Executive Summary

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.

Contents

1. The review process

1.1 This review examines agencies responses, provisions and support provided or available in the Cambridgeshire area 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.

1.2 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.

1.3 The Coroner's inquest has been opened and adjourned awaiting the completion of this review. A post-mortem took place in which the cause of death was found to be:

- Compression of the neck.

1.4 In accordance with Home Office guidelines to ensure confidentiality, pseudonyms have been used 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.

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

2. Review panel members

2.1 The following agencies/organisations/voluntary bodies have contributed to the Domestic Homicide Review by the provision of IMRs, Summary reports and chronologies.

2.2 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		Cambridgeshire Domestic Abuse and Sexual Violence Partnership (DASV) & IDVA Service

2.3 Thanks go to all who have assisted and contributed to this review with their valued time and cooperation.

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

4. Author of the Overview report and Chair

4.1 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.

4.2 She has completed several training courses including the Home Office online training, the Continuous Professional Development accredited AAFDA (Advocacy After Fatal Domestic Abuse) 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 in Chairing a Domestic Homicide Review and is on the register of accredited DHR/DARDR Chairs for England and Wales.

4.3 Mrs Dadd has completed and published several DHRs.

5. Terms of Reference

5.1 The Terms of Reference were discussed and agreed upon during the first panel meeting and was a working document throughout the review.

5.2 It was agreed that the main areas of focus and discussion would be based 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.

5.3 The full Terms of Reference are below:

- 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?

6. Summary chronology

6.1 Chloe grew up as the youngest child of three with her closest sibling being her elder sister, Becky who referred to her as the Tasmanian devil when she was younger. Chloe sadly lost her father to illness when she was ten years old.

6.2 Chloe lived on and off with her mother between boyfriends and had a history of depression on her medical records dating back to 2011. She had been medicated anti-depressants for this on occasions when she felt really down.

6.3 In 2018, Chloe disclosed abuse from her then boyfriend who she told the police that she had finished the relationship with. The police, GP and her family were aware and it was recorded as a vulnerable adult incident. The abusive relationship continued until 2019 when Chloe left him following him putting his hands around her neck.

6.4 In 2020, Chloe disclosed her anxiety to the Psychological Wellbeing Service as she had two previous consecutive mentally abusive relationships, difficulties in the workplace and was experiencing tensions at home with her mother. She was not offered a DASH risk assessment and later that year, re-started taking anti-depressants.

6.5 Keith was adopted by his parent's 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. 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.

6.6 Throughout his childhood, Keith had anger issues and showed aggression, being referred to the Child and Adolescent Mental Health Services (CAMH) with support being offered to his parents. He became known to the police for shoplifting and being involved in a fight at school with a weapon.

6.7 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-year-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." 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. There were two Early Help referrals during the summer of that year.

6.8 Keith suffered with mental health issues and disclosed to the CPFT Liaison and Diversion Service about him self-harming by cutting his wrist and chest previously with no intention to kill himself. He was still having conflict with his parents over the next few years in which they took a restraining order out against him and was also reported to the police by an ex-partner as he was sending a large number of threatening messages on social media for which a DASH was assessed as standard risk.

6.9 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.

6.10 Chloe and Keith began their relationship in the early months of 2023. During the March, Keith was arrested for attempting to incite a child for sexual activity and was interviewed and bailed. Becky states that Chloe was not aware of this and that Keith would not allow her to attend his court hearings and told her that it was to do with drugs.

6.11 Over the next two years, both Keith and Chloe had numerous contact and meetings with DWP with Keith attending Chloe's. He claimed carer allowance for caring for her which was granted although there was no Adult Social Care involvement. Chloe attended a wellbeing appointment online, accompanied by Keith.

6.12 Chloe and Keith both attended the doctors when needed and knew how to obtain medical support. Chloe was also accompanied to the doctors by Keith to ask about an ADHD assessment, stating that he had pointed out that she showed traits in her behaviour. CPFT were contacted by her GP and although the first steps were undertaken, Chloe never received an appointment as the waiting time for an ADHD assessment throughout the country is several years.

6.13 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.

6.14 Chloe's sister, Becky told the review how Chloe had been looking forward to starting a new job but Keith had told her, "I need you to stay here." He would constantly ring her whilst she was visiting her mother and insisted on attending the vets with her and her mother when the cat was put to sleep even though he had not met the cat. She would see her friends secretly when she was staying over at her mother's as she did not see them when she was with him.

6.15 In December 2023, Keith had been charged with attempting to incite a child to engage in sexual activity[1] and was bailed for a trial at Crown Court in February 2025. 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

[1] 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).

- 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.

6.16 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.

6.17 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.

6.18 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.

6.19 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.

6.20 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.

6.21 Officers had recontacted Keith's parents and went to see the 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.

6.22 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.'

6.23 "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."

6.24 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.

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

6.26 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 inked to a third-party and appeared to have been self-inflicted.

7. Key issues arising from the review

7.1 Chloe demonstrated confidence in accessing healthcare services and received timely medical attention when needed.

7.2 Throughout the timeline, various agencies interacted with Chloe and Keith, but opportunities to explore deeper relational dynamics and potential risks were sometimes missed. For instance, disclosures made by Keith were not fully explored in terms of their impact on relationships and emotional wellbeing. Similarly, Chloe's mother raised concerns about Keith but was not asked for specific details, which could have informed risk assessments more thoroughly.

7.3 There were moments where communication between services could have been more integrated. For example, Chloe's mother contacted police with concerns about her daughter's wellbeing while officers were already investigating Keith, but the two matters were not linked due to limitations in the information provided and procedural expectations.

7.4 Keith's background reveals a history of unmet needs during his youth, including limited access to sustained support services and adoption-related care. Records show frequent changes in social care workers and a lack of coordinated safeguarding responses, which may have contributed to ongoing challenges and behaviours in adult life.

7.5 Mental health services were accessed by both Chloe and Keith, but the system's structure—particularly around referrals and feedback—sometimes limited holistic understanding. For example, independent therapy access did not always result in updates to GPs or mental health teams, potentially affecting continuity of care.

7.6 There were documented disclosures and signs of controlling behaviour, yet coercion and relationship dynamics were not consistently explored in depth. Neighbours and family members later described concerning behaviours, but no formal reports of domestic abuse had been made, and police records did not indicate prior incidents. However, the absence of reports does not necessarily mean that abuse did not occur.

7.7 Overall, while many professionals acted with care and diligence, the findings suggest that a more joined-up approach across services—particularly in exploring relational risks, improving communication, and ensuring continuity of support—could enhance safeguarding and wellbeing outcomes.

8. Conclusions

8.1 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.

8.2 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.

8.3 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.

8.4 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.

8.5 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.

8.6 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.

8.7 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.

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

8.9 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.

8.10 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.
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8.11 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.

8.12 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.

9. Lessons to be learnt

National wait for ADHD assessment

9.1 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.

9.2 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.

9.3 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.

9.4 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.

9.5 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

9.6 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.

Disparity of provisions for mental health crisis

9.7 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).

9.8 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.

9.9 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.

9.10 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.

9.11 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.

9.12 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.

10. 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.'