at a time and had previously received support from Inclusion Drug & Alcohol Services but he felt he did not need any support with alcohol misuse. There is a lack of professional curiosity about his alcohol intake and the impact on him and others. He stated he last experienced alcohol withdrawal symptoms three days ago but was dismissive of concerns and he felt this was 'not an issue.'

2.3.37 Keith and the practitioner agreed on a plan; Following the screen, the practitioner telephoned the PDCS to inform them of his detention in custody and Keith's request to see him as soon as possible, which was good practice. The practitioner contacted social care to see if Keith had any current involvement or support options from the Looked After Children Team, but he was not open to their services. Keith was advised to self-refer again to specialist alcohol services Inclusion and although he was reluctant, he knew how to contact them if he changed his mind.

2.3.38 For his physical health, Keith was to have his wounds assessed by custody health staff and any health interventions would be met by them. A copy of the Vulnerability Screen and the plan was sent to the GP. The Practitioner demonstrated lots of good practice by reaching out to services who may have been able to support Keith. As a learning point there is no record of any discussion about relationships or risk to others on the screen. Since that time, DA and risk is embedded more fully into routine practice.

2.3.39 Keith failed to attend his appointment offered by PDCS on the 13th of July 2017, and a letter was sent offering him the option to self-refer if required.

2.3.40 On the 1st of January 2023, police contacted CPFT Crisis Resolution Home Treatment Team (CRHTT). Keith was not open to CPFT services at the time, but there is no record of the discussion, or any advice given by the CPFT practitioner to police, which has subsequently been raised with the Team as a learning point.

2.4 Summary reports

Children's Social Care – CSC

2.4.1 A key positive factor in Keith's life was his relationship with his young people's worker, who provided consistent support, guidance, and advocacy. This worker maintained a stable presence for Keith, something he lacked elsewhere.

2.4.2 Keith's adoptive mother found the tension within the family difficult, being both a victim of her husband's aggression and a caring parent to Keith. There is no indication that she sought refuge or that support was offered to ensure her safety, which complicated protective efforts.

2.4.3 In 2023, the Children's Commissioner reported that 61% of homeless 16- and 17-year-olds accommodated by local authorities are not being brought into care as they should be. The Southwark Judgement, made by the Law Lords in May 2009, obliges children's services to provide accommodation and support to homeless 16- and 17-year-olds. This was true for Keith, but he did not want to enter care despite his vulnerable circumstances. Recent data from the Department for Education shows that the number of children in care in England continues to rise, with 33,000 children entering care last year. As of March 2023, there were 83,840 children looked after, approximately one child in every 140. While there are no fixed number of children who "should" be in care, every child unable to live safely at home deserves a loving, stable alternative. Even when children do enter care, many 16- and 17-year-olds are placed in settings that do not meet legal care standards but offer only support.

2.4.4 Furthermore, the accommodation provided can sometimes be unsuitable or unsafe, highlighting critical gaps in the care system for vulnerable older children.

2.4.5 This next section will provide an overview of the research looking at homicide-suicide and consider factors associated with this, in particular ACEs and trauma.

2.4.6 Homicide–suicide events, though rare, devastate communities worldwide. Such incidents attract fear, extensive media attention and popular culture references (Friedman et al., 2018; Peterson et al., 2021). Though homicide and suicide have been independently well-researched, less is known about homicide–suicide events and little is known about the relevance of mental disorder in perpetrators (Flynn et al., 2016).

2.4.7 Explanations why people commit these acts have been proposed and classified in numerous typologies. Motivations include jealousy and revenge following real or perceived infidelity and relationship breakdown, altruism or mercy killing, financial problems and mental disorder. However, these typologies have their limitations and do not comprehensively capture the complexities of homicide–suicide. Reliable information on the role of mental disorder in these cases is lacking. The most common circumstances leading to the individual's emotional distress was the loss of a close personal relationship either through imminent separation or divorce; or a significant change in the relationship due to the victim's ill health (e.g. dementia). Other adverse events included problems with children (child custody/access problems or the perpetrator's belief that they were failing as a parent); financial problems; and adjusting to a new social situation (either because they were a recent immigrant or a recently released prisoner). Most offenders exhibited difficulty coping with emotional distress, resulting in violence and aggression or self-harm.

2.4.8 Where homicide–suicide is a factor; it is likely that there is also a history of mental illness. Literature shows that these acts are commonly carried out by middle-aged men, which supports the evidence that this is an emerging high-risk group for suicide. Personal loss through relationship breakdown at this stage in life has been shown to be an important trigger in these incidents, but the causes of homicide–suicide extend beyond emotional stress arising from relationship difficulties (which are common problems). The key factor associated with homicide–suicides is the individual's lack of resilience and inability to cope with stressful events, evidenced by their reaction to previous similar experiences, either responding violently towards themselves or other people.

2.4.9 Research into trauma-informed practice gained momentum in the early 2000s, with Maxine Harris and Roger Fallot introducing the term "trauma-informed care" (TIC) in 2001. They highlighted the importance of understanding individuals past trauma experiences and advocated for a shift in service delivery that prioritizes trauma awareness and empowerment. This framework was further supported by the establishment of the National Centre for Trauma-Informed Care by SAMHSA in 2005.

2.4.10 Trauma-informed care recognizes that trauma results from events or circumstances perceived as harmful or life-threatening, leading to lasting adverse effects on mental, physical, social, emotional, or spiritual well-being. The approach focuses on creating services that avoid re-traumatization, respect individuals' autonomy, and promote recovery. Central to understanding trauma's impact is the research on Adverse Childhood Experiences (ACEs), which include abuse, neglect, and household dysfunction. Studies show a strong relationship between the number of ACEs experienced and increased risk of chronic diseases (such as heart disease and diabetes), mental health disorders (including anxiety and depression), substance misuse, violence, and reduced social and academic functioning. The long-term effects of ACEs extend across the lifespan, affecting not only children and adults but also older populations, potentially complicating age-related health and care needs. The development of trauma-informed care evolved alongside advances in understanding PTSD, particularly in veteran populations, and has since expanded into fields such as education, criminal justice, and social services.

2.4.11 There is a strong link between exposure to domestic violence (DV) during childhood and an increased risk of perpetrating abuse later in life. Exposure to DV can lead to various consequences, including behavioural problems, mental health issues, and even an increased likelihood of becoming a perpetrator. Studies have shown that individuals who engage in intimate partner violence (IPV) as adults were exposed to DV in their childhood. Children exposed to DV may internalize abusive behaviour's and imitate the abusive patterns they witness, leading to the development of abusive tendencies themselves. Exposure to DV can have profound psychological consequences, including increased aggression, anxiety, and depression, which can contribute to abusive behaviour's later in life. The cycle of DV can be passed down through generations, as children exposed to abuse are more likely to become perpetrators or victims in their own adult relationships. Children exposed to domestic abuse are at a higher risk of developing mental health problems such as anxiety, depression, and PTSD. These mental health issues can also contribute to the development of abusive behaviours. Recognising and addressing the impact of childhood exposure to DV is crucial in preventing the cycle of violence and supporting individuals who may be at risk of

perpetrating abuse. Children may experience violence in many settings, including at home, in school, online or in neighbourhoods, and in many forms, such as bullying or harassment by peers, domestic violence, child maltreatment and community violence. Exposure to violence can harm a child's emotional, psychological and even physical development. Children exposed to violence are more likely to have difficulty in school, abuse drugs or alcohol, act aggressively, suffer from depression or other mental health problems and engage in criminal behaviour as adults.

2.4.12 Sources of Information

Community Care (2023) A trauma-informed approach to social work: practice tips accessed via A trauma-informed approach to social work: practice tips - Community Care

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Public Health Wales (2025) Impact of Childhood Adversity and School Experiences on Adult Health New Study Highlights Impact of Childhood Adversity and School Experiences on Adult Health - Public Health Wales

Silva C, Moreira P, Moreira DS, Rafael F, Rodrigues A, Leite Â, Lopes S, Moreira D. Impact of Adverse Childhood Experiences in Young Adults and Adults: A Systematic Literature Review. Pediatr Rep. 2024 Jun 7;16(2):461-481. doi: 10.3390/pediatric16020040. PMID: 38921705; PMCID: PMC11206640. Southwark Judgement (2010) accessed via Southwark Judgement - Community Care

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Integrated Care Board (ICB)

At Hinchingbrooke Hospital development work has been undertaken in recent years involving CPFT/NWAFT/ICB and NHSE to expand LPS (Liaison Psychiatric Service) provision from the previous established 9.00-17.00 Monday to Friday service. This work resulted in an extension of the service hours to 8.00-18.00 and the service operating seven days a week rather than five days a week.

Consideration of further extending operating hours noted that both Addenbrookes and PCH have a 24/7 LPS provision and as such support at outside HH LPS operating hours could be provided by the LPS team at PCH, while ED staff have the option to get advice/guidance from CPFT First Response Service.

Further consideration of HH LPS has been included in the system-wide 2024/25 MH Crisis Pathway development work. This work is taking a wider strategic view of the entire crisis pathway rather than focusing on services in isolation to decide how best we could meet the needs of our population, including attendances to Acute hospital ED for MH needs.

Section 3 - Analysis

3.1 Family and friends' involvement and perspective

Becky (Chloe's sister)

3.1.1 Becky speaks fondly of her sister, Chloe. She stated that Chloe always saw the good in people and although they were always close, the relationship changed to being more distant once Chloe had begun her relationship with Keith. She describes her as sweet, naïve and vulnerable and could not read a situation which made her susceptible to being manipulated.

3.1.2 Becky speaks of how good Chloe was in her jobs in retail and how she liked to work and was looking forward to her new job, which was working support for autistic children, especially as she had been out of work for a while due to her depression struggles. She states how Keith never wanted her to do anything on her own and him not being happy about her getting a new job and stating "I need you to stay here" was indicative of this.

3.1.3 Chloe would go and stay over her mum's house overnight once a week which she knew Keith disliked and Chloe would state how he would drink heavily when she was not there. Chloe's mum would not allow Keith round the house as she did not like him. He would constantly call her while she was there which annoyed her mum as it was her time with her.

Chloe would also use the time to see her friends as he thought she was with her mum as her friends never saw her alone as he would always make sure that he was there.

3.1.4 Becky thought that Chloe may suffer from ADHD as she told Becky that her brain never switched off and Becky encouraged her to go to the doctors for assessment as she could then get the appropriate support. Chloe only drank when she went out as she would never drink at her mums when she stayed over and Becky does not believe that she had any alcohol abuse issues.

3.1.5 Becky 'ran into' Chloe one day when she was on her way to the Doctors. Chloe was with Keith. The sisters had not seen each other in a while and hugged hello. Becky thought it strange that Keith would not let go of Chloe's hand in a type of possessive manner. Becky would sometimes have chats with Chloe about his behaviour and Chloe would say that it was sweet that he constantly rang her as it meant he missed her and she felt sorry for him as he had lost his mum at such a young age.

3.1.6 Chloe thought it was nice that he always wanted to be with her and did not see the more sinister side of it. Becky found it strange when Chloe said to her that he had received therapy to stop him killing people as that is how he had explained it to her.

3.1.7 Becky remembers seeing bruises on Chloe at times but never ever suspected any physical assault as she was always so accident prone and Becky thought that if she were assaulted, she would have left him immediately.

3.1.8 Chloe told Becky that Keith had told her that he was going to Court over drugs and that she was not allowed to go with him to support him. She is unaware if Chloe found out the real reason he was going to court prior to her death.

3.2 Terms of reference areas

The support and service availability and response to Chloe and what considerations were or should have been made by professionals in contact with her.

3.2.1 The chronology indicates that Chloe was confident to attend her GP Practice and received timely medical interventions when required. However, when she attended in regard to the ADHD assessment, Keith attended with her and she stated that it was he who had pointed out ADHD traits. This in isolation does not appear out of the ordinary as patients often take someone with them to the GP for support.

3.2.2 The GP IMR states that when Chloe requested a referral for ADHD this was made promptly but as previously mentioned there is an NHS waiting list of several years. They state that this is frustrating both for the patient and themselves as their GP.

3.2.3 It appears from review of the medical records that both parties were able to access medical care when required. They attended for both physical and mental health issues. Appropriate assessment of the mental health issues was performed, and there was exploration of the patients' ideas concerns and expectations.

3.2.4 Referrals were made promptly when appropriate and safety netting and follow up was arranged. There was no mention of domestic abuse in any consultations. It is not clear if it was discussed, but it was never documented.

3.2.5 DWP records show that Chloe stated on her PIP application that she was attending a mental health group in a therapy centre however no vulnerabilities were recorded or additional support noted. Chloe had always frequently attended her appointments alone yet in March 2023, Keith was present for a video call with a health professional. In isolation, this would not be out of the ordinary as people do attend to support during these meetings.

3.2.6 Although there is a history of engagement by the police with both the victim and perpetrator, there was no evidence of domestic abuse or violence having been reported by either subject, family, friends or a third-party. The police have examined other incidents in the locality in the event of any third-party reporting or pre-cursor occurrence that is indicative of any background of domestic incidents and can confirm that there are no incidents and no additional information. This does not infer that there was no abuse.

3.2.7 During the enquiries to find Keith and Chloe and the subsequent investigation thereafter, neighbours and family members of Chloe spoke about controlling behaviour, arguments and the fact that Chloe had to go to them for assistance on occasions.

3.2.8 CPFT reports show that there is no evidence in the records that coercion was explored in any detail. Disclosures were documented, but there is no indication that staff used professional curiosity to explore the context of Chloe's relationships or assessed for any coercive control.

3.2.9 Certain provisions in the area are commissioned by the ICB for specialisms within mental health. Where a patient is referred to CPFT Primary Care MH for triage, the outcome might be signposting to independent therapy services if it meets their needs. The patient can also independently self-refer and re-refer so CPFT and/or the GP may not be aware the patient is accessing therapy. The GP and CPFT do not then receive updates or feedback on this client who may well be referred to CPFT months later, preventing a holistic assessment of their progress. There is also the matter of consent to consider. (Recommendation refers)

The holistic areas that require consideration in order to ascertain risk of a potential perpetrator of domestic abuse.

3.2.10 Throughout 2013 to 2015, there were frequent changes of social care workers for Keith and a series of short-term interventions that opened and closed repeatedly. Records show no clear evidence of sustained or coordinated support such as strategy meetings, Section 47 enquiries, Adoption support and or Child in Need (CIN) plans for Keith or his family. Given the considerable concerns regarding Keith's adoption, family dynamics, and wellbeing, a formal and consistent safeguarding response would have been warranted.

3.2.11 It is evident that Keith and his family required significant support that was either insufficient or absent in his teenage years. Adoption support services, which might have

helped address ongoing difficulties, appear not to have been provided effectively. Keith was a vulnerable young person whose needs were not fully met by the system designed to protect him.

3.2.12 In 2018, there is no record of the police responding to a breach of a restraining order when Keith attended his parent's house but the panel are satisfied that this would not now be the case due to new policies and procedures.

3.2.13 The panel discussed the fact that a carer's allowance was awarded to Keith with no evidence of an assessment or that he was caring for Chloe. Chloe's sister states that Chloe did not require a carer and therefore, this may have been an avenue for Keith to use Chloe for his financial benefit. Both DWP and ASC state that it would be impracticable for DWP to make a referral on each person claiming carer's benefit due to the quantity and the demand this would cause on both agencies and that it would not necessarily provide any outcome.

3.2.14 Following the phone call to the police by Chloe's mother outlining concern for her well-being whilst an active enquiry to arrest Keith was already being conducted by police safeguarding officers, the two matters were not linked or associated. There is no expectation that they would have been linked based on the circumstances of the call as this would rely on a number of other factors. Had Keith been circulated as wanted at that time[10] and his details obtained by the call-handler; this may have provided further tangible links. Had the operator been provided with full details of the couple, this may have provided further background.

3.2.15 By late evening that day, Keith had not been located and the enquiries to establish his whereabouts would continue the following day. The warrant of arrest would be updated within 24 hours of issue and that would include an entry on the PNC record of Keith[11]. All of these separate actions require a timely response which may have then provided a holistic overview a lot sooner. (Recommendations refer)

3.2.16 Due to the call made from Chloe's mother around the time of her death, the Assistant Chief Constable, Operations, commissioned a rapid review (single agency internal review) concerning the communication and the policing response.

3.2.17 The incident and call-handling were examined by the Demand Hub senior officer (Force control room and contact centre) alongside the Demand Hub manager who identified that: There was an overlap to the right care, right person and missing person criteria which wasn't accurately addressed as it could have been by the call-handler.

3.2.18 Chloe's mother had raised general concerns about Keith; however, she was unable to elaborate on her specific concern relating to her daughter and was not asked for his name. Cambridgeshire Constabulary has positively engaged using force systems checks in order to help better understand risk and this could have been completed to determine if there was anything further to be considered within the risk assessing.

3.2.19 Police records from Chloe's mother phone call stated that she was unable to attend the location to check on her daughter. This was not explored in detail but, to enhance levels

[10] Warrants issued by the Courts will take up to 24 hours to appear on the PNC

[11] PNC file name is Keith's adoptive surname. The record does identify both names used by Keith.

of service, the call-handler could have broadened this conversation supportively with the caller and helped her to explore other options e.g. asking for support from family/friend/relative. It is noted that there is also comment elsewhere of the mother attending and not hearing the dog bark which is in contrast to this. (Recommendation refers)

3.2.20 Similar to CPFT findings with Chloe, Keith's disclosures were not explored sufficiently to discuss relationships and the impact of his anger on those relationships.

Section 4 – Conclusions and Recommendations

4.1 Conclusions

4.1.1 The family of the victim state that Keith was controlling of Chloe, a matter that was refuted by his family, who, in turn, suggested the opposite.

4.1.2 There is no tangible evidence within the police records of coercion and control on either part, or no evidence has been presented to the homicide investigation on the part of either subject.

4.1.3 CPFT do not have access to external service's confidential therapy records, whether they are commissioned by the ICB or not which creates a gap in holistic knowledge of the outcome/progress of treatment and prevents an informed assessment of their mental state. The ICB and the commissioned service should review the information sharing agreement and consider if any changes are required.

4.1.4 Chloe disclosed a history of emotionally abusive relationships and anxiety to CPFT, which were documented in her 2020 PWS assessment. However, there is no evidence that this led to the offer of a DASH, signposting to support or a safeguarding referral although her vulnerability was acknowledged clinically but not escalated through safeguarding pathways. However, this was 2020 and CPFT can now evidence a new domestic abuse policy and responses by staff.

4.1.5 Since implementation of the Domestic Abuse Act (2021) and the Statutory Guidance (2022), CPFT has new safeguarding and DA policies and procedures. CPFT has expanded its Safeguarding Team making it more accessible to staff for case supervision and guidance. In keeping with the DA statutory guidance, the DA policy requires CPFT staff to ask service users about relationships and DA as part of routine enquiry. Any disclosure or observation of DA or safeguarding requires a response from staff and a written report to CPFT safeguarding for case review, supervision and guidance. For these reasons, the panel did not make a recommendation on the initial findings.

4.1.6 Due to the findings of the Police rapid review, all contact centre staff have been advised that when dealing with calls in particular where there is a potential overlap of the background to the call, that relevant system checks must be completed in order to ensure the information being communicated is interpreted and additional information sought before the risk assessment and incident grading decision is made. (Recommendation refers).

It has now been confirmed by the Court service that all warrants issued by the respective courts in the area are notified to the PNC Bureau as soon as practicable and by the end of the daily list by the court, for circulation by the receiving force. The court has confirmed that there was no adverse delay in this case and the PNC Bureau and Warrants Team have been notified that 'No distribution' communicated from the Court system, does not affect the police circulating the warrant on PNC. Therefore, no recommendation in relation to this is necessary.

4.1.7 Ideally, when patients are referred on to another agency by the GP or CPFT, particularly when they are an ICB commissioned service, an arrangement should be in place for the GP to be notified when a therapy intervention is:

a) Intervention completed and discharged
b) Intervention incomplete and discharged

So that it can be evaluated as to if any follow-up is required. In terms of practicality, this may be difficult to achieve and there may also need to be a patient opt out of sharing information but this area requires further exploration by the ICB.

4.1.8 No professionals records noted any alcohol abuse by Keith and no referrals were made for support for him in this area.

4.1.9 There are a number of areas of information obtained for this review that could potentially be explicable. However, when looked at holistically, a pattern of behaviour emerges. Becky speaks of bruises being seen on Chloe on occasions but they were not asked about as she was known to be accident prone and she had already previously left a relationship when violence occurred. However, the family were not aware that Chloe did not leave the relationship on the first occasion of violence. It is recorded on numerous occasions of Keith's anger issues and the fact that he grew up in a home where his father abused his mother.

4.1.10 Neighbours speak of Chloe having to go to them for help and being upset following arguments and incidents in which Keith was known to have been drinking. Although outwardly, the couple appeared loving and Chloe explained Keith's behaviour was due to him missing her and his upbringing, showing empathy, the family noted a number of behaviours and occasions which they found as controlling on his part:

- Constantly ringing/facetiming Chloe when she was not with him and when she stayed at her mums (believed to be so that he could see whether she was where she had said he was)
- Not letting go of her hand in a possessive manner when she tried to hug her sister
- Isolation from her friends and only seeing them when she was stayed around her mum's
- Insisting on going with her to the vet's for her mum's cat to be put to sleep
- Telling her that she could not go to Court and lying to her on the reasons for his court case.
- Using emotional blackmail to try and persuade her not to take a job as a carer for autistic children.

4.1.11 The panel consider all of these as traits of controlling and coercive behaviour when taken account of them all together. There are also the additional appointments that Keith attended for Chloe's GP and DWP appointments which are not unusual in isolation but taken holistically with the other information and the fact that the family state she could not go anywhere without him, these add to the controlling behaviour. It cannot be clarified whether physical violence led to her bruises or financial abuse took place with Keith orchestrating joint applications and his carer application to use Chloe's vulnerability for his own financial gain but these must be taken into account in this review.

4.1.12 The act of murdering Chloe is defined as domestic abuse in itself but this panel have found in this review that the likelihood of Chloe suffering from domestic abuse throughout her relationship in numerous forms with Keith is high.

4.2 Lessons to be learnt

National wait for ADHD assessment

4.2.1 The GP Practice, ICB and CPFT have informed the review that the wait time for an appointment for an ADHD assessment nationally is several years.

4.2.2 Chloe was referred to CPFT's Adult ADHD Service and triaged appropriately. However, due to long waiting times, she was signposted to Right to Choose. She opted to wait for CPFT but later did not attend her appointment. While the process followed protocol, the delay may have contributed to disengagement. Accurate information on the length of the waiting list for this service is not given to patients by CPFT.

4.2.3 There has been a marked increase in demand for ADHD assessments with an increase in referrals to CPFT between 2019 and 2023 by over 270%. Nationally the wait for adult ADHD assessment is approximately five to twelve months, but many Trusts report much longer waiting lists. CPFT's waiting list is amongst the highest in the country, though exact figures are not published. This will clearly have had an impact on Chloe as she has made the approach to be assessed and then cannot complete this.

4.2.4 If there is a lack of transparency it makes it difficult to benchmark CPFT's performance or help individuals make informed choices about whether to seek assessment outside of CPFT or remain in the waiting list. There is a clear opportunity for CPFT to improve reporting and communication around adult ADHD pathway timelines.

4.2.5 The Integrated Care Board (ICB) have identified that this is an issue both Nationally and locally.

- Locally: an active ICB ADHD working group acting to address current issues including the waiting list situation. A paper is due to go to the commissioning investment committee in September 2025 outlining local plans to progress.
- Nationally: ADHD waiting lists are a national issue

There is a national ADHD task force, early recommendations were published in June 2025 https://www.england.nhs.uk/publication/report-of-the-independent-adhd-taskforce/
NB: ICB will be following recommendations

4.2.6 Due to the above, a specific recommendation in relation to this will not be made but is now very much highlighted as a need for ongoing response. The above information clearly had a direct impact on Chloe and her ability to gain understanding of her own personality and traits which , if diagnosed, may have assisted in her identifying aspects of Keith's controlling behaviour.

Disparity of provisions for mental health crisis

4.2.7 The North West Anglia NHS Foundation Trust (NWAFT) runs three acute hospital sites in England, two of these being within Cambridgeshire. Each of these has a Liaison Psychiatry Service (LPS) which provides a response to those patients presenting mental health issues to the emergency department (ED).

4.2.8 Peterborough Hospital provides the facility of 24-hour LPS response whereas Hinchingbrooke hospital does not have a face to face out of hours response but offers a phone call with a clinician at Peterborough hospital if deemed necessary causing a disparity in the services offered within the County dependant on which hospital you attend.

4.2.9 Keith attended the Hinchingbrooke Hospital Emergency Department (ED) in November 2016. The ED practitioner telephoned FRS service at Peterborough hospital for advice as the CPFT Liaison Psychiatry Service (LPS) at this acute hospital is not commissioned to provide out-of-hours mental health services.

4.2.10 In June 2017, there were two calls to FRS from Keith's mother and Keith agreed to a triage over the phone. He said he had self-harmed a couple of days previous and had attended the ED for treatment, requiring 17 and 12 stitches for lacerations along his left and right arm and chest. He said the ED doctors had wanted him to wait to be seen by CPFT LPS the service was available, however, he left the ED once he had been given medical treatment as he did not want to wait. Due to the limited operating hours of LPS commissioned at this acute hospital, these were missed opportunities for a mental health assessment.

4.2.11 Although Keith was found in the toilets at the hospital, there appears to be no evidence that Keith attempted to seek help or even entered the ED. It is possible his presence at the hospital at that time was simply due to it being an open location with facilities.

4.2.12 However, this is the third DHR out of six for Huntingdonshire CSP since 2018 that has highlighted the lack of service out of hours as an issue. The two previous DHRs are with the Home Office for panel scrutiny at this time.

4.3 Recommendations

National

1. **The College of Policing to consider whether a trigger question in relation to protected characteristics should be included in the DARA process for risk assessing.**
   The DARA is the new method of risk assessing which has replaced the DASH for the Police service. Although the DARA is comprehensive, it does not include a trigger question concerning protected characteristics and such information may therefore not be sought, which may by default, fail to identify or broaden the impact of disabilities or other relevant characteristics.

Local

2. **GP Practice to ensure information on support for domestic abuse is updated on the practice website.**
   This is an area that was identified by the GP Practice when collating information for this review and was found that certain information required refreshing.

3. **GP Practice to ensure that all DNA (Do Not Attend) surgery arranged mental health appointments are followed up by the surgery. (clinician or delegated where necessary)**
   This to provide support and engagement and will provide a further opportunity to ascertain any crisis or response required as to why they did not attend.

4. **GP Practice to consider formal review of a patient when repeated mental health related certificates are issued or requested.**
   This will ensure that informed rationale is recorded and up to date information held prior to issuing repeat certificates and ensure they are still required and relevant.

5. **All GP Practice staff are to enquire regarding domestic abuse when people present with low mood or depression.**
   This will provide an opportunity for disclosure and discussion for appropriate referrals to be made for support.

6. **Cambridgeshire Constabulary to ensure that all relevant staff within the contact centre are tasked with completing thorough systems checks to understand and interpret all information prior to completing a risk assessment and incident grading decision making.**
   This will negate decision making based on minimal information and prevent assumptions so that all information is available and taken into account.

7. **Cambridgeshire Police are to implement that where a suspect is sought for a serious offence, an immediate wanted person circulation should be made on the**

Police National Computer (or equivalent) in addition to any local policing circulation.
Expediting this circulation will ensure that any police officer checking the PNC across the country will have access to that information and will be able to respond appropriately.

8. **ICB to scope the feasibility of information sharing between GP and external services when commissioning and referring to other organisations (e.g. Private therapy). This should include regular feedback loops and integrated care plans to ensure continuity of care and holistic evaluation, or early review if there is disengagement with the referred to organisation.**
   This will assist with an informed assessment of the status of a person's mental health evaluation, particularly in those patients who have multiple referrals and all information collated together as one rather than in silo with each service.

9. **North West Anglia NHS Foundation Trust to review the parity of out of hours provisions in providing access to face-to-face 24/7 Mental Health Assessment and support in the emergency department across their establishments.**
   This will ensure individuals mental health needs can be adequately met and provisions are not a 'postcode lottery.'

Appendices

Appendix A

Terms of Reference

- The data parameters under consideration are from 2020 onwards. Any relevant further information held outside this data parameter is to be included by agencies.
- This is to be reviewed as a Homicide followed by a suicide based on the investigation by appropriate authorities.
- Ensure the review seeks to involve the family in the process and takes account of who the family may wish to have involved as lead members. Identify any other people the family think may assist or be relevant in the review process.
- Was Chloe recognised as vulnerable in her own right?
- Is there sufficient sharing of information with the referee when a referral has been made in order to holistically evaluate at a later stage?
- Were adequate referrals made for both Chloe and Keith in relation to disclosures they made about incidents in their life and also their health.
- Are adults who request or require an ADHD assessment provided an adequate service response?
- Are there any barriers within Cambridgeshire to Chloe accessing support from DA services.
- Are professionals cognisant of ACES and the impact on future relationships?
- Are suitable checks made to ensure the accuracy of the claims and whether any person may be coerced?
- Identify good practice
- Were procedures sensitive to any protected characteristics of the deceased's that are relevant in this case?

Appendix B

Alongside all forces across England and Wales and developed in close collaboration with health partners 'Right Care, Right Person' is a model designed to ensure that when there are concerns for a person's welfare linked to mental health, medical or social care issues, the right person with the right skills, training and experience will respond.

In recent years, police officers have often been required to offer support to those who really require specialist medical or psychological care.

Under 'Right Care, Right Person,' our officers will no longer be taking on this responsibility when it is not appropriate to do so.

Indeed, police intervention can sometimes have a detrimental effect on vulnerable patients who feel they are being criminalised because of their health or social care issues.

The care will now be provided by the agency that can best meet the individual's needs.

From 16 July 2024 the Demand Hub will begin to make decision about deployment to Concern for Welfare calls based on an updated set of criteria.

Right Care Right Person (RCRP) aims to ensure vulnerable people get the right support from the right emergency services. It applies to calls for service about:

- concern for the welfare of a person
- people who have walked out of a healthcare setting
- people who are absent without leave (AWOL) from mental health services
- medical incidents

This toolkit supports forces in England and Wales to:

- decide the appropriateness of a police response to these calls.
- implement RCRP successfully and consistently, in partnership with health and social care agencies.

It is based on legal advice.

ECHR Article 2

Where there is real and immediate threat to life.

The threat must be 'substantial or significant' and 'present and continuing.'

ECHR Article 3

Where there is a real and immediate threat of torture, inhumane/degrading treatment, or punishment.

In relation to RCRP this is considered the threat of suffering serious harm.

Core Duties

The police have a duty to:

- Preserve life or property (criminal act).
- Keeps King's peace.
- Prevent offences.
- Bring offenders to justice.

Or to prevent a child from suffering, or being likely to suffer, significant harm.

Or where an AWOL patient is:

- Especially vulnerable (not just vulnerable)
- They are a danger to themselves or others.
- Subject to Part 3 of the MHA S37/41 (Where they are detained in hospital instead of a custodial sentence)