



Safer Cambridge Community Safety Partnership

Domestic Abuse Related Death Review – Executive Summary

Diya: November 2022

Cherryl Henry-Leach, Independent Chair

Date report completed – 24th June 2025

Date Submitted to Home Office – 10th June 2026



Diya is described by a friend as *“beautiful – she was so kind and caring. Despite the...difficulties she had, she did not give up hope that she would be reunited with her child...If I had known I would never see her beautiful face, her smile, again I would have gone to her...we liked to eat together – I liked to cook for her because she needed to eat for strength. We would listen to music and talk. We...spoke the same language...she confided in me about her life...I wanted to support her, and I wanted her to heal, to have her child and a future...and [her] loss is indescribable.”*



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1. INTRODUCTION

1.1 On behalf of the Community Safety Partnership, the Chair and Panel express its sincerest condolences to the family of Diya and all who knew her.

1.2 The Chair and panel also express its gratitude to those that contributed to the review.

1.3 This review explores the circumstances leading up to the death of Diya. Diya was found at home, unexpectedly deceased, at the beginning of November 2022. It is understood that police officers attended Diya's home in Cambridge, following a call from a friend of Diya who was concerned for her welfare. After gaining access to the home, Diya was found deceased.

1.4 For ease of reference there now follows an outline of Diya's significant relationships:

Name and date of birth	Relationship to the review
Diya	Deceased
Adult 2	Diya's estranged spouse
Child 1	Diya's biological child
Adult 3	Diya's colleague
Adult 4	Diya's sibling
Adult 5	Diya's in-law

1.5 The review began on 6th September 2023 but a change in chair was required after this date and new chair needed to be commissioned. This resulted in a delay to the process and the current chair recommenced the review in early October 2023. IMRs were commissioned, but one agency delayed submission of their report until August 2024 – due to an administrative error during internal staffing transitions, the IMR was not allocated for authorship and once authored, the content of the IMR required extensive internal discussion prior to its submission.

1.6 There was also a need to raise a potential safeguarding matter in relation to Child 1 and await the outcome of discussions before the review could be progressed.

Other delays occurred due to:

- Information being shared with the Panel that Child 1, a year after the death of Diya was still unaware of Diya's death. At the chair's request, consideration was



undertaken by the relevant agencies as to whether or not this was a safeguarding concern and what the appropriate response to this situation ought to be. The review was paused whilst this took place.

- The need to meet with Adults 2 and 3 at mutually convenient times.
- Following a meeting between the chair and Adult 3, there was need to share information with policing colleagues to ensure his safety and the review was paused whilst this took place.
- The chair being advised that Adult 4 wished to meet with her and contribute to this review. Adult 4 did not respond to invitations to meet with the chair.
- One agency needing to clarify information shared within their IMR.
- The panel needing to consider Home Office feedback and resubmit the reports to the Home Office Quality Assurance Panel.

1.7 The review concluded on 10th June 2026, which is the date the reports were re-submitted to the Home Office Quality Assurance Panel.

2. INVOLVEMENT OF FAMILY, FRIENDS, WORK COLLEAGUES, NEIGHBOURS AND WIDER COMMUNITY

2.1 Adult 2 was contacted by the Chair on behalf of the panel. He was clear that he was not happy with the review being undertaken as this prolonged his grieving process. He declined to enable an introduction to Adult 5, and any opportunity for the Chair speak with Child 1¹ to prevent Child 1 being re-traumatised. Adult 2 did suggest that the Chair may wish to speak with Adult 4, and that Adult 4 would enable the introduction to other members of Diya's family. An email introduction and attempts to invite Adult 4 to contribute to this review were sent via the email address provided by Adult 1. This correspondence was not responded to.

2.2 Adult 2 also declined to receive information or support from Advocacy After Fatal Domestic Abuse.

2.3 Adult 3 contributed to the review and the panel is grateful for their tribute to Diya and input to this review.

3. INDEPENDENCE STATEMENTS:

- **Chair and Author of the Overview Report**

¹

[\[1\]](#) At the time of this interview, Child 1 was unaware of the death of Diya and was told by her family that Diya had gone to work away and this was why she was not in contact with Child 1.



- The Chair and author of this report, is independent of all agencies involved, has not been previously employed in this area, and had no prior contact with any family members. She has undertaken the Home Office online training modules in addition to attending and completing the accredited training for DHR Chairs and annual refresher training provided by AAFDA (Advocacy After Fatal Domestic Abuse). She holds the requisite skills as set out in the statutory guidance for the undertaking of Domestic Homicide Reviews², which includes her experience in relation to domestic violence and abuse, having been strategically and operationally active in this area of work for nearly three decades. Additionally, she holds two judicial appointments, supports regulatory activity in relation to social workers and is also an Independent Chair for a Domestic Abuse Board.
- The Chair was also supported by HOPE Training and Consultancy³, who have not been previously employed in this area and had no prior contact with any family members.
- The Chair also sought information and guidance from Karma Nirvana⁴ in relation to one point of information.

Review Panel Members

3.1 All Panel members were independent of any direct contact with the subjects of this DHR and nor were they the immediate line managers of anyone who had had direct contact.

3.2 The panel membership included specialists in line with the statutory guidance for this review and is set out below:

- Independent Chair
- Cambridgeshire Police (the Police)
- Health Independent Domestic Violence Advocate
- Daliah Project⁵
- Cambridge City Council
- Cambridge University Hospital (CUH)

² [Domestic homicide reviews: statutory guidance - GOV.UK \(www.gov.uk\)](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/612222/DHSC-Domestic-Homicide-Reviews-Statutory-Guidance-2020.pdf)

³ A national trainer delivering training on Forced marriage, “Honour” abuse and female genital mutilation. The Hope Training and Leadership CIC has also developed and delivers the first Global Majorities Professionals Leadership Program in the Domestic Abuse sector.

⁴ Karma Nirvana is a national leading charity that works to end Honour Based Abuse in the UK and has developed the national specialist Honour Based Abuse police risk assessment tool and has trained 26 police forces across England and Wales in use of this tool. Ms Rattu is also a qualified UK Barrister.

⁵ <https://www.dahliaproject.org/who-we-are/>



- Cambridgeshire and Peterborough Foundation Trust (CPFT)
- Education
- Children's Social Care (CSC)
- NHS Integrated Care Board (ICB) – Primary Care and Suicide Prevention

4. TERMS OF REFERENCE

Purpose of the review

4.1 The Statutory Guidance for the Conduct of Domestic Homicide Reviews outlines the purpose of a DHR process is to:

- Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims;
- Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result;
- Apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate;
- 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;
- Contribute to a better understanding of the nature of domestic violence and abuse; and
- Highlight good practice.

Temporal scope of the review and key learning

4.2 The terms of reference agreed by the panel enabled it to consider contact and involvement with Diya from 1st March 2016 and the end of the month in which she died. This confirmed that Diya was being supported in relation to her mental health.

4.3 The panel applied an intersectional lens to Diya's lived experiences throughout the chronological information it reviewed. Diya made many disclosures that she was experiencing difficulties, and deep shame, in relation to her separation, child contact, finances and housing. At times, these factors became overwhelming for her and significantly impacted on her mental well-being.

4.4 There was substantial evidence that indicated Diya was also acutely aware of the belief, expressed by others, that some of her behaviours were considered, by others, to



bring shame upon her family and community. The cultural expectations and gender norms demanded of Diya were also factors that most likely influenced her ability to seek or access support. This was reflective of the distinct cultural/structural barriers that Global Majority communities face in accessing support.

4.5 When Diya had contact with agencies, there was a lack of consideration that Diya may have been subjected to, and may have suffered, abuse, including coercive control, so-called honour based abuse, harmful practices, economic abuse or marital captivity. As this was not explored with her, there was no consideration of whether this linked to her mental well-being and health. This was underpinned by lack of professional/agency understanding and wider cultural awareness, that many Global Majority women in need of support may be impacted by notions of shame, secrecy and isolation as a result of abuse.

4.6 The panel noted that the following changes have taken place or are being progressed since Diya's death:

CUH Addenbrookes

- A copy of the child safeguarding referral is now shared with CUH child safeguarding team to ensure appropriate information sharing.
- Child Safeguarding team to ensure when required an alert is put on the child's CUH record.
- Consideration of DASH risk assessment training for ward-based staff.
- Review of CUH Domestic Abuse Policy and CUH staff DA policy to include reference to protected characteristics and the specialist support services available to patients and staff.

CPFT

- Services are now expected to acknowledge service users as parents and the impact their mental health/experiences will have on children and the ability to parent, even when not cohabiting.
- It is expected that, on each contact, service users' details are reviewed and updated when needed.
- There is also an expectation of CPFT Services to routinely document who is attending appointments with service user, acknowledging any barriers to completing any elements of a full assessment, including safeguarding/risk factors because of this.



- When contact is made by service user to FRS during working hours, and is open to another CPFT service, while it is appropriate for service users to be redirected to care treating team, records are now required to evidence professional liaison between teams to alert them to the contact and service users made aware of this. This allows for:
 - transparency with service users.
 - reduce responsibility on service user to make the contact.
 - ensure service users are receiving the right support at the right time.
 - reduce splitting between services and increase continuity for the service user.
 - This does not eliminate the need for FRS to react in emergency situations where risk is high i.e., immediate suicidality.
- All CPFT services are now expected to comply with the Trust DA policy and evidence how this is being done through routine/safe enquiries.
- Where suicidal thoughts are documented in service users' records, it is now required that there direct quotes of the thoughts to demonstrate understanding of the thoughts. This informs increased understanding of lived experience and also enables informed risk management.
- HBV and forced marriage to continue to be on the training agenda to all staff but bespoke training offered to those front-line services seeing service users for one off contact such as LPS, FRS and Crisis Team.
- Consideration is being given to how LPS assessments can be reflected in SystmOne records as service documents on different systems. This needs to include consideration for alerts.
- Discussions are underway to enable robust liaison between LPS and GP following assessment and discharging a service user where risk of DA is present, and a GP has potential to be link GP for whole family.
- When services are referring to another CPFT formal referral pathway and paperwork, it is now expected that urgency rating is agreed and reflected in handover documentation.

Workforce

- The Trust continues to ensure widespread awareness of domestic abuse issues amongst staff and to ensure that line managers are better aware on how to identify and respond to it and the support services available.
- The organisation is in the process of developing a Pre and Post Suicide prevention strategy and plan of implementation.
- All Staff were invited to complete free online suicide prevention training by Zero



Suicide Alliance and Mersey Care NHS Foundation to educate on the signs of when someone may be thinking about suicide and how to have a conversation with someone about suicide.

- Promotes White Ribbon Day on all staff bulletins to highlight the charity White Ribbon which is taking action against gender based violence. Communication includes sources of support and signposting to individuals within the organisation.

5. CONCLUSIONS

5.1 The panel concluded that the interactions led by professionals with Diya, in the main, did not fully explore if there was the prevalence of abuse in Diya's situation. The interactions also lacked a culturally competent response. Specifically, responses did not acknowledge the differences in cultures that presented in their discussions with her, how these differences may have been impacting on Diya, or how they needed to inform the support provided to her.

5.2 The panel agreed that Diya's case reminds us of the importance of ensuring culturally competent responses to an individual's wellbeing, including mental health, whilst focusing on their safety. By doing so, the panel concluded we can mitigate the risk of adverse impacts that can contribute to and/or result in someone making the decision to end their life.

5.3 In reaching its conclusions, the panel was cognisant of research that indicates that victims from global majority backgrounds may experience additional barriers to identifying, disclosing, seeking help for or reporting abuse. It agreed that this may have contributed to Diya being unable to view support as a realistic option for her and there was limited professional consideration that this could be the case.

5.4 The panel agreed that it can never be known if Diya, had she received formal support that was personalised to her intersecting needs, would have overcome the practical barriers she faced (e.g. access to suitable housing, economic support) and if this would have enabled her reunification with Child 1.

5.5 The panel express its sincerest condolences to all who knew Diya and are impacted by her loss of life.