Safer West Sussex Partnership

Domestic Homicide Review relating to the death of Emma

Overview Report

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Permission to publish has been granted by the Home Office

Contents

GLOSSARY

ABBREVIATION	DEFINITION
CIS	Criminal Information System
CME	Children missing education
CPS	Crown Prosecution Service
DA	Domestic Abuse
DHR	Domestic Homicide Review
IDVA	Independent Domestic Violence Advisor
LGBT	Lesbian, Gay, Bi-Sexual and Transgender
MARAC	Multi Agency Risk assessment Conference
MASH	Multi Agency Safeguarding Hub
MEOG	Multi -Agency and exploitation operational group
Niche	Police Record Management System
SCARF	Social Care Adult/Child Referral Form
SDAS	Serious Domestic Abuse Flag
SPFT	Sussex Partnership Foundation Trust
SR NHS HT	St Richards Hospital, Sussex University Hospitals NHS Foundation Trust
SWSP	Safer West Sussex Partnership
WSCC CSC	West Sussex County Council Children's Social Care
WSCC Education	West Sussex County Council Safeguarding in Education Team
WSCC	West Sussex County Council
WSCC CSCFRT	West Sussex County Council Children Social Care Family Resource Team

The Safer West Sussex Partnership and the DHR Panel wish to express their sincere condolences to the family and friends of Emma.

Pen Portrait

Emma was a kind, compassionate, fun-loving daughter who had an infectious giggle. Emma loved helping others, especially people with a learning difficulty and Emma was hard working. Emma was also a good mum. I miss her very much.

Sophie - Emma's Mum

Emma always had a smile on her face and was a free spirit. Emma never saw any wrong in anybody and she was also very resourceful. Emma loved her sisters and always offered to do things with them. My daughters miss Emma so much as I do.

Fred - Emma's dad

1. Preface

1.1.1 This Domestic Homicide Review (DHR) examines agency responses and support given to Emma (the victim), Emma's family and Ben (perpetrator), prior to Emma's murder in May 2018. The Safer West Sussex Partnership (SWSP) determined that the criteria for a DHR had been met under DHR Statutory Guidance 2016, in particular paras 5(1) and 18.

1.1.2 The review will identify any agency involvement and will also seek to understand the events leading up to Emma's murder, whether support was accessed within the community, whether there are identified gaps in provision and whether there were any barriers to accessing support. By taking a comprehensive approach, the review seeks to identify appropriate solutions to make the future safer.

2. Domestic Homicide Reviews

2.1.1 Domestic Homicide Reviews (DHR) became statutory under Section 9 of the Domestic Violence, Crime and Victims Act 2004 and came into force on 13 April 2011. The Act requires a review of the circumstances in which the death of a person aged sixteen or over has, or appears to have, resulted from violence, abuse or neglect by a person to whom they were either related, in an intimate personal relationship with or living with in the same household.

2.1.2 The Domestic Abuse Act 2021 defines domestic abuse as:

2.1.3 Behaviour by a person is "domestic abuse" if:

a. Persons involved are aged sixteen or over and are personally connected to each other, and
b. The behaviour is abusive.

2.1.4 Behaviour is "abusive" if it consists of any of the following:

- physical or sexual abuse
- violent or threatening behaviour
- controlling or coercive behaviour
- economic abuse
- psychological, emotional or other abuse

2.1.5 It does not matter whether the behaviour consists of a single incident or a course of conduct.

c. Economic abuse is any behaviour that has a substantial adverse effect on the victim's ability to:

- acquire, use or maintain money or other property, or
- obtain goods or services.

d. For the purposes of this Act, the perpetrator's behaviour "towards" the victim includes any conduct directed at another person linked to the victim (for example the victim's child).
e. 'Personally connected.'

2.1.6 For the purposes of this Act, two people are "personally connected" to each other if any of the following applies:

- they are, or have been, married to each other;
- they are, or have been, civil partners of each other;
- they have agreed to marry one another (whether or not the agreement has been terminated);
- they have entered into a civil partnership agreement (whether or not the agreement has been terminated);
- they are, or have been in an intimate personal relationship with each other;
- they each have, or there has been a time when they each have had, a parental relationship in relation to the same child.
- they are relatives.

2.1.7 The key purpose for undertaking a DHR is to enable lessons to be learned from homicides where a person is killed because of domestic violence and abuse. For these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each homicide, and most importantly, what needs to change to reduce the risk of such tragedies happening in the future.

3. Time scales

3.1.1 A notification of Emma's death was received by SWSP on 02 July 2021 and the Home Office were notified of a decision that a review would take place on 16 July 2021. Following the decision by SWSP that the circumstances of Emma's death met the criteria of a DHR the review began in December 2021 and concluded with submission to the Home Office in July 2023.

3.1.2 The Home Office guidance states that a DHR should be completed within six months of the initial decision to establish one. This timeframe was extended for several reasons;

- The extensive criminal investigation into the death of Emma
- Impact of Covid Pandemic
- Appeal process for the perpetrator
- To allow the family sufficient time to review the DHR findings, lessons learnt and recommendations with the support of the Independent Chair and the Police Family Liaison Officer who remained the family advocate throughout the trial and the DHR.

3.1.3 The DHR was commissioned by SWSP in accordance with the revised Statutory Guidance for the conduct of a Domestic Homicide Review published by the Home Office in December 2016.

4. Confidentiality

4.1.1 The detailed findings of each review are confidential. Information is available only to participating officers / professionals and their line managers. A confidentiality agreement has been signed by DHR Panel members at the commencement of the DHR and reconfirmed at the start of each Panel meeting.

4.1.2 This DHR has been anonymised in accordance with the statutory guidance. The specific date of the homicide has been removed, with only the Independent Chair and Review Panel members being named.

4.1.3 The following pseudonyms have been used to protect the identity of the victims, other parties, those of family members and the perpetrator.

Name	Relationship to Emma
Emma	N/A (Victim)
Ben	Boyfriend of Emma / perpetrator
Emma's baby	Emma's baby
Sophie	Emma's mother
Fred	Emma's father
Stepmother	Fred's wife and Emma's stepmother
Great Aunt	Emma's great aunt
Liz	Ben's previous girlfriend
Mary	Ben's previous girlfriend
Pam	Ben's previous girlfriend

4.1.4 Emma's family chose the pseudonyms for Emma and themselves and the DHR Panel chose the pseudonyms for the perpetrator and others involved in the review. Emma's baby is referred throughout as Emma's baby as the baby is adopted and therefore the DHR Panel felt it was not appropriate for anyone to choose a name.

4.1.5 Ben's previous girlfriends are included as they are relevant to the narrative of this DHR.

5. Terms Of Reference

5.1.1 Terms of Reference (TOR) were agreed by the DHR Panel, December 2021 and were regularly reviewed and amended as further details of events in Emma's life emerged. The full TOR are included in Appendix One. The DHR aims to identify the learning from this case and for actions to be taken from that learning, with a view to preventing homicide and ensuring that individuals and families are better supported.

5.1.2 The Review Panel was comprised of agencies from West Sussex as this was the area that the victim and perpetrator were living at the time of the homicide. Agencies were contacted as soon as the DHR was established to inform them it was taking place and that their participation was required and to secure their records.

5.1.3 At its first meeting, the Review Panel considered the initial scoping exercise undertaken by SWSP about agency contact with Emma, Emma's family and Ben. This indicated significant contact with Emma and her family over several years and that the review would cover the period 6 December 2011 until spring 2018 for Emma and her family and 18 November 2007 until spring 2018 for Ben unless there had been significant events prior to this. Significant events included engagement due to allegations of previous domestic abuse, mental health, other noteworthy medical issues and other wellbeing issues.

6. Key Lines of Inquiry

6.1.1 The Review Panel considered both the generic issues as set out in the DHR statutory guidance and identified the following case specific issues;

a. Awareness and understanding of professionals and also the wider community of the potential presence of coercive control and how this may have impacted on the behaviour of Emma and Ben.
b. Consideration of any equality and diversity issues that appear pertinent to Emma and Ben e.g. Femicide, men and women's roles in society, for example Ben did not accept any criticism of his behaviour.
c. Whether there were any barriers experienced by Emma or her family / friends in seeking support from professional service providers.
d. Whether there were any barriers experienced by professionals / agencies in offering support services to Emma.
e. To consider any agencies or wider community groups that had no contact with Emma and her family and whether helpful support could have been provided e.g. specialist domestic abuse services, housing/welfare benefits and if so, why this was not accessed.
f. Identification of any training or awareness-raising requirements required to ensure a greater knowledge and understanding of the impact of domestic abuse and availability of support services.
g. Impact of drug/ alcohol issues on the wellbeing of Emma and Ben.

h. Possible impact of trauma and possible neglect in Emma's childhood which may have impacted on her wellbeing and whether professionals/practitioners considered Emma's childhood experiences when assessing Emma's needs and support. Any support Children's social care provided to Emma, post adoption of her child.
i. To consider previous domestic abuse by Ben in his relationships and any interventions by agencies.
j. The impact of homelessness and access to welfare benefits for Emma including the difficulties of CSC and other agencies trying to contact Emma as she had no fixed address.
k. To consider any previous convictions and risk factors for Emma and Ben.

7. Methodology

7.1.1 Involvement of Family, Friends, Work Colleagues, Neighbours and the wider Community:

7.1.2 The statutory guidance for a DHR requires the SWSP to inform the family of the victim of the decision to conduct a DHR. A letter was sent to the family from the SWSP, along with the Home Office Family Guidance note and details of advocacy services.

7.1.3 The Independent Chair wrote to Sophie and Fred who said that they wished to engage with the review. The family was supported throughout the DHR by the Sussex Police Family Liaison Officer. The family had several face-to-face meetings with the Chair and have been regularly updated about progress of the DHR. They were provided with a copy of the Terms of Reference at the start of the review, and the Independent Chair, Police Family Liaison Officer met with the family to discuss the learning from the review, and they were provided with a copy of the draft Executive Summary. This approach was agreed as it considered the needs of Sophie and Fred. Sophie and Fred also received a final copy of the Executive Summary.

7.1.4 The Independent Chair would like to place on record her thanks to the Police Family Liaison Officer who facilitated the contact with the family and supported the family for over five years. This relationship ensured the family felt confident participating in the DHR and more importantly helped their voices to be heard.

7.1.5 The Independent Chair also spoke with Emma's great aunt who had supported Emma throughout her life.

7.1.6 The Independent Chair also contacted Liz, a previous partner of Ben, who initially said she was willing to speak as she had experienced domestic abuse whilst in her relationship with him. Despite contacting Liz several times there was no further response and the Independent Chair felt that it was not appropriate to make any further contact. Liz had already given valuable evidence in the criminal proceedings and that she may have felt she has contributed sufficiently to the process.

7.1.7 Contact with the Perpetrator - Ben:

7.1.8 The Independent Chair wrote to Ben via the Prison Governor and Ben initially confirmed that he would speak with the Independent Chair. A meeting was set up and the Independent Chair shared with Ben and his Offender Manager (OM) some areas to discuss at the meeting including relationships and substance misuse. Ben informed his OM that he had never had an issue with substance misuse or relationships but that he would meet with the Independent Chair to see what they had to say. The Independent Chair in discussion with the SWSP representative agreed not to proceed with a meeting as it was unlikely to fulfil the proposed purpose of understanding how agencies may have supported Ben.

7.1.9 To note that Ben had made two appeals to the Crown Prosecution Service about his conviction and on each occasion the appeal failed. Ben's Offender Manager has confirmed that he has now applied to the Criminal Cases Review Commission (CCRC). The CCRC provides an opportunity to individuals who feel they have been wrongly convicted or sentenced and have previously lost their appeals. The CCRC is the only body that has the jurisdiction to send a case back to an appeal court.

7.1.10 Statutory and Voluntary Agencies:

7.1.11 Each involved agency submitted an Individual Management Review (IMR) in accordance with the statutory guidance. Authors were independent of the incident and the reports were Quality Assured by the organisation. As the review progressed, additional agencies were identified who had contact with the family members and further information was requested. IMRs were received from:

- Sussex Police (the Police)
- West Sussex County Council Children Social Care (WSCC CSC)
- West Sussex County Council Education Dept (WSCC Education)
- Sussex Clinical Commissioning Group (CCG)* (now the Sussex Integrated Commissioning Board, the Sussex ICB)
- Sussex Partnership Foundation Trust (Mental Health support) (SPFT)
- Sussex University Hospitals NHS Foundation Trust
- Sussex Community NHS Foundation Trust
- Change Grow Live (drug and alcohol support CGL)
- Stonepillow (homelessness support)
- Arun District Council Housing Service

7.1.12 The DHR Panel has given detailed consideration and professional challenge to the IMRs submitted by agencies including inviting IMR authors to the second Panel meeting. This enabled the authors to be questioned directly by Panel members and allowed the authors to fully understand the DHR process and the interaction between agencies involved with Emma, her family and Ben.

7.1.13 At the third meeting of the DHR Panel the WSCC CSC IMR was reviewed and the new representative representing WSCC CSC felt that the IMR was not of a high

standard and requested the opportunity to review and submit a more comprehensive IMR. (To note that the new representative for WSCC CSC had no previous involvement with the preparation and sign off of the existing IMR). The IMR was subsequently reviewed and updated and was resubmitted in December 2022. The IMRs and additional information have contributed significantly to this DHR.

7.1.14 Further contact with agencies:

7.1.15 To support the DHR, the Independent Chair spoke directly with the following organisations to gather further information and to also understand the developments that have taken place to improve practice and support for victims of domestic homicide since Emma's death.

7.1.16 Stonepillow: Discussion around the partnership support for victims of domestic abuse and vulnerable adults, especially young people who have been supported by WSCC CSC.

7.1.17 West Sussex Children Social Care: Discussion around how the service supported Emma (or not), the Ofsted report 2019 and the new model of Children's Social Care in West Sussex, the 'Family Safeguarding Model'.

7.1.18 Changing Futures Programme: Discussion around the Pan Sussex system change programme focussing on improving the process for people experiencing multiple disadvantages including a journey mapping process for vulnerable people.

7.1.19 WORTH Specialist Domestic Abuse Service: Discussion of the training offer to agencies and professionals within West Sussex and for the Independent Chair to better understand the significant transformation of service delivery in West Sussex.

7.1.20 West Sussex County Council Community Safety and Wellbeing Communities Directorate: Discussion around the changes within West Sussex County Council; training provided, the Community Safety Partnership Development programme to support victims of domestic abuse and information around the wide provision of domestic abuse services by the third sector.

7.1.21 Arun District Council Housing Department: To identify the housing options changes that Arun District Council have implemented since the implementation of the Domestic Abuse Act 2021.

7.1.22 Document Reviews:

7.1.23 In addition to the IMRs and the interviews with agencies, other documents were reviewed including the SWSP DHR protocol, emerging DHR recommendations from other SWSP DHRs and the Changing Futures Programme.

7.1.24 *To note that Sussex Integrated Care Boards (ICBs) replaced Clinical Commissioning Groups (CCG) in the NHS in England from 1 July 2022. When

Emma was alive, the CCG was the commissioner of relevant health services and therefore the CCG is the reference throughout this report.

8. Panel Membership and Representatives

8.1.1 The Panel consisted of senior representatives from the following agencies.

Name	**Organisation**
Liz Cooper	Independent DHR Chair / Overview Report Author
Debbie Stitt	Independent DHR Coordinator
Emma Fawell	West Sussex County Council, Community Safety Lead Officer
Emma Heater (replaced by Helen Upton)	Sussex Police
Christine Impey (replaced by Sophie Carter)	West Sussex County Council Head of Safeguarding (Children)
Jez Prior (replaced by Sally Arbuckle)	West Sussex County Council Safeguarding in Education Manager.
Bryan Lynch	Sussex Partnership NHS Foundation Trust -Director of Social Work
Gail Addison	Interim Head of Midwifery -Worthing & St Richards Hospitals, Sussex University Hospitals NHS Foundation Trust
Monique Devlin	Safeguarding Adults Nurse Specialist - Worthing & St Richards Hospital, Sussex University Hospitals NHS Foundation Trust
Frank Ungani	Trust Senior Lead for Adult Safeguarding - Worthing & St Richards Hospital, Sussex University Hospitals NHS Foundation Trust
Georgina Colenutt	Sussex Community NHS Foundation Trust
Fiona Crimmins	Designated Nurse Adult Safeguarding - Sussex NHS Integrated Care Board (ICB)
Jayne Hardy	Regional Manager Domestic Abuse Services - The You Trust - Domestic Abuse Service
Hilary Bartle	Chief Executive Officer – Stonepillow
Claire Dyke	Arun District Council Housing Services
Katherine Wadbrook	CGL West Sussex YP & Families Service Manager-Change Grow Live, Substance Misuse Services

8.1.2 The panel met five times during the review. All meetings were virtual. The SWSP met to review the findings of the DHR and make comments relating to the report in July 2023 and agree the final report for submission to the Home Office.

9. Statement of Independence

9.1.1 The Chair and Author of the review is Liz Cooper-Borthwick, formerly Assistant Chief Executive at Spelthorne Borough Council in Surrey. Liz has a wide range of expertise including Services for vulnerable adults and children, housing, health, community safety, safeguarding and equality and diversity. Liz has conducted numerous Domestic Homicide Reviews for the Home Office and has attended Home Office Independent Chair training for DHRs and further DHR Chair training with Advocacy after Fatal Domestic Abuse (AAFDA). Liz has also been involved with several Serious Case Reviews and Safeguarding Adult Reviews. Liz has no connection with any of the agencies in this case.

9.1.2 DHR coordination and support was provided by Debbie Stitt who has worked in the Community Safety field for many years, including for local authorities and Surrey Police where she was a domestic abuse mentor. This is the 7th DHR in which she has been involved.

9.1.3 The Independent Chair wishes to thank everyone who contributed their time, patience, co-operation and challenge.

10. Parallel Investigations and Related Processes

10.1.1 **Criminal Investigation:**

10.1.2 Following a very lengthy criminal investigation into Emma's death, Ben was found guilty of smothering Emma and was convicted late June 2021. The sentence was life imprisonment with a minimum of 16 years. Ben appealed against his conviction twice with the last appeal in 2022. The appeals were not successful. Ben has made a further appeal to the Criminal Review Commission but the outcome as of June 2023 is not known.

10.1.3 **Inquest:**

10.1.4 Following the conclusion of the criminal trial and the murder conviction, a final death certificate was issued relating to Emma's death.

11. Equalities

- Emma was a heterosexual, white British woman, aged 22, no known disability and religion not known.
- Ben is a heterosexual, white British man, aged 29, no known disability and religion not known.

12. The nine protected characteristics of the Equality Act 2010 were considered (age, disability, gender re-assignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex/gender, sexual orientation). Sex/gender, pregnancy, age and disability are the characteristics which had an impact, and this will be considered later in this report.

13. Dissemination

13.1.1 The Overview Report, Recommendations and Executive Summary have been redacted to ensure confidentiality, with pseudonyms used for the victim, children, and family. The reports have been disseminated to the following groups:

- Safer West Sussex Partnership
- West Sussex Safeguarding Adults Board
- West Sussex Safeguarding Children's Partnership
- Domestic Abuse Commissioner for England and Wales
- Emma's family (Executive Summary)

14. Background Information - The Facts

15. The Homicide

15.1.1 Emma and Ben were camping. An argument was heard between them in the early hours of the morning in mid-May 2018. Neighbouring campers were woken around 6am to the sounds of Ben crying and counting as he 'performed' cardiopulmonary resuscitation (CPR), so the neighbours rushed to help. The neighbouring campers found Ben counting CPR compressions but not actually performing them. Emma was deceased and had blue lips. Paramedics arrived quickly after being called and confirmed that Emma had been dead for at least two hours as rigor mortis had already set in.

15.1.2 After a very lengthy investigation by Sussex Police, the Crown Prosecution Service (CPS) authorised a charge of murder and Ben was convicted in late 2021.

15.1.3 The main subjects of this review are:

DHR subject	Relationship to victim	Age at victim's death	Ethnic Origin	Disability Y/N
Emma (victim of domestic abuse and murder)	n/a	22 years old	White /British	Not known
Ben (perpetrator)	Perpetrator	29 years old	White/ British	Not known

DHR subject	Relationship to victim
Emma's baby	Daughter of Emma now adopted.
Fred	Emma's father
Sophie	Emma's mother
Stepmother	Emma's stepmother
Great Aunt	Sophie's Aunt and Emma's great Aunt
Liz	Previous girlfriend of Ben
Mary	Previous girlfriend of Ben
Pam	Previous girlfriend of Ben

15.1.4 Emma's daughter was removed from Emma's care in September 2016 and has had no contact with Emma or the family since that time.

16. Background information on Victim and Perpetrator

16.1.1 **Emma (victim):**

16.1.2 Emma became known to local services in Sussex in around 2009 having previously been living in Hampshire. Emma's mother, Sophie, was experiencing her own issues and was struggling to look after Emma, who was missing school. There were concerns for Emma's welfare as she was mixing with older men and was going missing from home as well as school.

16.1.3 It was agreed between Sophie and Emma's father (Fred) that Emma should stay with him. Fred and Emma and the family were to be supported by WSCC CSC and the Education Welfare Team.

16.1.4 Emma became a young mother with the birth of a baby in 2013 and evidence suggest that although Emma may have struggled at times looking after her, she showed some very caring support for her daughter. WSCC CSC were extensively

involved with Emma, Fred and his family and her baby. The baby was removed from Emma and the family into care in 2017, which left Emma devasted.

16.1.5 Emma led a transient life from 2016 up until she met Ben who appeared to provide Emma with what she may have felt was some stability.

16.1.6 **Ben (Perpetrator):**

16.1.7 Ben was known to several police forces due to a number of domestic abuse allegations from previous girlfriends, including incidents in 2011, 2013 and 2015. The incidents often happened during the breakdown in the relationship. Ben was charged with rape by a partner which proceeded to a Crown Court where he was found not guilty by a jury.

16.1.8 Evidence suggests that Ben was required to attend an alcohol awareness programme due to excessive drinking although Ben denied he had an issue with alcohol.

16.1.9 **Relationship between Emma and Ben:**

16.1.10 Although agencies were not aware of any relationship between Emma and Ben, her parents and Great Aunt were aware of the relationship and the family stated that Emma and Ben had become engaged prior to her death. Ben was living with his grandparents who lived close to Emma's paternal grandparents. At the time Emma met Ben she was homeless, had no money and was very vulnerable. In Sophie's words "Ben appeared to offer Emma a roof over her head, money and some stability, something which was missing from Emma's life."

17. The Chronology

17.1.1 Significant information has been made available for this review and the DHR Independent Chair has utilised the Social Care Institute for Excellence (SCIE) - Learning Together approach to identify the key episodes in the lives of Emma, her family and Ben in the lead up to Emma's murder.

17.1.2 The Key Practice Episodes (KPEs) are identified below and will be referred to throughout the report.

- KPE One: Emma's arrival in Sussex and involvement with agencies.
- KPE Two: Ben and allegations of Domestic Abuse with a partner.
- KPE Three: Deterioration in Emma's wellbeing including episodes when she went missing.
- KPE Four: Emma's pregnancy.
- KPE Five: Further Domestic Abuse by Ben
- KPE Six: Emma needing increasing welfare support.
- KPE Seven: Domestic Abuse Incident involving Ben.
- KPE Eight: Emma's baby being taken into care and a deterioration In Emma's mental wellbeing.

- KPE Nine: Emma and Ben in a known relationship (by family) and ongoing housing issues for Emma
- KPE Ten: Death of Emma

17.1.3 The information below has been drawn from a range of sources: the IMRs submitted by agencies (referenced where appropriate) and information from the family.

17.1.4 **KPE One:** Emma's arrival in Sussex and involvement with agencies:

17.1.5 Emma moved into West Sussex in October 2009 and became known to the Children Missing Education team (CME) as she was a child without any form of education provision. Her previous education authority shared information which stated that Emma's relationship with her mother had broken down and that there were concerns around Emma's engagement with education. Emma was placed on the register of a local school and the case was then closed by CME. Emma remained on roll until June 2013 when she ceased to be of compulsory school age. (Source: WSCC Education IMR).

17.1.6 In March 2010, West Sussex Children Social Care Family Resource Team (WSCC CSC FRT) became involved with Emma and Fred (with whom she was living), due to her poor school attendance. WSCC CSC FRT noted the good relationship between Emma and Fred and that they "worked as a team". In the same month there was a referral to the Sussex Partnership Foundation Trust from Emma's school stating that Emma was "vulnerable, insecure and needy". There was direct contact with Emma, but records did not indicate whether it was in person or by phone. (Source: SWCSC and SPFT IMR)

17.1.7 In March 2011, WSCC Education Welfare informed Fred that they would be applying to West Sussex County Council to request legal action due to Emma's poor attendance at school. It was decided that rather than prosecute the parent(s) under Section 444, Education Act 1996, there would be an application for an Education Supervision Order (CA 1989).

17.1.8 In May 2011, Emma was still not attending school fully, with reported episodes of missing from school and her whereabouts unknown. Emma would eventually return home, but WSCC CSC FRT transferred the case to the West Sussex Intensive Family Support Team with the recommendation that if "Emma continued to place herself at further risk a child protection investigation may have to take place". (Example of victim blaming language used in agency records).

17.1.9 A Child in Need (CIN) review meeting took place in September 2011, and it was noted that the relationship between Emma and Fred was much better, but that Emma was still struggling to attend school despite the school providing her with an increased support package. As part of the Education Support Order, Emma was required to have an attendance at school of no lower than 80%. Emma's school was providing a pastoral plan and therefore the agencies involved with

Emma agreed that there was no role for WSCC CSC, and the case was closed. (Source: IMR WSCC CSC and WSCC Education).

17.1.10 **KPE Two:** Ben and allegations of Domestic Abuse with a partner:

17.1.11 16 March 2011: Ben's then girlfriend (Liz) made a statement to Hertfordshire Police concerning the domestic abuse that occurred during her three-year relationship with him. Liz met Ben when she was 15 years old, and she ended the relationship in 2011. After this, Ben messaged Liz continuously and threatened to take his life and he persistently turned up at her workplace. This behaviour resulted in a Police Caution for Harassment (Hertfordshire Police). Liz's statement detailed being subjected to violent assaults, controlling behaviour, psychological abuse and harassment when trying to leave the relationship.

17.1.12 Liz described one incident when Ben tried to smother her with a pillow until she passed out. After the violence, Ben would then apologise but repeat the same again. Liz did see a text on Ben's phone to friends about killing her. This allegation was transferred to Sussex Police who carried out an investigation. The DASH form was initially graded High Risk by Hertfordshire Police but was downgraded by Sussex Police to medium due to the distance of travel for Ben. (Source: Police IMR).

17.1.13 Sussex Police stated that the DASH was downgraded to medium as Ben was no longer in the vicinity of Liz and was living 100 miles away.

17.1.14 March 2011, Ben approached Liz and engaged in a verbal altercation before grabbing her around the neck, resulting in reddening around the neck. Ben was arrested and interviewed about this incident, but no further action was taken.

17.1.15 There are no further details now available as limited details were transferred across to the Police Record Management System (Niche) from the Criminal Information System. The DHR Panel would want to remind all agencies that when a new information system is implemented in the future that sufficient information is transferred relating to domestic abuse incidents in order to identify the risks of a perpetrator of domestic abuse and possible future victims.

17.1.16 **KPE Three:** Deterioration in Emma's wellbeing, including episodes of going missing:

17.1.17 Fred reported Emma missing to the police on 21 February 2012. This was recorded on the Compact 18363 missing person database. According to the report Emma had gone missing from her home on four previous occasions. It was noted that Emma usually returned home a couple of days later but would not explain to Fred where she had been. The report was graded Medium Risk and Emma was found at her friend's address a couple of days later. The friend was six to seven years older than Emma and had learning difficulties. The friend had just moved into a new flat and Emma said she would be staying just one night

before going home. This indicated that Emma was interacting with older people. The Compact report relating to the incident with Emma also recorded three male names and addresses, one of which was Ben. There was no explanation on the report as to what the contact may have been, although a friend of Emma's did inform the police that Emma had a secret boyfriend. Emma did not disclose any domestic violence with her present boyfriend whose name she never shared and spoke positively about her relationship. (Source: Police IMR)

17.1.18 (Emma's family indicated that Emma did not start a relationship with Ben until much later in her life and therefore no further information is known about this "boyfriend" mentioned above).

17.1.19 Emma's school contacted the police at the same time, as it was reported that Fred no longer wanted Emma back and he was planning to move to another part of the country.

17.1.20 It was agreed with WSCC CSC that Emma could go to her Great Aunt for a few days and that the Great Aunt would try to help Emma resolve some of her issues with WSCC CSC and her family. WSCC CSC were told by the Great Aunt that Sophie (Emma's mother) had moved into the locality and that Emma wanted to live with her. The school identified concerns around this arrangement as Sophie had mental health and substance misuse issues, but Emma stated she did not want to go back to living with Fred. (Source: WSCC CSC, WSCC Education IMR).

17.1.21 When Emma returned home, she had a debrief with the police. No issues of concern or risks relating to Emma were raised. (Source: Police, WSCC CSC IMRs)

17.1.22 The police noted in their IMR that this incident took place prior to the awareness of County Lines and Child Sexual Exploitation (CSE). Today such an incident would include an investigation specifically around these issues.

17.1.23 Late March 2012, the Education Welfare Officer was concerned about Emma's attendance at school and the 39 Club and nobody was able to contact Fred. When Fred was finally contacted, he said he had had enough of Emma and wanted her taken into care. The Education Welfare Officer was concerned that the relationship between Emma and Fred was breaking down and there was no therapeutic work taking place. A professional was willing to work with Emma and Fred and it was also noted that Sophie had moved into the vicinity and Emma had mixed views on this. (Source: WSCC CSC IMR)

17.1.24 A Family Resource Team (FRT) care planning meeting took place late March 2012, with Emma and Fred attending along with key professionals. The FRT highlighted that there were concerns at the school about Emma's vulnerability in the community and her lack of attendance at school. Records described concerns about "Emma placing herself in vulnerable positions with no one knowing where she was, and she could have been at risk of exploitation". (Example of victim blaming language used in agency records).

17.1.25 Following the meeting, the case was transferred from Education Welfare to the Referral and Assessment Team for an initial assessment.

17.1.26 Records held by WSCC Education records relating to March 2012 state that Emma had left the care of Fred and was living with someone else and concerns were raised about her vulnerabilities and that she could be at risk of exploitation. (Source WSCC Education IMR)

17.1.27 The IMR Author WSCC Education highlighted that the case notes recorded did not capture the detail required in order to make an assessment of effective practice on the standards at the time. In addition, due to the professionals no longer being employed by WSCC, the author did not have the opportunity to have conversations to understand their perspective, both in terms of practice and guidance at the time and the training they had received to undertake their roles.

17.1.28 Since 2015 significant changes have been made in WSCC Education practice with the implementation of Keeping Children Safe in Education 2015 (KCSiE) (further updated in 2022) and the inception of the West Sussex Safeguarding in Education Team in 2016. The implementation of 'Keeping Children Safe in Education' (KCSiE) came after Emma's time in education, but it recognises exploitation and the need to protect victims of exploitation).

17.1.29 Late April 2012 an email was sent by the Referral Assessment Team to the Children and Young Person's Service highlighting the concerns relating to Emma. Emma had been living with her friend for some weeks and the arrangement was not working. One day Emma arrived at school wearing wet clothes. Dry clothes were provided to Emma, but Emma had not attended school for several weeks. The school did contact Fred who said Emma was not his problem. It was recorded on Emma's file that she was 15 years old and that her basic needs were not being met. (Source: WSCC CSC IMR).

17.1.30 In May 2012, Fred consented to WSCC CSC undertaking an initial assessment relating to Emma and key checks. A meeting took place at Emma's school along with her, Sophie and Fred as part of the assessment. Emma's non-attendance at school, college and the 39 Club were all discussed. It was agreed by all that Emma had no mental health issues and was just choosing not to attend the education establishments. Fred expressed his anger with Emma and that his health had been affected and that he wanted to give away his parental rights for Emma. Fred explained that he had tried to get WSCC CSC involved but nobody would listen. There was a lengthy discussion about Emma wanting to push boundaries and that when boundaries were put in place, Emma ran away. Concerns were raised about Emma's relationships with older men, and it was agreed that there would be a follow up with a health nurse. (Source: WSCC CSC)

17.1.31 Later in May 2012, Emma attended the 39 Club and said she had moved in with Sophie and things had improved. WSCC CSC wrote to the school, Education

Welfare Officer and 39 Club to state that they were closing the case. (Source: WSCC CSC IMR).

17.1.32 **KPE Four:** Emma's pregnancy:

17.1.33 Emma became pregnant in 2012, and there were concerns by WSCC CSC around Emma's vulnerabilities. Emma was 15 years old, and the baby's father was well known to WSCC CSC for drug use and a chaotic behaviour lifestyle. Emma visited her GP in September 2012 who confirmed her pregnancy. Emma was enrolled with the family nurse and smoking cessation programmes at the practice.

17.1.34 Early January 2013, Emma had a multi-agency Pre-Birth Planning meeting, and it was explained that she would be required to do a Pre-Birth Assessment. Emma was no longer attending school but was receiving five hours home tuition and would be taking some GCSEs. There were issues with the home tuition as Emma was spending some time with her father and some with her mother and therefore the home tuition did not always take place. (Source: GP and WSCC CSC IMRs).

17.1.35 25 March 2013, WSCC CSC met with Fred, and he said he was very happy for Emma and the baby to stay with him and his wife (Emma's stepmother) for as long as they wished. Fred said that Emma had changed and although it was not ideal for Emma to have a child so young, it may be the best thing for her as she has had to grow up. Fred confirmed that he was attending the FRT meetings and how useful they had been in having a good relationship with Emma. (Source: WSCC CSC IMR).

17.1.36 Late March 2013, following the birth of her baby, Emma continued with post-natal support. It was noted on Emma's records that she was living with Fred and her stepmother and receiving support from them. (Source: NHS FT IMR).

17.1.37 **KPE Five:** Further Domestic Abuse by Ben:

17.1.38 23 August 2013: Mary, Ben's girlfriend, contacted the police and told them she had been in a relationship with him for about six weeks. Mary was in a nightclub and Ben became verbally abusive to a male acquaintance and Mary told him to leave. At 4.30 am, Ben arrived at the address where Mary was staying. He was drunk and loud, so she let him in. Ben started to demand Mary's car keys and he said he wanted money. Ben followed Mary upstairs and pinned her on the bed. Mary was scared and bit him on the cheek. Ben became calm and then Mary tended his injuries and then took him to Accident and Emergency (A&E). Ben was arrested and denied attacking Mary. Mary told the police that he pushed her away as she was attacking him. A DASH was completed, and graded Standard and as there was no supporting evidence it was not possible to proceed with a victimless prosecution.

17.1.39 **KPE Six:** Emma needing increased welfare support:

17.1.40 October 2013: The Young Person's Advisor (Sussex YMCA), contacted the Child Access Point Team (WSCC CSC) as they had concerns about Emma and her housing needs. Emma and her baby had been living with both parents, but the relationships had broken down. Emma had run away and left the baby in the care of Fred and on another occasion, she had run away with her baby and was non-contactable.

17.1.41 The Young Person Advisor stated that the baby did have a social worker, but Emma did not. Emma was staying with her family until September 2013, when Emma allegedly placed the baby in danger by going missing with her. The baby was placed in the immediate care of Fred and Emma's stepmother. The Young Person Advisor stated that Emma had no support plan or advocate in place. (Source: WSCC CSC IMR).

17.1.42 20 October 2013, Emma's baby was suffering from croup and the emergency services were called and when they arrived, they found, Emma with her two younger siblings, the baby and no adult available at home. The baby was taken to A&E but there was no record of any treatment. (Source: NHS FT IMR).

17.1.43 30 May 2014: The Police were called by a witness who had viewed a man assaulting a woman in a house. The police attended and spoke to two individuals, believed to be Emma and Fred. Both admitted there had been an altercation but denied any violence and there were no signs of any injuries. Emma's baby and another child were present at the time. A DASH was completed and graded Standard risk and the police submitted a MOGP11 (Memorandum of Good Practice to Child Protection team and WSCC CSC (child to notice). (Source: Police IMR).

17.1.44 13 October 2014: Emma went to see her GP as she had kicked a wall in temper and had broken a toe. The GP sent Emma to A&E. The following day Emma attended A&E minor injuries unit with bruising to the right foot and Emma was given advice to elevate the foot and to take pain relief medicine. This incident may have indicated that Emma was anxious and struggling.

17.1.45 From late November 2014 Emma attended a weekly smoking cessation clinic at her GP surgery with two nurses. Emma was very motivated and engaged with the two nurses and they explored why Emma wanted to give up smoking (for health and family reasons), and what was stressing Emma at the time. Emma spoke about her baby being ill, and she was suffering dental problems. Later entries on Emma's notes expressed how positive Emma was and that the nurses and Emma spoke about strategies for going out with friends who may smoke and that she was looking for work.

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[1] Cases where children come to note of Sussex Police, they will submit a MOGP1 Memorandum of Good Practice to their child protection team and WSCC CSC assessment team. East Sussex MARAC Operating Protocol

17.1.46 Emma did have a good relationship with the nurses (continuity of care) but there is no indication that there was any routine enquiry by the nurses with Emma about domestic abuse. This may have been a missed opportunity to explore if Emma was experiencing any abuse in a relationship or in the home. The Independent Chair and the DHR Panel did seek assurance from the CCG/ICB IMR author that local General Practices have policies and procedures in place to ensure professionals/practitioners working within their services make a routine enquiry about domestic abuse with individuals and if a disclosure is made then appropriate signposting/ support can be implemented. This DHR has included an action in the CCG/ICB service recommendations for general practices to ensure that a routine enquiry about domestic abuse is embedded in professional practice. See section 8 of this report.

17.1.47 **KPE Seven:** Domestic Abuse Incident involving Ben:

17.1.48 3 April 2015: The police responded to a call from Pam (Ben's then girlfriend) who was outside Ben's address. Pam told the police she had been in a relationship with Ben for two months and that she wanted to end it and she had just told him. Ben then put a lot of tablets in his mouth which led to Pam phoning 999. Ben then spat out the tablets. Ben and Pam were spoken to, and Pam then went to stay with her family in another county. A DASH was completed and graded Standard risk. Later in the day, Pam informed the police that whilst at Ben's address, he continued to have sex with her when she said no. Ben was arrested and interviewed where he said the sex was consensual and that Pam instigated it. Ben was bailed with conditions and the Crown Prosecution Service (CPS) authorised a charge of rape.

17.1.49 19 April 2015: Ben breached his bail by sending a Facebook message to Pam. Although the message was not abusive, it did breach his bail and the police gave Ben words of advice. Ben was charged with rape but was found not guilty by a jury at a Crown Court in early February 2016.

17.1.50 **KPE Eight:** Emma's baby being taken into care and the deterioration in Emma's mental health:

17.1.51 Late March 2015, Emma was referred by WSCC CSC and completed a ten-week programme which included emotional wellbeing, unhealthy relationships at the Phoenix Centre (a centre providing support and information for young people in West Sussex). Emma was also referred to Find it Out Service and continued to attend the Young Parents Programme. Professionals commented on how well Emma engaged and how well she reacted with her baby.

17.1.52 At the same time a referral was made to WSCC CSC by a local nursery which Emma and her baby were attending as they were concerned that Emma was being excluded within the family home and not given the opportunity to be the primary carer for her baby. WSCC CSC made a Child Protection Visit that day and it was noted that Emma was out with a friend who lived next door. The social

worker visited the friend's house and was told by the friend's mother that Emma was not allowed to take her baby out unless she asked her father for permission. The friend's mother also alleged that Emma was looking after her siblings, doing the housework and cooking.

17.1.53 The social worker visited Fred, and he said he had consulted a solicitor about adopting Emma's baby as he felt that the baby was not safe with Emma as she had returned to drugs and prostitution. The social worker went back to the neighbour's house and Emma stated she was living with the neighbour as she had left her father due to arguments. Emma said she wanted to get her baby back but had no place to live. Emma was advised to make an application to Arun District Council's housing department. (Source; WSCC CSC IMR).

17.1.54 27 May 2015: Emma went to A&E with facial injuries, reporting that she had fallen over a stair gate into the kitchen resulting in large bruises. The practitioner advised Emma to use an ice pack and pain-relieving medication and a letter was sent to Emma's GP. The following day she went to see her GP and the GP noted that Emma had two distinct areas of bruising on her face, one on the forehead and a black eye. The GP sent Emma to ophthalmology for an immediate review of the injuries. (There is no evidence that the GP or practitioners in A&E considered the injuries as possible domestic abuse or that there was a routine enquiry, a missed opportunity).

17.1.55 Mid-May 2015, it was recorded by WSCC CSC that Emma had returned to live with her family following the above incident.

17.1.56 Early August 2015, Emma visited her GP stating that she could not sleep and told the GP that her baby had been removed by WSCC CSC. Emma was self-referred to counselling and the GP sent a letter to Sussex Partnership Foundation Trust (SPFT) to say that they had triaged her to psychiatry. The letter also noted a previous suicide attempt, but this was not coded on the notes, so it is not clear when the suicide attempt happened or what happened. (The IMR author noted trauma informed practice should have triggered an assessment and a possible support plan).

17.1.57 Emma attended A&E on 11 December 2015 intoxicated with alcohol and ecstasy (MDMA - Methylenedioxymethamphetamine). Emma was observed for six hours, had an electrocardiogram (ECG), blood tests, all of which were normal, and Emma was discharged, and a letter was sent to the GP.

17.1.58 In December 2015, the GP received a letter from A&E which highlighted that Emma had attended with alcohol intoxication, use of ecstasy and an infection. The GP treated the infection but there was nothing recorded around the substance misuse or whether any information or support was offered to Emma. (Source: GP IMR).

17.1.59 Between December 2015 and February 2016, the police received a report via the Resolution Centre from Emma's stepmother regarding abusive messages that she

was receiving from Emma. The messages were sent by social media and the content related to Emma's baby. Emma accused her stepmother of taking the baby away from her and not allowing access. At the time, the stepmother was caring for Emma's baby at the request of WSCC CSC. The stepmother did not want an investigation, so a SCARF (Single Combined Assessment of Risk Form) was completed and sent to WSCC CSC. The stepmother did inform the police that Emma was misusing alcohol and controlled drugs, and this was recorded on the SCARF. (Source: Police IMR).

17.1.60 April 2016, WSCC CSC held a legal planning meeting which identified that Emma's baby had been exposed to domestic abuse, abusive language, a hostile and aggressive home environment and it was agreed that pre-proceedings would start.

17.1.61 23 July 2016: Emma made an application to the local council to join the housing register in her own name stating that she was applying because she was homeless. Emma stated on her housing form that she had left her previous address (her father's) in January 2015 because of a violent breakdown in the relationship with others. Emma did not identify who she lived with or who the relationship breakdown was with. Emma explained that there were no health/medical needs and that she was not accessing any support. The housing application was cancelled after a renewal letter was returned as "addressee" gone away. (Source: Housing IMR).

17.1.62 Mid-August 2016, telephone calls were made by WSCC CSC to Emma to deliver the Pre-Proceedings Letter, but Emma could not be contacted. Late September 2016, Emma signed a Section 20[2] agreement for her baby to be accommodated by WSCC CSC. In June 2017 an Interim Care Order was granted for Emma's baby and following a Family Court Decision, Emma's baby was taken into care and then adopted. (It was noted by the IMR author that although there was no evidence on the file that social workers had any direct contact with Emma up until her death it was highlighted that she did attend Children Looked After Review meetings for her baby).

17.1.63 In March, July and August 2017, there were three incidents concerning "an" Emma, but the police could not confirm it was Emma or another Emma. The incident in March involved a phone call from a male friend of Emma's saying she had not turned up at his house. He was concerned for her as he had seen her drunk near a pier. The police operator ascertained there were no immediate safety concerns, Emma was called on her mobile number but there was no answer.

17.1.64 The second incident in July 2017, was a safeguarding concern from a support worker seeking advice regarding the behaviour of a homeless couple who were

[2] Duties of the local authority when a child is accommodated under section 20 of the Children Act 1989.

taking advantage of a resident with learning difficulties. It was stated that the couple were occupying the friend's bed, borrowing money and using bus passes and that the couple were involved with drugs. The support worker thought the name of the person was Emma. The report was flagged to the Neighbourhood Housing Team and the caller was advised to contact WSCC CSC. The incident in August 2017 related to a civil dispute between a man and Emma who owed him £50 and had not paid him back despite his requests.

17.1.65 On 9 August 2017: Stonepillow made a referral to Change Grow Live (CGL). The referral was a request to help Emma with abstinence as she had not used drugs for three weeks before the referral. It was highlighted that the substances that Emma was involved with were alcohol, cannabis, cocaine, MDMA/ecstasy and amphetamines.

17.1.66 CGL made attempts to engage with Emma by telephone and a centre where she was known to attend. Emma was deciding whether she wanted to be supported by the service and she met with a CGL recovery worker to discuss. The recovery worker began to complete the assessment with Emma which included a risk assessment and management plan.

17.1.67 **KPE Nine:** Emma in a known relationship with Ben (Family) and ongoing housing issues for Emma:

17.1.68 On 25 September 2017, Emma had changed her GP practice and visited her new GP for a mental health and substance misuse review.

17.1.69 Emma met her CGL recovery worker again 4 October 2017. Emma said she was in a new relationship and that it was going well and there was no mention of any domestic abuse. Emma told the recovery worker that she would often disengage with services when she was in a relationship. The recovery worker was concerned about this as Emma appeared to be influenced by others and found it difficult to implement boundaries which could put her in a volatile situation relating to drugs and alcohol. Emma did indicate that she would use cocaine to give her confidence in a male environment. It was also noted by the recovery worker that Emma's mood was lower since her baby was taken into care. (Source: CGL IMR).

17.1.70 Emma cancelled her appointment with the recovery worker in October 2017 and did not attend another on 7 November 2017. CGL were unable to make further contact with Emma so the recovery worker liaised with Stonepillow (early December 2017) and Stonepillow said that they would be meeting with Emma and would let her know she could contact CGL.

17.1.71 Emma did meet the recovery worker when she went to the Find It Out Centre and Emma was invited to the next drop-in session at the centre so they could have more time together. (Source: CGL and Stonepillow IMRs).

17.1.72 Emma made a further homeless application to the local council in early January 2018 because she was homeless on that night. The Housing Officer established that Emma had been sofa surfing after she had been asked to leave Stonepillow's hostel, where it was stated that "she had failed" to attend appointments.

17.1.73 Emma told the housing officer that she was suffering with depression and mood swings that would range from feeling good to suicidal. Emma also stated that there had been previous drug and alcohol misuse, but it was noted that this was not a problem now, and she was taking medication given to her by her GP for her anxiety. The housing officer considered the information available and did not believe that Emma was a priority need and therefore did not offer any emergency accommodation. Emma had confirmed that she had previously slept rough for a few days at a time. The question on Emma's housing option form relating to domestic abuse was crossed through as non-applicable (NA)

17.1.74 The housing options officer had the following tasks:

- To contact Emma's GP for further information relating to her health.
- To fast track her housing register application once Emma had submitted it.
- To notify Emma of any suitable accommodation that may be available.
- To confirm to Emma that her maximum local housing allowance would be £296 per month.

17.1.75 Emma was also given some tasks to help her application:

- To contact letting agents on the list provided, to try to source accommodation.
- To look at websites that offered house shares.
- To apply for Job Seekers Allowance (JSA).
- To supply some extra documents.

17.1.76 On 19 February 2018, Emma again visited the Housing department at Arun District Council to ask for temporary accommodation, but no further evidence had been provided to establish that Emma was a priority need. Emma was again advised to apply for JSA and to submit her application to join the housing register. The housing department made two referrals to supported housing projects (Stonepillow and Homegroup) but neither had any vacancies.

17.1.77 On 28 February 2018, it was agreed that CGL would send Emma a letter to encourage her to contact the service and that if they did not hear from her then the case would be closed. The letter was sent 12 March 2018 and the referral with Emma was closed 26 March 2018 following no further contact from Emma. Prior to the closure of the referral, contact was made by CGL to Stonepillow who informed them that Emma had moved to other accommodation, but it was not known where. (Source: Stonepillow IMR).

17.1.78 **KPE Ten:** Death of Emma:

17.1.79 Late spring 2018, Emma was found dead in a tent on a camp site and Ben was charged with her murder.

18. Overview

18.1.1 **Overview of information from Family and Friends:**

18.1.2 The family participated in the DHR review as they wished to support the process. Sophie and Fred met the Independent Chair separately, but each was supported by the Family Liaison Officer (Sussex Police) with whom they had built up an established and trusting relationship.

18.1.3 **Sophie:**

18.1.4 Sophie stated that Emma had a brilliant sense of humour, but she also suffered with anxiety. Emma loved helping people with learning difficulties and she loved a party and being with friends. Sophie explained that Emma began to change when she hit puberty, she loved her primary school but began to rebel at secondary school. Emma became involved with Children's Social Care, but it was not always clear to Sophie where to go for support. At the weekends Emma would go and stay with her great aunt who provided support to the family.

18.1.5 Sophie explained that she was unable to look after Emma as she had several issues, she herself was needing to deal with, and that is possibly what attracted Emma to Ben. At the time Emma met Ben she was very vulnerable, and Ben provided a home, food on the table and money.

18.1.6 When Emma's baby was taken away from Emma in 2017, Emma was lost, and it seemed no one was helping her. Emma was a good Mum; she loved her baby. Emma struggled to find somewhere to live, and her mental health was really suffering.

18.1.7 Emma became involved with Ben, and they would go drinking and Ben became angry, but they did not know what he was really like. Sophie spoke of Emma not seeing her friends as much after starting her relationship with Ben and he was very controlling about Emma's smoking.

18.1.8 Sophie concluded that Emma may have seen Ben as someone who could provide some stability for her.

18.1.9 **Fred:**

18.1.10 Fred described Emma as having a "heart of gold", but she would not listen. Emma had a generosity of spirit but was very stubborn and strong willed. "Emma was very resourceful and survived life despite what was thrown at her."

18.1.11 Fred was concerned about the relationship between Emma and Ben. Fred thought there was something wrong, that he (Ben) treated Emma like dirt and tried to control her.

18.1.12 This is an example of controlling coercive behaviour and identifies a need to raise awareness with the community about behaviour and warning signs of an unhealthy relationship.

18.1.13 Fred stated that he struggled to get the support he felt he needed from WSCC CSC. Social workers would change frequently and therefore it was difficult to build up relationships. Emma did struggle at school; she hated the structure and boundaries relating to school life. Emma did have a lot of friends and she enjoyed socialising. This seemed to stop when she met Ben.

18.1.14 When Emma's baby was born, both Emma and the baby lived with Fred, his wife (Emma's stepmother) and their children. Emma would leave the home and take her baby, and this did create concern for their safety. When the baby was taken into care, Emma was devasted. Emma said that "she would do anything to get her baby back." Fred stated that Emma was not provided with any support when the baby was taken into care and Emma was suffering acute anger and sadness at the loss of her baby.

18.1.15 Fred felt that the social workers were difficult, and that the family were being judged by professionals. It was felt by the family that nobody would listen, their voice was not considered.

18.1.16 Fred concluded that he loved Emma although they did not always see eye to eye. Emma needed help as a lot had been thrown at her through life. Fred also commented that he was not aware of what had happened to Emma's baby as there had been no dialogue with WSCC CSC since the baby was removed from Emma's care.

18.1.17 **Great Aunt:**

18.1.18 Emma's Great Aunt (maternal) engaged in Emma's life from a very early age. The Great Aunt describes Emma as "a person with a heart of gold, a caring helpful girl, a free spirit and a really lovely girl to know."

18.1.19 The Great Aunt spoke of losing her sister (Sophie's mum) when Sophie was quite young and therefore the Great Aunt took on a maternal role to support Sophie. Sophie became involved with alcohol and drugs, and this did impact on her mental health. Sophie met Fred and the Great Aunt spoke of how Fred was supportive of Sophie and was trying to help her. Sophie became pregnant with Emma and once born, Sophie and Emma stayed with the Great Aunt for a while so Sophie could be supported to parent Emma.

18.1.20 Sophie continued to struggle with her issues and the relationship with Fred broke down. Sophie tried to parent Emma, but it was very difficult for her and Emma. Emma would go to stay with the Great Aunt to provide some respite for Sophie but mostly for the Great Aunt to provide care and support to Emma.

18.1.21 It was agreed between Sophie and Fred that it would be best that Emma moved in with Fred as Sophie could not provide the parenting support that Emma needed. Fred and Emma were remarkably close but also very similar in their character, "very head strong", which did lead to arguments. Emma did help Fred and her stepmother with their children (Emma's half siblings) and enjoyed being with them.

18.1.22 When Emma signed the legal papers when her baby was taken into care, she was heartbroken but felt it was in the best interest of the baby.

18.1.23 Emma did introduce Ben to her Great Aunt. One day she brought him to the Great Aunt's house and when the Great Aunt and Emma were alone, Emma said "What do you think of him?" The Great Aunt responded that if Emma was happy then so be it, although the Great Aunt had concerns about Ben. The Great Aunt described Ben as being very controlling although she felt that to Emma he provided security, support and Ben's mother was also very supportive of Emma and they got on well. Emma's Great Aunt felt that Emma may have felt she was part of a family being with Ben and his family.

18.1.24 The Great Aunt described the social workers involved with the family at different times as particularly good and supportive but that when Emma reached eighteen, she "fell through the net" and there was no support for her even though she was still very vulnerable.

18.1.25 The Great Aunt confirmed that Emma and Ben got engaged just before her death. Although the Great Aunt still had doubts over Ben, she was pleased to see Emma happy and full of life.

18.1.26 Summary of Information known to the agencies and professionals involved:

18.1.27 Emma was known to several agencies and Ben had been involved with several police forces.

18.1.28 **Sussex Police IMR:**

18.1.29 Sussex Police had limited direct personal contact with Emma, although in 2012 Emma came to notice as a missing person on four or five occasions. There were a couple of further contacts with Emma and her family for incidents seen by neighbours and alleged theft of money by Emma from a vulnerable adult. There the police had no records of any reports of domestic abuse involving Emma.

18.1.30 Ben was known to Sussex Police for domestic abuse. The PNC record for Ben commenced with a police caution for the harassment of his partner at that time in March 2009. In November 2010, Ben volunteered to attend an alcohol diversion scheme to reduce the fine for being drunk and verbally abusive. Sussex Police received allegations of domestic abuse from three separate partners:

18.1.31 March 2011: An allegation of controlling, coercive behaviour (CCB) was made by a previous partner during the preceding three years.

18.1.32 August 2013: Another partner alleged assault after being in the relationship for six weeks.

18.1.33 April 2015: Another partner alleged rape and harassment after being in a relationship for two months. Sussex Police arrested Ben on each occasion who denied the allegations. Ben was charged with rape but was acquitted at Crown Court.

18.1.34 Sussex Police followed good practice and in 2013 following several incidents, Ben was identified as a Serious Domestic Abuse Suspect (SDAS) the Niche records were marked accordingly with a SDAS flag. This was in accordance with Association of Chief Police Officers definition of "An individual suspected of offending against two or more partners since April 2006". This should have alerted all staff dealing with Ben that there was a domestic abuse history and that this would be taken into consideration relating to domestic abuse matters. The existence of a relevant history after 2014 might have led to a request through the Domestic Violence Disclosure Scheme by a partner.

18.1.35 The police had no knowledge of a relationship between Emma and Ben and therefore were not able to offer any support to Emma. Sussex Police did respond to the incidents involving Ben to arrest and gather evidence in accordance with police policy. The IMR author identified that the investigations undertaken were to a good standard.

18.1.36 **West Sussex Children Social Care (WSCC CSC):**

18.1.37 WSCC CSC had a long history of involvement with Emma and other agencies including the police, education welfare and housing. Housing reported ongoing safety concerns for Emma's overall holistic care needs and identified that they were not being met.

18.1.38 The IMR author identified that threshold procedures were not activated for Strategy meetings or Section 47 enquiries, where joined up multi-agency working would have implemented agreed safety plans and review levels of risk with appropriate levels of intervention. A lack of comprehensive assessments, safety plans and a review of Emma's basic needs were never fully explored.

18.1.39 Emma went missing on several occasions and there appeared to be no exploration by CSC to understand Emma as a child or young person. There was a sense that there was no consideration of Child Sexual Exploitation (CSE), or any risk assessments carried out especially during the episodes when Emma was considered most vulnerable.

18.1.40 Emma did have a pre-birth assessment which would have been conducted to ascertain Emma's ability and capacity to parent on her own, but this was not on the file.

18.1.41 WSCC CSC ensured that Emma was engaged in parenting group sessions, they also supported Emma through a ten-week programme to keep safe, healthy and unhealthy relationships. It was noted that Emma "engaged brilliantly". Emma was also referred to Find it out Services. This helped Emma learn how to budget and how to understand children's behaviour.

18.1.42 The IMR author identified that CSC did not capture Emma's lived experiences and the levels of intervention by CSC appeared to be limited to do this. At certain points in Emma's life, she was exposed to risky situations. Emma appeared to suffer from low self-esteem, isolation and when her child was removed from her it is unclear what support was provided to Emma having to cope with this loss. It is important to highlight that that there has been significant progress between WSCC CSC and the police in the response to young people who go missing and a multi-agency approach to understanding the reasons for this in the risk to child sexual exploitation.

18.1.43 Emma's level of need was significantly high, and interventions were intermittent and not consistently provided, which therefore failed to capture a full picture of Emma's lived experience.

18.1.44 **West Sussex County Council Education - West Sussex Safeguarding in Education (WSCC Education):**

18.1.45 WSCC Education first encountered Emma in October 2009 when she came to the attention of the CME team as she was a child without any form of education provision.

18.1.46 Emma was enrolled in a local community college. The CME team identified Emma's potential welfare concerns. It was noted that she had moved to the area as the relationship with her mother had broken down and there were concerns around Emma's attendance at school. Emma was on the school roll until 2013 when she was no longer compulsory school age. Emma was given extensive support as she had a very turbulent time at school, in terms of behaviour and several internal and external boundaries. Details of these boundaries and how Emma was perceived to have breached them are not commented upon.

18.1.47 WSCC Education Psychology Service further supported Emma by providing catch up learning plans, and the appointment of a sixth form pupil as a mentor.

18.1.48 WSCC Education had several contacts with Fred due to her poor attendance at school which included the instigation of the legal process for failure to attend at school. WSCC Education identified potential neglect, physical abuse, domestic abuse within Emma's family home, being a young carer with extreme poor attendance at school and a potential risk of sexual exploitation.

18.1.49 The IMR author identified that the records relating to Emma did not capture details and therefore it was not possible to assess whether there were effective practice meeting standards at that time.

18.1.50 The IMR author identified the single biggest failing throughout was poor record keeping and especially concerning Emma's voice and her lived experience.

18.1.51 **Sussex Clinical Commissioning Group. (CCG) now the Integrated Commissioning Board (ICB since July 2022):**

18.1.52 Emma had over 50 GP consultations with two local GP practices, with the majority being for minor ailments. The IMR author noted that there was good engagement and continuity of care when she was seeing the practice nurses for smoking cessation therapy in 2014.

18.1.53 Emma moved surgeries at two significant points in her life; the first was after the birth of her baby and the second to another GP practice in 2017. This move was around the time Emma became involved with Ben.

18.1.54 The IMR author noted that despite other agencies having concerns for Emma at an early age, this was not reflected in GP records. Apart from a couple of brief notes on Emma's health records it is unclear what, if any, information the GPs had relating to Emma's historic risk and vulnerabilities.

18.1.55 Emma engaged positively with the practice nurses for her smoking cessation therapy as she was seeing the same professionals and was able to build up a positive relationship. Following this contact over three months, Emma did not see any clinician consistently and there was no documented analysis of "accumulating potentially risky behaviours and incidents either in the general practice or from external agencies". (Example of victim blaming language used in agency records).

18.1.56 The IMR author comments that the lack of documented risk assessment meant that it was not possible to offer proactive support to Emma.

18.1.57 **St Richards Hospital, Sussex University Hospitals NHS Foundation Trust:**

18.1.58 Emma was involved with SR NHS HT during her pregnancy with her baby. Emma was offered enhanced midwifery care due to her age when she was pregnant. The care was transferred across from Worthing to SR NHS HT when Emma was temporarily housed in Worthing. Emma continued to receive the same level of care.

18.1.59 Emma was referred to a Family Nurse Partnership and WSCC CSC. The records identified that Emma engaged well with all the maternity services whilst she was receiving maternity care.

18.1.60 **Sussex University Hospitals NHS Foundation Trust:**

18.1.61 The notes available did not identify any information regarding Emma's vulnerabilities or any concerning features regarding Ben.

18.1.62 The IMR author noted that it has been difficult to make any judgements on the attendance at A&E by Emma and Ben as the A&E system has been decommissioned and not transferred onto the new database.

18.1.63 Although Emma and Ben had contact with SR NHS HT, nothing was known about their backgrounds and any risks; therefore, there was not an opportunity to share information with other agencies.

18.1.64 **Sussex Partnership Foundation Trust (SPFT):**

18.1.65 SPFT had little involvement with Emma with the most recent involvement in 2015. The SPFT records identified that there was a response to the referral and that Emma was referred as appropriate, but SPFT felt that Emma did not engage.

18.1.66 **Change Grow Live (CGL):**

18.1.67 Emma engaged with CGL between September 2017-2018. She attended six out of ten appointments but some of the meetings did not last as long as the care worker hoped and therefore it was challenging to gather all the work. Emma did disclose that in 2017 that she was in a relationship which was going well but she never disclosed whether there were any issues with the relationship. Emma told her worker that when she was in a relationship she disengaged with agencies, and it was noted by the worker that Emma seemed to be influenced by others. The CGL recovery worker focused on Emma's drug and alcohol use in the one-to-one sessions and domestic abuse was not explored as Emma did not report any information to give the worker any concerns in relation to domestic abuse.

18.1.68 The case worker supported Emma in relation to alcohol and drug use reduction. Support was also provided to help Emma access mental health support from her GP by the case worker attending the appointment.

18.1.69 (The DHR Panel would like to highlight this support as good practice. Information within this DHR identifies that Emma responded well if she had a professional, she knew and had built up a relationship).

18.1.70 Since Emma's involvement with CGL there have been improvements to the CRiiS system to support workers to reflect conversations and risk in more depth. The new Service User Plan and Full Risk review modules are designed to support a worker to regularly update risk assessment and management plans.

18.1.71 **Stonepillow - St Richards of Chichester Christian Care Association:**

18.1.72 Emma was in contact with Stonepillow from July 2017 to December 2017 on several occasions as Emma was living within supported accommodation as she had presented homeless. Emma was evicted from the supported accommodation due to non-payment of rent. This was following warnings and

followed due process as part of the licence agreement. Stonepillow also made the referral to CGL for support with her substance misuse. Emma was not able attend her meetings with her support workers, although they supported Emma's aspirations to get back into sport and volunteering.

18.1.73 At the time of Stonepillow's contact with Emma there was not an electronic client management system in place. In 2019, an electronic system was introduced which now provides a full audit trail of contact and information about a client.

18.1.74 **Arun District Council Housing:**

18.1.75 Contact with Emma commenced in July 2016 in her name as she wanted to join the housing register as she was homeless. Emma stated that her previous address was the family home but that there had been a break down in the relationship. In January 2018, Emma made a homeless application. Emma's housing register application was managed online with letters being sent out. Emma had two face to face contacts when she was completing her homelessness application.

18.1.76 Arun District Council housing demonstrated good practice by signposting Emma to other housing options and helped her maximise her income.

19. Analysis

19.1.1 This analysis is based on information provided by Emma's family, the IMRs and any additional interviews as conducted by the Independent Chair. The analysis relates to the key lines of enquiry as detailed in the TOR and issues that have arisen in consultation with professionals. Where relevant this includes an assessment of appropriateness of actions taken (or not) and offers recommendations to ensure lessons are learnt by relevant agencies. The Independent Chair and the Panel are keen to emphasise that these comments and recommendations are made with the benefit of hindsight. It is also noted that Emma died over four years ago, and many agencies have already reviewed their culture, policies and procedures and learning around Emma's death which will hopefully improve support for victims of domestic abuse in the future.

19.1.2 From information provided, Emma was very vulnerable from a young age. Sophie spoke about her own experiences and challenges with mental health and addiction issues which meant that she sometimes struggled to support Emma as a child. When Emma moved to live with Fred, Emma was a teenager and struggled with understanding boundaries and her education attendance was suffering. What is clear from speaking with Emma's parents is that they clearly loved her and did try to provide support, but due to family circumstances this was not always possible.

19.1.3 Emma had a long history of involvement with agencies from a young age, mainly WSCC CSC, WSCC Education Services and the police. When Emma became

pregnant at a young age, health services, housing and substance misuse services also supported Emma.

19.1.4 Emma had episodes of going missing from home and then returning and not disclosing where she had been or who she had been with. This sometimes made it difficult for agencies to engage with Emma and provide the holistic support that she needed.

19.1.5 Emma was fifteen years old when she had her baby and was 17 years old when the baby was removed from her care. A traumatic time for any parent and Emma was also struggling with being homeless which created further difficulties for her, including an inability to support herself financially. When Ben came into Emma's life, she may have seen a roof over her head, someone to support her and someone to care for her.

19.1.6 Key Themes identified through the IMRs and discussion with professionals and the family:

- Domestic Abuse: physical and coercive and controlling behaviour/harassment.
- Lack of comprehensive assessments.
- Understanding of all Emma's vulnerabilities and a comprehensive approach to support her.
- Lack of support for Emma when her baby was removed from her care.
- Emma being exposed at a young age to sexual activities / abuse/ drug and alcohol misuse.
- Lack of understanding by professionals of Emma's lived experiences, hearing Emma's voice.
- The family and Emma being judged by agencies.
- Professional bias/unconditional bias.

19.1.7 Awareness and understanding of professionals and the wider community of the potential presence of coercive control and how this may have impacted on the behaviour of Emma and Ben:

19.1.8 Although there were no reported incidents of domestic abuse between Emma and Ben, and agencies had no knowledge that they were in a relationship, Ben had a history of domestic abuse including coercive control. Liz, Ben's girlfriend between 2007 and 2009, reported to Hertfordshire police that Ben had been controlling in their relationship. Hertfordshire Police gave a warning to Ben about his behaviour. Hertfordshire Police confirmed that the incidents were dealt with following procedures at the time, but the incidents now would be dealt with differently due to updated legislation. In 2013, another girlfriend, Mary, alleged assault by Ben. Following this disclosure, Ben was identified as a Serial Domestic Abuse Suspect and his Niche record was marked accordingly. The final allegation against Ben was made by Pam in 2015 with an allegation of rape and harassment in a relationship lasting two months. The police took appropriate action at the

time of the incidents, including an investigation of rape which resulted in an acquittal at Crown Court.

19.1.9 There was never any disclosure of domestic abuse between Emma and Ben and no agency was even aware of a relationship between them. It is not known whether Emma suffered any abuse with any of her relationships although she did visit her GP and A&E with injuries which could have been accidental or because of an assault.

19.1.10 Despite controlling and coercive behaviour becoming a crime in The Serious Crime Act 2015, some professionals and especially the wider community, do not understand domestic abuse in all its forms, which includes physical, emotional/psychological, (including stalking and harassment), verbal, sexual, and economic abuse.

19.1.11 The police, in their management of Ben and the allegations made against him, acted in the most appropriate way within the legislation at that time.

19.1.12 Emma's GPs could have been best placed to make a routine enquiry about any abuse that Emma may be experiencing but there was no documentation that any enquiry took place. Emma also had one to one contact with a CGL worker, who was supporting Emma to try to address her substance misuse. The DHR Panel have sought confirmation that routine enquiry about domestic abuse is embedded in professional practice. CGL's response confirms that their services routinely enquire at different stages throughout service user's engagement: at Triage stage, Personalised Assessment, Service User Plan and when completing Full Risk Review, routine questions are asked about witnessing or experiencing domestic abuse as well as fear of feeling threatened or unsafe in any relationships. Emma was also involved with midwifery/health visitor services during and after her pregnancy with her baby. There was no disclosure of domestic abuse by Emma during or after her pregnancy, but the DHR panel did request information about the policy and practice for Sussex Community NHS Foundation Trust. The following information was provided;

19.1.13 Sussex Community NHS Foundation Trust confirmed that at the beginning of engagement with a client and ongoing through any programme that relationships are explored. There are set times within the engagement for a pregnancy that domestic violence is explored, 20 weeks gestation, infancy 6-8 weeks and toddlerhood at 12 months. A domestic violence enquiry is also completed at the antenatal visit at 36 weeks and new birth post-delivery. All family nurses have specialist training around intimate partner violence, and they are encouraged to take every opportunity to speak about relationships whenever there is a concern.

19.1.14 GPs have an important role in the identification of domestic abuse. The Domestic Homicide Review Case Analysis (Sharp and Kelly, 2016) for Standing Together Against Domestic Abuse identified that GPs are well placed to identify victims of

domestic abuse through injury, mental health, depression and substance misuse and with perpetrators.

19.1.15 GPs are mostly likely to be the one contact with a victim of domestic abuse. What is important is that they have the skills to enquire about domestic abuse and that GPs are reminded about the importance of record keeping, ensuring a holistic picture can be established about the victim and the abuse that they may be experiencing.

19.1.16 Whilst Emma was pregnant and in contact with midwifery services, she received extensive support during her pregnancy due to her age. Midwives should discuss domestic abuse at the booking appointment and subsequent appointments unless it puts the person at risk. The IMR author (Sussex University Hospitals NHS Foundation Trust) identified that Emma did not disclose any domestic abuse and therefore no further support was offered. What has come to light during this review is the disparity between Independent Domestic Violence Advisers (IDVA) support between East and West Sussex acute care settings. Like GPs, health professionals are often best placed to enquire about domestic abuse and an IDVA would be able to provide better outcomes for victims of domestic abuse. The disparity should be addressed so victims of domestic abuse in Sussex do not face a "post code lottery" about the support they are given.

19.1.17 (An update of the developments around the support offered by the West Sussex acute care setting is detailed in section seven, Lessons Learnt).

19.1.18 With Emma's life experience, she may not have understood what a healthy relationship should look like. Emma was very vulnerable when she met Ben, she was homeless, had lost her baby, she may have felt that he gave her a home, perceived friendship and some money, something she needed at that time but whether the relationship was healthy is questionable. The family highlighted that Ben was always telling Emma not to smoke (although Emma tried to give up smoking when she was pregnant) and did not allow her to see her friends and tried to isolate her (examples of controlling behaviour).

19.1.19 WSCC CSC did provide an opportunity for Emma to understand healthy/unhealthy relationships through a structured ten-week programme which Emma attended and engaged well.

19.1.20 (An example of good practice by WSCC CSC and shows that Emma was motivated to try to improve her wellbeing).

19.1.21 Consideration of any equality and diversity issues that appear pertinent to Emma and Ben e.g. Femicide, men and women's role in society e.g. Ben did not accept any criticism of his behaviour:

19.1.22 Four characteristics seem pertinent to consider when reviewing why Emma was killed, gender, pregnancy, age and disability.

19.1.23 Gender

19.1.24 Emma was more likely to have suffered domestic abuse because she was a female. Research by the Office for National Statistics (year ending March 2020) stated that 2.3 million adults aged 16-74 experienced domestic abuse in the last year, of which 1.6 million were women and 757,000 were men.

19.1.25 Ben was more likely to be the perpetrator of abuse as a male. Women's Aid research identified that in 2019, most perpetrators were male (98%). Research also identifies those men are significantly more likely to be repeat offenders (It is known that Ben abused at least three females before murdering Emma).

19.1.26 Gender also played a role in Ben's behaviour. It was identified that Ben did not accept criticism about his behaviour, including his abuse of previous partners. Gender roles can be conceptualised as behavioural expectations based on biological sex. Traditionally for men to be masculine, they are expected to display attributes such as strength, power and competitiveness (discussed in this research). Ben may not have accepted criticism as he felt it was undermining his strength and power.

19.1.27 **Pregnancy**

19.1.28 Although Emma was not pregnant at the time of her death, it was well known to professionals that Emma was a very young mother who had, and was still experiencing, several traumas in her young life. Information provided within the IMRs indicates that Emma did try to improve her health whilst pregnant for example by regularly attending a smoking cessation programme. (Source: CCG IMR). Emma was offered support by health professionals during her pregnancy and was appropriately referred to the Family Nurse Partnership. Due to Emma's age, she was offered enhanced midwifery care and Emma did engage with the young parents antenatal and postnatal groups.

19.1.29 WSCC CSC also ensured that Emma was engaged in parenting groups, and it was observed that Emma was bonding very well with the baby and being very nurturing.

19.1.30 Emma had a contract with WSCC CSC with the plan that Emma and the baby would live with Fred. Evidence indicates that in October 2013, Emma's relationship had broken down with Fred and the stepmother and she had run away, once with the baby. The baby was assigned a social worker, but it would appear, despite Emma's age she may not have been given the holistic support she needed from agencies including WSCC CSC following the birth of her baby as a young person in her own right. WSCC CSC's focus was very much around the baby and there appeared to be very little support for Emma. When the baby was taken into care, the family stated that Emma was very distressed and angry and was desperate to get the baby back.

19.1.31 WSCC CSC IMR author noted that although social workers had considered Emma and the baby being offered a place in a foster placement or a residential parenting assessment unit, this was never progressed. This meant that Emma was never given an opportunity to care for her baby independently.

19.1.32 The University of Warwick and Refuge in their research, 'Domestic Abuse and Suicide', (Ruth Aitken and Vanessa Munro (2018)) identified in the research that children appeared to be a positive, protective factor for many clients involved with Refuge. For many mothers who felt suicidal, children were the main reason they did not act upon the suicidal thoughts. This research identifies the strength of the bond between mothers and their child and in Emma's case a very young mother. When Emma's baby was taken into care, Emma's needs and support should have been considered along with the needs and safety of her baby. There is no evidence to say that this happened, and Emma was left very vulnerable. In discussion with Stonepillow, they feel that with many of their very vulnerable clients there is a perceived lack of support when their child is taken into care, resulting in many entering relationships which are not healthy, for example relationships were the mother is being controlled and coerced.

19.1.33 The DHR Panel have identified a recommendation to try to increase support for vulnerable young women whose children have been taken into care.

19.1.34 **Age**

19.1.35 Emma was very young when she was experiencing domestic abuse in her relationship with Ben and when she died. Research by Safelives, "Safe Young Lives: Young People and Domestic Abuse" cited the Crime Survey for England and Wales (2015) that identified that in the age range of sixteen to nineteen year olds, 12.6% of girls/women had experienced domestic abuse compared to 6.6% of males. For the girls and women this was significantly higher than the next age category of ages (ages 20-24 years). The research also identified that young people including those under sixteen can experience all forms of domestic abuse, physical, controlling coercive behaviour, stalking, economic abuse and harassment and that the highest severity of abuse may be highest for young people aged thirteen years and above.

19.1.36 Since 2013, sixteen and seventeen-year-olds have been entitled to access adult domestic abuse services, the rate of referrals into such services is low compared to other age groups. For victims younger than sixteen, there is limited access to services.

19.1.37 Young people experience a complex transition from childhood to adulthood and Emma certainly did, she was homeless, lost her daughter into the care system and she herself left the support of the care system. Safelives identified that transition period can impact on behaviours and decision making, how a young person responds to abuse and how they engage with services.

19.1.38 Evidence identified as part of the review into Emma's life, was that she was experiencing abuse from older men and Ben, which included controlling, coercive behaviour. Due to Emma's age, services may not have been available to support her, or she did not know how to access such services. Professionals also need to be aware that age can create a barrier for disclosure of abuse and engagement with services.

19.1.39 **Disability**

19.1.40 Although Emma had no identified disability, Emma was very vulnerable due to her lack of education and traumas in her life including mental health and substance misuse. Emma and her family's lack of a formal education may have inhibited their ability to identify that Emma was experiencing domestic abuse and what support was available. Emma also experienced significant trauma when her child was removed from her care, and this impacted on her mental health which may have inhibited her seeking support.

19.1.41 Professionals need to understand that disability may be in many forms and that it can create a barrier for a person seeking support.

19.1.42 Whether there were any barriers experienced by Emma or her family/friends in seeking support from service providers?

19.1.43 Emma and her family were involved with many agencies throughout her life; Children's Social Care, the police, education, drug/alcohol services, health services and housing. Despite this, the family felt there were barriers to seeking support. The family felt that they were judged by professionals as Sophie had her own substance misuse and mental health issues and the police had several reports of issues relating to Fred.

19.1.44 It was documented by agencies that Fred may have had difficulty accessing information for several reasons, and that Emma's non-attendance at school could have inhibited her education and possibly impacted on the family's ability to seek information and support. This could have potentially marginalized the family even further from agency support.

19.1.45 People can be excluded from information as they may not have good literacy skills, are unfamiliar with the internet or may not have access to it. Many agencies only provide web-based information and contact is sometimes via the web through emails and forms. According to the National Literacy Trust, 16% of adults in England are considered functionally illiterate which can be very disadvantaged for social skills and can exclude people from information. Agencies should consider the needs of not only vulnerable victims but also vulnerable families when providing information.

19.1.46 Emma's homelessness and accommodation moves meant she changed GPs several times. This meant that continuity of care was compromised. Records were often slow to be transferred and information not always available. This

meant that a complete picture of Emma's needs was not available and therefore the appropriate support / signposting was not identified.

19.1.47 When Emma did have continuity of care, for example the same nurses supporting her smoking cessation course, Emma responded well and engaged. The nurses showed support, friendship and gave some boundaries to Emma. (Good practice).

19.1.48 During Emma's homelessness and housing support issues, Emma was also struggling with money management. Following Emma's contact with Arun District Council's housing department in January 2018, Emma was advised to apply for Job Seekers Allowance (JSA). Evidence highlights that Emma did contact the Department for Work and Pensions and made a claim for JSA but not until May 2018, but that Emma never pursued the claim further. Emma was murdered in May 2018 and therefore this would explain why no claim was made.

19.1.49 Arun Housing Options Team did give clear indication of Emma's housing allowance and advice/recommendations for sources of income such as JSA. This is an example of good practice.

19.1.50 Despite this support, Emma still struggled with debt and money. Emma was experiencing so much trauma, loss of her baby, being homeless, possible mental health issues, substance misuse, that trying to navigate financial support was difficult for Emma. There appears not to have been any signposting by agencies to any debt management support for Emma such as Citizen's Advice Bureaus (CAB) of which there are three centres in West Sussex. The CAB provides confidential advice to explain options for dealing with debt. Whether Emma would have been able to source such support could be questioned as she was so vulnerable, was involved with so many agencies, but the lack of financial support and the debt she was experiencing may have made her vulnerable to Ben. Ben was financially supporting Emma and keeping a roof over her head, feeding her and supporting her basic needs.

19.1.51 It was also felt that the focus shifted from Emma to her baby when it was born and therefore Emma was no longer seen as a vulnerable young person and her support needs were not supported. The IMR author, WSCC CSC identified that Emma's voice was not heard by WSCC CSC, there was no confirmation of any discussion between Emma and WSCC CSC professionals about Emma's lived experience, including attachment trauma, possible mental health concerns, loss of separation from Sophie, her mother and neglect from her family.

19.1.52 Whether there were any barriers experienced by professionals / agencies in offering services to Emma:

19.1.53 Several agencies identified a difficulty in engaging with Emma, due to her not being able to attend sessions. For example, Stonepillow stated that Emma was unable to turn up to meetings, SPFT tried to contact Emma following a referral in

2015 and CGL, when supporting Emma around her substance misuse were unable to contact Emma.

19.1.54 A further barrier for Emma was her engagement with GPs. Emma changed GPs at key points in her adult life, and this would have created a lack of continuity of care which may have meant that information was fragmented or missing and did not allow for an overreaching oversight of any identified risks. This underlines the need for the use of a template to code risk factors within primary care and a mechanism for managing those identified as high risk.

19.1.55 IMR authors highlighted that several professionals had recorded that Emma "did not attend" and therefore support was not available to Emma. Professionals need to ask, why is the person not attending and look at different ways of engaging with vulnerable people. Emma was very vulnerable, homeless, had no money, was experiencing mental health and substance misuse and may have been sexually exploited.

19.1.56 Following a DHR in East Sussex, SPFT made an agency recommendation to review its "Did Not Attend" policy to ensure that it responded more appropriately to support vulnerable adults.

19.1.57 Agencies involved with children and young people should consider their "Was Not Brought" policy as children usually rely on someone such as an adult to bring them to an appointment. This may have referred to Emma as she was under eighteen years old for many of the contacts with agencies.

19.1.58 Homelessness would have had an impact on agencies engaging with Emma. The impact of this is detailed later within this report in Lessons Learnt.

19.1.59 WSCC CSC and health professionals did identify that sometimes they felt that the family (Fred) put up a barrier to professionals engaging with the family and especially Emma. The Independent Chair spoke with Fred on this issue, and he stated, "he felt the family was being judged by professionals and that he struggled with this". Within the family there was evidence of substance misuse, mental health issues (Sophie), Fred had been involved in violence himself and was open and candid about this. Potentially the family dynamics may have influenced how professionals viewed and engaged with the family.

19.1.60 To consider any agencies or wider community groups that had no contact with Emma and her family and whether helpful support could have been provided. e.g., specialist domestic abuse services, housing/welfare benefits:

19.1.61 No agency had any knowledge of a relationship between Emma and Ben and there were no reported incidents of domestic abuse between them. The family were aware of the relationship and although Fred and Sophie identified examples of Ben trying to control Emma (stopping her seeing friends, and stopping her smoking, although Emma herself tried to stop when pregnant) it is not clear whether they saw this as abuse. The family were not aware of Ben having a

history of abusing his previous girlfriends which included controlling coercive behaviour.

19.1.62 There is a range of domestic abuse services within West Sussex with Worth Specialist Domestic Abuse Service being the main provider of support for domestic abuse victims. Worth Specialist Domestic Abuse Service offers a range of information and advice services in West Sussex. Services include Independent Domestic Abuse Violence Advisors (IDVAs) who to identify, assess and assist people at risk. The service is funded by West Sussex County Council and following a restructure in 2022, has three key components:

1. Integrated Front Door (IFD) - Domestic Abuse Hub - This team process all incoming referrals for victim/survivors referred into the service as part of the Children's Directorate. The hub team work closely with colleagues in the IFD to assess, safety plan, explore the current presenting risks, understand the impact of the abuse on both adult and child victim/survivors and identify the most appropriate ongoing support for the victim/survivor(s). Within this IFD team there are two specialist Independent Domestic Violence Advisor roles, a Young Person Independent Domestic Violence Advisor (YPIDVA) supporting victim/survivors aged 13-18yrs and a specialist Independent Domestic Violence Advisor working with the Resettlement Team supporting victim/survivors who are refugees, seeking asylum or have experienced forced migration.
2. The Family Safeguarding Team - Domestic Abuse Practitioners (DAPs) are co-located within the Family Safeguarding Teams across West Sussex within the Children's Directorate. DAPs provide specialist 1-2-1 and group support for adult parent victim/survivors identified to be at medium or high risk of current domestic abuse, with children open on a Child Protection Plan or Child In Need Plan.
3. Community Safety and Wellbeing Team - Independent Domestic Violence Advisors (IDVA) work across West Sussex as part of the Communities Directorate and provide specialist 1-2-1 support to identified high risk victim/survivors of domestic and sexual violence and abuse aged 16yrs and over. They focus on reducing risk, increasing safety and completion of tailored Individual Support and Safety Plans, working in close partnership with other agencies to support this. Within this team there are two specialist sexual abuse roles, an Independent Sexual Violence Advisor (ISVA), supporting adult victims of sexual abuse who have reported to the police and a Young Persons Sexual Violence Advisor (YPSVA), who supports victim/survivors of sexual abuse aged 13-18yrs who have reported to the police.

19.1.63 There are also several specialist domestic abuse services including Safe in Sussex, and others supporting specific, vulnerable groups such as older people (Hourglass), Black ethnic minorities (Hersana) and My Sisters' House, Arun and Chichester Women's Centre. My Sisters' House support a population of

vulnerable women who have a history of physical, emotional, sexual abuse, drug and alcohol addiction, trauma and mental health problems. They also offer support to the Lesbian, Gay, Bisexual and Transgender community (LGBT). My Sister's House may have been able to support Emma who had multiple needs if she or her family had been aware of the organisation.

19.1.64 The wider community does not always understand how to navigate information around specialist domestic abuse services, whether it be local or national. If Emma was being abused by Ben, then due to some of the barriers already described they may have struggled to obtain information and support. It is therefore important that information is provided in different formats e.g. not just web-based information but that agencies and professional working with families also sign post to such services.

19.1.65 Identification of any training or awareness-training requirements to ensure a greater knowledge and understanding of the impact of domestic abuse and availability of support:

19.1.66 Evidence indicates that there is a wide training offer in West Sussex for professionals including the third sector. Worth Domestic Abuse Services offer training to domestic abuse practitioners, IDVAs, professionals with the Multi Agency Safeguarding Hub (MASH) and the Family Safeguarding Service. Training programmes curriculums vary according to need but include basic domestic abuse awareness, key indicators, safety planning, impact of domestic abuse on children, DASH and MARAC referrals. West Sussex Community Safety and Wellbeing Directorate offer a complimentary training offer which is subject informed for example young people and domestic abuse, trauma and domestic abuse.

19.1.67 Health IMR authors (Hospital Trust and CCG) identified a need for a more coordinated training programme for health professionals, which should form part of a wider Domestic Abuse Strategy for acute care.

19.1.68 It is good practice to see that training is offered in specific subjects such as young people, but this review highlights the importance of an understanding by professional and the wider community of the homicide timeline. Although only the family were aware of the relationship between Emma and Ben, some of Ben's behaviours and actions were consistent with the homicide timeline for example; relationship dominated by coercive control; Ben not allowing Emma to smoke; cutting Emma off from family and friends; in previous relationships, threatening suicide when a relationship ends; relationship developing quickly with Emma and Emma being dependent on Ben for her basic needs.

19.1.69 Some training and awareness relating to the Homicide Timeline has been offered in West Sussex to specific professionals and there is an acceptance that the training offer should be expanded to include a wider range of professionals and that there should be a wider awareness campaign for the community.

19.1.70 Impact of drug/alcohol issues on the wellbeing of Emma and Ben:

19.1.71 It has been well documented that Emma (drugs and alcohol) and Ben (alcohol) had issues with substance misuse at some point in their lives. Emma did engage with Change Grow Live to help address her substance misuse. She disclosed a new relationship to the CGL worker and stated that she tended to disengage with services if she was in a relationship. The CGL worker noted that it seemed that Emma was influenced by others, and it was difficult for her to implement boundaries which meant she ended up in volatile situations. Emma said she needed to take drugs to give her confidence in male company. This would indicate low self-esteem and further impact on Emma's wellbeing.

19.1.72 It has been identified that Emma mixed regularly with older adults including males. It is not confirmed whether this was related to drugs or relationships. Emma presented to her GP with a sexually transmitted disease in 2013 and this could have indicated sexual exploitation.

19.1.73 Child Exploitation did not become law until 2017 and it states that children and young people in sexually exploitive situations and relationships can be persuaded to perform sexual activities in return for gifts, money or drugs.

19.1.74 The impact of Emma taking drugs and alcohol meant that she was placed in risky situations, and this could have impacted on her mental and physical wellbeing.

19.1.75 Ben also had issues with alcohol, and he voluntarily participated in an alcohol awareness programme but there is no information to say he took drugs, and it was highlighted that he was "fanatically anti-drugs". There is well documented evidence that alcohol and domestic abuse are linked. The World Health Organisation (WHO) estimates that 55% of domestic abuse perpetrators were drinking alcohol prior to an assault. Alcohol can change a person's behaviour, make them more confident and make them more aggressive. Evidence within the review identifies that Ben committed domestic abuse and that he also had an issue with alcohol.

19.1.76 Possible impact of trauma and possible neglect in Emma's childhood which may have impacted on her wellbeing and whether professionals/practitioners considered Emma's childhood experiences when assessing Emma's needs and support:

19.1.77 When Emma moved to Sussex, WSCC CSC, the police, education, health and housing were all involved with Emma. Prior to Emma's arrival in Sussex, it was documented that she was not attending education and potentially she was caring for her mother who had mental health and substance misuse issues. Emma was never considered a young carer at that time which may have had an impact on Emma. It was recorded in December 2012, when Emma was pregnant, that she had been smoking from the age of ten years. Emma arrived in Sussex as it was difficult for her to continue living with her mother due to the issues her mother was experiencing.

19.1.78 Emma lived with her father and his wife and children who tried to provide a safe environment for Emma but there were arguments with her father which led to Emma running away on several occasions. Emma appeared to suffer low self-esteem, she engaged little in her education and therefore her life prospects seemed low.

19.1.79 The WSCC CSC IMR author identified that Emma's overall holistic care needs were not met. Evidence suggests that no one ever sat down with Emma to hear her voice, what she had experienced and what support would help her. Words such as 'Emma's safety in chaos, uncertainty and anxiety' are detailed in the IMR.

19.1.80 A housing advisor for Sussex Central YMCA reported concerns about Emma to WSCC CSC. The worker stated that there was no support plan or advocate in place to support Emma who was experiencing significant trauma as her relationship had broken down with both parents and she was becoming more withdrawn. Emma was being exposed to Sophie's substance misuse and although Emma's baby had a social worker Emma did not. (Good practice by the YMCA housing advisor).

19.1.81 Threshold procedures were never activated for Strategy meetings/S47 enquiries where a joined up multi-agency meeting would have taken place which would have implemented an agreed safety plan and appropriate levels of intervention.

19.1.82 In 2015, West Sussex CC CSC had an Ofsted (Office for Standards in Education, Children's Services and Skills) Inspection, (a statutory inspection) which was critical of the service being provided at that time. It stated that there were widespread and serious weaknesses in the provision of services to support, protect and care for children in West Sussex. Although this inspection took place several years after Emma and her family were involved with the service, some of the issues highlighted in the inspection report resonate with what the IMR author highlighted, such as Emma's lived experience not being explored, lack of assessment of risk when Emma went missing, the many different social workers in Emma and the family's life, thus creating a difficulty in building up a relationship and the lack of support for Emma when she was homeless.

19.1.83 There was a further Ofsted Inspection in 2019, which again highlighted the need for improvement but monitoring visits have taken place since 2019 by Ofsted in October 2020, May 2021, March 2022. The March 2022 Inspection letter highlighted that the voice of the child/young people are being heard and responded to. A full Ofsted inspection took place in April 2023, and although the overall Inspection grading was Requires Improvement, in relation to this DHR and of reassurance to the DHR panel and partners, Ofsted has identified that through improvement work;

- The domestic abuse hub within the MASH ensures a timely and comprehensive response to children and their families where domestic abuse is a concern.
- The oversight and response to children when they go missing has been strengthened since the last inspection. Comprehensive performance information is used effectively to provide managers with oversight of children who go missing and ensure appropriate actions are taken when situations escalate.

19.1.84 What support Children Social Care provided to Emma, pre and post adoption of her child?

19.1.85 Emma's family have spoken about how much she loved her baby. Whilst pregnant Emma was looked after by a young parent midwife who saw Emma at home for antenatal care. Emma's GP supported Emma through her pregnancy and offered smoking cessation practices. WSCC CSC supported Emma with a programme following the baby's birth. Education also supported Emma during her pregnancy with home tuition. Emma's baby was allocated her own social worker when she was born but Emma did not have an allocated social worker. Emma stayed with her father Fred and her stepmother when the baby was born. The social worker had concerns that the stepmother was getting very close to Emma's baby and that Fred, and the stepmother could be quite controlling of her care, but it was highlighted that the baby was thriving (IMR notes). There were a couple of incidences where Emma left the family home including once with the baby and no one knew where she had gone. Emma contacted the ambulance service one evening as the baby had croup, on arrival the ambulance staff found Emma, her baby plus two younger siblings alone in the house as Fred and the stepmother had gone away, although a family friend was with Emma.

19.1.86 The IMR author (WSCC CSC) highlights that it was surprising that a Pre-birth Conference was not held prior to Emma giving birth and that a legal planning meeting was not held when Emma was disappearing and leaving her baby in the care of Fred and the stepmother. The pre-assessment/conference would have identified Emma's ability and capacity to parent her baby and identified what support would enable Emma to parent in the most appropriate way possible.

19.1.87 The family have stated that Emma was devasted when the baby was taken into care. In the words of Fred, "Emma said I am going to fight to get my baby back." The reasons for the baby being removed from Emma and her family were not clear; and any information has been recorded on Emma's baby's file which is restricted.

19.1.88 The decision to remove Emma's baby and a placement for adoption would have been made by the family court. The decision would have been made on the evidence provided by agencies such as WSCC CSC, health and the police and a solicitor would have acted on behalf of Emma's baby and another solicitor on behalf of Emma.

19.1.89 Although the court made the decision relating to the removal and adoption of the baby, Emma was a very vulnerable young person when the baby was taken into care, with no secure base, loss and separation from her own mother, low self-esteem and lack of trust with agencies. The impact of being judged an unfit parent will have only increased Emma's vulnerabilities. It is therefore important that agencies should have considered what support Emma may have needed.

19.1.90 The Panel welcome the WSCC CSC agency recommendation that when a young person becomes pregnant and that it is evident they do not have support of their family or there is the evidence they are vulnerable and at risk of child exploitation, substance misuse etc. an Initial Child Protection Conference should be considered as this would be a multi-agency approach. The Child Protection Conference should ideally be prior to the birth so that a multi-agency safeguarding plan is in place to support both the young person and the baby.

19.1.91 Professor Karen Broadhurst at Lancaster University carried out research in 2017 which uncovered that those women who had troubled childhoods and became pregnant in their teenage years, struggled with parenting, due to limited family and professional support and emotional difficulties resulting in the trauma of their childhood. The research also identified that when a child is taken away into care that mothers experienced a sense of grief, loss and isolation. Suicidal thoughts were common, and, in most cases, women described self-harming behaviours such as excessive drinking, drug taking and negative intimate relationships. The women interviewed for the study stated that they were constantly unable to access psychological help following the removal of their children. The research did identity that several of the women involved in the research had made positive progress in their lives, including simply "growing up" as many were teenage mothers. The research identified that professionals had a major role to play where they could provide early, consistent and empathetic help for vulnerable women.

19.1.92 Emma's childhood experiences, her vulnerabilities and her welfare would reflect many of the women's experiences in the research above. Sadly, Emma did not have the opportunity to "grow up" due to her death.

19.1.93 West Sussex County Council (WSCC) made the decision to redesign its support for children and young people and to follow a Family Safeguarding Model which was first implemented in Hertfordshire County Council. The focus of the model includes:

- Working in partnership with families instead of "doing to" families
- Enabling children to stay with their parents and/or wider extended family.
- Enabling families to develop their own care plan to address their child's needs.

19.1.94 Family Support Teams include social workers along with domestic abuse practitioners, mental health and substance misuse specialists. Research

identifies that the main risks for children are domestic abuse, substance misuse and mental health issues: all were relevant to Emma.

19.1.95 The key interventions in the WSCC model of family safeguarding are;

- Structured parenting assessments.
- Parenting programmes tailored to different age group of children.
- Treatment programmes for perpetrators of domestic abuse (including impact on children).
- Treatments and recovery programmes for victims of domestic abuse (including impact on children).
- Programmes to promote children's resilience.
- Drug and alcohol recovery programmes.

19.1.96 This model of delivery which is still in the process of becoming fully functional, could have provided Emma with the support that she needed to parent as a young mother and therefore the need for Emma's baby to be taken into care may have been avoided.

19.1.97 To consider previous domestic abuse by Ben in his relationships and any interventions by agencies:

19.1.98 There were three known incidents of reported domestic abuse by Ben as identified in KPEs Two, Five and Seven. When Ben was in his relationship with Liz in 2008, she was aged fifteen. Liz then ended the relationship three years later, Ben would constantly message Liz and threaten to take his own life. Liz detailed to the police his violent assaults, controlling behaviour and psychological abuse and harassment when she tried to leave the relationship. He allegedly smothered Liz until she passed out and made verbal threats to kill her. Examples of perpetrator behaviour - stage 3 of Jane Monkton Smith's DHR Timeline). At the time, Hertfordshire Police issued a police caution of harassment to Ben.

19.1.99 The DASH form was initially graded High risk but when the case was transferred to Sussex Police it was downgraded to a Medium. Ben denied the offence, there was no medical evidence to support Liz's account and all of Ben's family and friends supported his account.

19.1.100 Sussex Police did downgrade the DASH form from High risk to Medium as they felt that the distance of travel between them reduced the risk. Today, distance of travel would not be relevant as abuse can be emotional, stalking and with the common use of social media.

19.1.101 Information provided by the Metropolitan Police and Hertfordshire Police identifies that the various incidences involving Ben and his partners were dealt with appropriately at the time but now would be dealt with very differently. At the time of the incidents, controlling coercive behaviour had not been identified as a crime, (Section 76 of the Serious Crime Act 2015) nor had non-fatal strangulation, (Domestic Abuse Act 2021).

19.1.102 In 2013, Mary told the police that she had only been in a relationship with Ben for six weeks when he became abusive to one of her friends at a nightclub. Ben was very drunk, and he then visited Mary and her house early in the morning and demanded her car keys and cash. Ben pinned Mary to the bed, and she bit him. Mary considered the relationship had ended and therefore did not want to support a prosecution. A DASH was completed and assessed as Standard.

19.1.103 The last reported incident of domestic abuse to the police was by Pam. Pam phoned the police as she had told Ben that she wanted to end the relationship. He had responded by taking tablets. When Pam phoned 999, Ben spat the tablets out. Pam informed the police that Ben had continued to have sex with her against her consent. When Ben was challenged, he stated it was consensual. Ben was charged with rape but was acquitted at Crown Court.

19.1.104 Following Mary's allegations, the police identified Ben as a Serial Domestic Abuse Suspect and his Niche record was marked with the SDAS flag. Ben was identified in accordance with ACPO definition "An individual suspected of offending against two or more intimate partners since 2006." At the time this was the appropriate action by the police.

19.1.105 The police did react to the incidents in an appropriate way, considering when the alleged abuse took place but nowadays, with the implementation of the S17 Serious Crime Act 2015, and latterly the Domestic Abuse Act 2021 there is different legislation which can be utilised by the police.

19.1.106 The Domestic Abuse Act 2021 places the guidance supporting the Domestic Violence Disclosure Scheme (Clare's Law) onto a statutory footing. Since 2014, Clare's Law was implemented across all police forces in England and Wales. The scheme had two elements the Right to Ask and the Right to Know if an individual may be at risk of domestic abuse from a partner or ex-partner then the police will consider disclosing the information. The Domestic Abuse Act 2021 provided the framework for this scheme to ensure all police forces operated in the same manner. Although the police were not aware that Emma and Ben were in a relationship, Emma or her family could have requested information from the police about Ben to see if there had been any previous violent acts or evidence of controlling coercive behaviour. Whether Emma or her family had knowledge of Clare's Law is questionable. The DHR Panel believe that although the police and other agencies understand Clare's Law there is concern that it is not sufficiently known about by the wider community and especially those who are harder to reach and potentially more vulnerable.

19.1.107 Ben was acquitted of rape by a jury in February 2016. With the new Draft Victims Bill May 2022, those who report rape should expect a level of professionalism and empathy from the police and the CPS. Despite such support rape prosecutions have fallen with data suggesting that rape prosecutions have

fallen by 70%. In 2016/17 there were over five thousand prosecution outcomes and in 2020-21 this had fallen to 1500.

19.1.108 When identifying characteristics of a perpetrator of domestic abuse, Ben conformed to such behaviours including;

- Extreme jealousy: Ben objecting to Emma speaking with friends.
- When losing control in a relationship, Ben overdosed and threatened suicide.
- Ben telling Emma not to smoke.

19.1.109 Dr Jane Monckton in her 'Intimate partner femicide timeline' identifies several warning signs which are applicable to Ben; he liked to control, he had an inability to accept challenge, he would get jealous, he would make threats about suicide when the victim wanted the relationship to end.

19.1.110 It is important that professionals and the wider community understand the Intimate Partner timeline. It helps professionals to identify the risks to a victim and the wider community to understand what a healthy / non healthy relationship is.

19.1.111 Ben volunteered to attend an alcohol diversion scheme to reduce a fine for being drunk and verbally abusive. There are strong links between substance misuse and being a perpetrator of domestic abuse (as identified by Gilcrest). Domestic abuse perpetration was common among men attending treatment for substance misuse. Although substance misuse is not the only factor impacting on a perpetrator of domestic abuse (lower socio-economic status, adverse childhood experience, psychological problems), men receiving substance misuse treatment reported a higher rate of domestic abuse perpetration compared to men in the general population. Alcohol, cocaine and methamphetamine use is associated with domestic abuse perpetration as it can impair cognitive processing or may be the mechanism for reducing the threshold at which a provocation results.

19.1.112 The impact of homelessness and access to welfare benefits for Emma including the difficulties of WSCC CSC and other agencies trying to contact Emma as she had no fixed address:

19.1.113 Emma was homeless on several occasions as detailed in KPEs six, eight and nine. Most of the episodes related to breakdown in Emma's family relationship. Emma would also go missing and would be found either staying with older friends or sofa surfing. Emma approached Arun District Council Housing Options Team to apply to the housing register. The housing application was cancelled after a renewal letter was returned with addressee gone away. Emma then approached the Housing Options Team again stating she was homeless as she had been asked to leave her Stonepillow accommodation, due to non-payment of rent.

19.1.114 Homelessness and frequent moves of address would have been a hindrance for continuity of health care for Emma and meant it was more difficult for support agencies to maintain contact.

19.1.115 The Independent Chair contacted the Department of Work and Pensions, and they had minimal information relating to Emma which would indicate that Emma was not accessing the benefits which could have helped her.

19.1.116 People who are homeless are more likely to suffer low self-esteem, lack of ability to care for themselves, increase in substance misuse and an increased danger of abuse, violence and participation in risky behaviour. Emma was involved with drugs; professionals viewed that some of Emma's behaviour was "risky," and she was very vulnerable.

19.1.117 The Domestic Abuse Act 2021 highlights the importance of housing in supporting victims of domestic abuse including guidance which states that victim should be allowed to stay in their current area. Whether victims of domestic abuse and their families are aware of their new housing rights is questionable and there should be more raising awareness with the wider community of what housing support is available for victims of domestic abuse.

19.1.118 Kelda Henderson (in research around The role of housing in a coordinated response to domestic abuse 2019) states that housing is often overlooked in favour of the criminal justice dominance within a community response to domestic abuse. This is changing with increasing attention on the role of housing.

19.1.119 The Domestic Abuse Act 2021 provides that all eligible homeless victims of domestic abuse (as Emma would have had) have "priority" needs for homelessness assistance. This will also ensure that where a local authority, for reasons connected to domestic abuse, grants a new secure tenancy to a social tenant who had or has a secure lifetime or assured tenancy, this must be a secure lifetime tenancy (Domestic Abuse Act 2021-Part 4 Local Authority Support Section 57).

19.1.120 At a local level, the DHR Panel welcome the implementation of the Pan Sussex Domestic Abuse Accommodation and Support Strategy 2021-2024 which will ensure that victims and survivors are able to access the high-quality services they need and the justice to which they are entitled. The support provided will include work to allow victims and survivors to remain safely in their own homes or in safe accommodation.

19.1.121 It is of relevance that Arun District Council in responding to a previous DHR incident in its borough have made several changes to their housing practice which includes the following;

- Communication and Information

19.1.122 Prior to lockdown in March 2019, there was very little reference to domestic abuse in the housing section of the Council's website. Since the first lockdown, a dedicated area has been created, giving advice in different languages to represent the diversity of the communities in Arun. A safe exit button has also been added. A leaflet has also been devised outlining local and national support which has been shared on social media and printed for Sussex Police attending domestic abuse incidences in Arun. This leaflet is also available in Arun's Boots Pharmacy consulting rooms.

- Training

19.1.123 Domestic Abuse training was provided to key operational staff in November 2019 with refresher training in June 2020. From June 2021, domestic abuse training formed part of Adult Safeguarding training.

- Strategic

19.1.124 Domestic Abuse has also been added to the priority of Serious Violence under the Safer Arun Partnership and representatives from Arun District Council Housing Options Team now attend the Arun DA Multi Agency Risk Assessment Conference (MARAC). This is a multi-agency meeting where information is shared on the highest risk domestic abuse cases.

19.1.125 The Panel welcome the changes in practice at Arun District Council but what has been discussed is whether the implementation of the Pan-Sussex Domestic Abuse Accommodation and Support Strategy is fully owned by all agencies for example Boroughs and Districts in West Sussex, and this needs to be reviewed.

19.1.126 Examples of good practice:

- WSCC CSC provided a range of programmes and services for Emma to participate in to support her health and wellbeing and her parenting for example, Young Parents Programme, Find it Out Service and a programme aimed at trying to help Emma understand healthy/unhealthy relationships.
- Emma received information and support from Arun Housing about joining the housing register and applying for sources of income to help her situation.
- Arun District Council Housing implementing learning from a previous DHR to improve housing support for victims of DA.
- Emma was referred to a smoking cessation programme by health professionals and she built up a good, positive relationship with the practitioners as the same practitioners were at every session. This shows the importance of a regular, constant, contact with practitioners who can build a relationship with a vulnerable young adult.
- The various police forces responded to the domestic abuse allegation made by previous partners of Ben within the legal framework at the time.

20. Conclusions

20.1.1 The DHR Panel acknowledge that practice and procedure have significantly developed and improved since Emma was an adolescent, of which some details have been highlighted in section five, The Analysis. Also, the DHR Panel have the benefit of hindsight of Emma's lived experience and a range of detailed information from agencies.

20.1.2 Emma was a very vulnerable child and a vulnerable young adult. She suffered deep childhood trauma, separation, low self-esteem and perhaps she felt this included low attainment in life which would have impacted her wellbeing. Emma experienced abandonment at a young age, possible mental health issues, exposure to complex situations as a child and an adolescent.

20.1.3 There was agency involvement with Emma from an early age, but this review has identified that's Emma's voice did not seem to be heard. If there had been assessments and Emma's lived experience had been explored, then a holistic approach to her care could have been provided. The DHR identifies that Emma as a child and an adolescent was not always given the support she needed and professionals within WSCC CSC and health identified this, although service delivery has substantially improved, and the expectation is that someone in Emma's circumstances would now get the support they need. There were several safeguarding concerns reported by the police, housing and education about Emma's overall holistic care needs not being met.

20.1.4 (It is of note that West Sussex Safeguarding Children's Partnership now have an escalation process which means that empowers professionals who may have concerns about the outcome of a Child Protection Plan. Any dissent by a professional is recorded and is escalated to the Head of Safeguarding and Review Service to enable a review of the decisions made and then acted on as required).

20.1.5 Emma was a child when she had her baby, had her baby removed when she was young and lost her life as a young adult. When Emma's baby was born, the focus of support moved to the baby and Emma's needs were not always considered, despite her being still a child herself. With Emma having no advocate/support, she would have felt abandoned yet again which appears to have led her into risky situations.

20.1.6 At the time, following the loss of Emma's baby and difficulties in family relationships then Emma may have seen Ben as someone who could give her a home, support her emotionally and financially. However, he was controlling, had a history of domestic abuse and finally he took her life at a very young age.

20.1.7 Despite the extensive traumas in Emma's life, she did show great strength. Her parents said she was resourceful and evidence from agencies showed that Emma could engage if she had the continuity of care, and that she had aspirations for the future; she wanted to get into her fitness, she wanted to volunteer. Professionals also highlighted that Emma would engage in programmes provided

and she showed great nurturing for her baby in certain settings. Emma should be remembered as a person who liked to care for people, was fun and engaging.

21. Lessons Learnt

21.1.1 This DHR had identified several lessons to be learnt.

21.1.2 Lack of support for young people with support needs transitioning from children to adult services:

21.1.3 Emma and her family were involved with WSCC CSC and WSCC Education services from the age of twelve when Emma came to live with Fred as Sophie felt she could not support Emma due to her own mental health and substance misuse issues. Emma's attendance at school was very spasmodic resulting in an Education Supervision Order and Emma went missing on several occasions, for a couple of days. Agencies identified that Emma was in relationships with older males, with one relationship resulting in Emma having her baby when she 15 years old. Emma was legally underage to consent to sexual intercourse and it is likely that there would have been an imbalance of power within the relationship which should have been identified as child sexual abuse /child exploitation. Although evidence identifies that Emma was spoken to about the dangers of relationships with older men, there is no evidence that there was any support, guidance or any criminal investigations against the older males. When the baby was born, a social worker was allocated to the baby, but evidence suggests that there was no social worker assigned to Emma. Despite Emma and the baby staying with Fred, his wife and family, Emma would again go missing and on one occasion went missing with the baby. As already identified, the shift and focus were on the safety for baby, despite Emma still being a child herself. The baby was taken into care when Emma was around 17-18 years old. WSCC CSC involvement with Emma and her family ceased early 2016 despite Emma having continuing support needs. Emma was homeless on several occasions, she was suffering from some mental health and substance misuse issues and experiencing the loss of a child.

21.1.4 Section 17 Children Act 1989 states;

21.1.5 It shall be a general duty of every local authority to;

- Safeguard and promote the welfare of children within their area who are in need and;
- As far as is consistent with that duty, promote the upbringing of such children and their families by providing a range and level of services appropriate to those children's needs.

21.1.6 In England, a child is defined as anyone who has not yet reached their 18th birthday. The last full contact with WSCC CSC and Emma was in 2016.

21.1.7 Transition for a vulnerable young person, who may have multiple disadvantages such as Emma to adult services can be very difficult to navigate and many young people like Emma can be "lost". Emma was literally lost as agencies had multiple addresses for Emma and therefore did not know how to contact her.

21.1.8 The DHR Panel welcome the development of the West Sussex Safeguarding Adults Board and West Sussex Safeguarding Children's Partnership, Safeguarding Young People's 17.5 + Protocol which was implemented in July 2021 and reviewed early in 2022.

21.1.9 The purpose of the protocol is to set out the arrangements for young people aged 17.5 to 25 years whose circumstances may mean that Safeguarding Adults procedures would apply when they reach 18. This includes young people who have care and support needs for example leaving care or as in Emma's case, experiencing or at risk of abuse, neglect and are therefore unable to protect themselves.

21.1.10 The Protocol sets out clear procedures for referring a young person and highlights that it should not be assumed that a young person will not meet the eligibility criteria and states that if in doubt, then to check with the safeguarding hub.

21.1.11 A multi-agency response to Emma and her family's needs when she was transitioning into adulthood may have supported her in a holistic way to ensure her basic needs were met and that she could navigate herself away from risky relationships.

21.1.12 What is important is that professionals in the police, health sector, care sector and voluntary sector understand the impact of transition for young people to adulthood and that there is a Safeguarding protocol in place which should provide a more holistic approach to a victim experiencing multi disadvantage including domestic abuse.

21.1.13 Better support for mother's involved in their children being taken into care:

21.1.14 The family also spoke about Emma taking on the responsibility of being a parent despite her early age. When Emma's baby was removed from her care, this would have reinforced Emma's view that she was being judged by adults and professionals and could have reinforced the push and pull factors of further exploitation, including by Ben.

21.1.15 As already highlighted, children are a protective factor for women, and this was removed when the baby was taken into care. The family stated that no support was provided, and Emma's vulnerabilities were not considered. There was no documentation within the IMR whether any support was provided to Emma during the removal of the baby.

21.1.16 In section 4.1.36 WSCC CSC have identified the need to ensure that an appropriate assessment takes place prior to the birth of a child to ensure a multi-agency approach to support a baby and the young person.

21.1.17 Although some agencies who work with multi disadvantaged young mothers feel that there is still a lack of support when a child is removed into care for the mother. In the coastal area of West Sussex, PAUSE is providing a valuable service for women who are presenting pregnant year after year and then their children are taken into care. Many of the women are experiencing multiple disadvantages. Vulnerable women and professionals have identified the benefits and value of the service. Although the DHR Panel understand that financial resources will be an issue, it has requested that there should be opportunities to explore whether the service can be expanded to support women who are multi disadvantaged in other areas of West Sussex.

21.1.18 (The DHR Panel welcome the significant support for this recommendation from the West Sussex Children's Safeguarding Partnership).

21.1.19 Multi agency approach to support people who are multiple disadvantaged:

21.1.20 Emma had many disadvantages to overcome in her short life. Sophie, due to her own issues was unable support Emma (Sophie's words). Emma struggled to attend school and therefore her education was limited. Despite moving to live with Fred, Emma would often go missing and she seemed not to have a sense of belonging and no secure base.

21.1.21 Emma's needs were significantly high, but interventions were intermittent. Threshold procedures were not activated about strategy meetings/S47 enquiries, where joined up multi agency working would have implemented agreed safety plans and would have reviewed the risk with an appropriate level of intervention.

21.1.22 Emma and members of her family were involved with many agencies but trying to navigate and engage with the agencies on an individual basis would have been difficult for Emma and her family.

21.1.23 There is no doubt that West Sussex County Council has placed significant investment both in finances and strategic time to improve its provision to children, young people and their families with the expectation that the new Family Safeguarding Model will support in a more coordinated way. The expectation is that families can stay together, it reduces the risk to children and young people and that Health and Education outcomes will be improved.

21.1.24 Pan Sussex (East Sussex County Council, West Sussex County Council and Brighton and Hove Council) was successful in in a bid to Ministry of Housing, Communities and Local Government (MHCLG) in 2021 to develop a programme to support people with multiple disadvantage or multiple complex needs who are defined by experiencing three or more of the following;

- Homelessness, (Emma)
- Current historical offending
- Domestic abuse (Emma)
- Mental ill health (Emma - never formally diagnosed)
- Substance misuse (Emma)

21.1.25 The programme, called Changing Futures, is about improving the way local systems and services work together to support adults experiencing multiple disadvantage. The programme's aim is to ensure that there is a more joined up person-centred approach to support, and which aims to make long term change to local systems and will provide better outcomes for individuals experiencing multiple disadvantage.

21.1.26 Part of the programme includes a journey mapping with local support providers to identify the journey an individual has had with different agencies and to review how that journey could have been improved for that individual.

21.1.27 Emma would have benefitted from a more joined up approach to her services and one element of the journey mapping process is to review some individual cases when the person died. The DHR Panel would recommend that Emma's journey should be mapped to see how it could be improved and therefore improve learning.

21.1.28 The DHR panel welcome the changes within WSCC CSC and its implementation of the Family Safeguarding Model and the development of West Sussex County Council Changing Future Programme. There is a note of caution, that with several departments and partnerships (Adult Safeguarding Board, Children Safeguarding Partnership and the Community Safety Partnership) being responsible or involved with the domestic abuse strategy and support but are confident that the Four Board Collaborative Working Arrangements will ensure that services and strategies are coordinated.

21.1.29 Importance and understanding by professionals of the housing needs and support for victims of domestic abuse:

21.1.30 Emma was homeless several times, resulting in sofa surfing with known and unknown associates which potentially put Emma at risk of exploitation. Emma did engage with Arun District Council housing services in 2016 as she stated she was homeless. Her housing application was cancelled in September 2017 as her housing register renewal letter was returned, saying the addressee had gone away. Emma presented as homeless again in 2018 but the officer at the time felt that Emma needed emergency accommodation.

21.1.31 What is not clear is when Emma met Ben, but her relationship with him provided a home for her, an individual's basic need (as identified by Maslow). Emma's need for shelter placed her in a position of need and made her very vulnerable to a risky relationship.

21.1.32 If Emma was homeless today, then the Domestic Abuse Act 2021 would have supported her if she were known to be a victim of domestic abuse.

21.1.33 The Domestic Abuse Act 2021 will provide duties on local authority housing services to ensure victims and their children are supported. Housing duties will include;

- Proving all eligible homeless victims of domestic abuse to automatically have a priority need for homelessness assistance.
- Ensuring that where a local authority, for reasons connected with domestic abuse, grants a new secure tenancy who had or has a secure lifetime or assured tenancy (other than an assured shorthold tenancy) this must be a secure lifetime tenancy.
- The new duty will cover the provision of support to victims and their children residing in: * refuge accommodation; * specialist safe accommodation; * dispersed accommodation; * sanctuary schemes; and * move-on or second stage accommodation.
- B&B or homeless hostels or other generic temporary accommodation will not be considered 'safe'. Only accommodation dedicated to DA victims can be included in commissioned support.
- All support provided under their duty, must be provided to victims of domestic abuse, or their children, who reside in relevant accommodation as set out above and should meet the MHCLG Quality Standards, Women's Aid National Quality Standards and / or Imkaan Accredited Quality Standards.

21.1.34 It is important that professionals dealing with victims of domestic abuse and not only housing professionals understand what housing support there is now for a victim of domestic abuse. This should include the police, health professionals and other organisations supporting victims of domestic abuse having a basic knowledge of housing support and where to signpost victims to in West Sussex.

21.1.35 The wider community should also be aware of what support is available if they want to flee domestic abuse. It is well documented that victims of DA stay with a perpetrator as they fear homelessness if they leave. A campaign to raise awareness of housing entitlement for victims of DA should be developed by the Safer West Sussex Partnership and promoted widely to the local community in West Sussex.

21.1.36 Comprehensive Support for victims of Domestic Abuse by the acute care settings:

21.1.37 Sussex University Hospitals NHS Foundation Trust (West and St Richards Hospital) did have contacts with Emma and Ben, either in attendance at A&E or when Emma was receiving support during her pregnancy with her baby. Health settings, either via the primary care or acute care setting can be the one agency that a domestic abuse victim has a contact with. A lack of routine enquiry by health practitioners is often identified in DHRs.

21.1.38 Both hospitals have identified the need to develop a domestic abuse strategy, which includes an IDVA navigator, a flagging system, body mapping, clinical photography for preserving evidence.

21.1.39 It has been highlighted in this review that there is an inequality of IDVA provision in West Sussex compared to East Sussex and Brighton and Hove. This should be addressed by the CCG and the hospital trusts to ensure a consistency of support for victims of domestic abuse whether someone lives in East or West Sussex.

21.1.40 The DHR welcome the news that funding has been agreed to provide two IDVAs in the West Sussex Acute settings who will sit within the line management of WORTH Services (the specialist domestic abuse service). In addition, funding has been made available for front line staff for developing a network of domestic abuse champions across the NHS Trust. The NHS Trust will be working with Safelives to deliver the training which will allow professionals in the acute health arena to build confidence and essential skills to;

- Recognise and respond to signs of domestic abuse.
- Understand the barriers faced when asking questions and manging a disclosure.
- Identifying a victim's level of risk using a DASH risk checklist.
- Referring a victim to a specialist domestic violence service or a MARAC so a victim can receive some support.

21.1.41 When developing the acute care setting domestic abuse strategy, both hospitals should utilise the support offered by panel members in providing acute trust strategies already developed which have been identified as good practice.

21.1.42 Professional bias when supporting a victim of domestic abuse and their family:

21.1.43 Family evidence would suggest that Emma and her family were judged by agencies. Fred informed the Independent Chair that he had a prison record, Sophie was open about her health and substance misuse and the family felt these issues clouded professionals view of the family and created a barrier between the professional and the family. Fred commented that he thought he was being watched by a social worker from a neighbour's caravan, thus creating mistrust and a barrier to cooperation. The unconscious bias that professionals may have had when dealing with Emma and her family may have impacted on the support she and the wider family received.

21.1.44 Unconscious bias is triggered by the brain making quick judgements and assessments. It is also influenced by professionals own personal experiences and societal stereotypes. Unconscious bias can have a significant influence on attitudes and behaviours and how professional deal with a victim.

21.1.45 Professionals need to understand the unconscious bias that is in everyone and that when making decisions, time needs to be taken and decisions need to be justified and based on the evidence available.

21.1.46 If professionals understand unconscious bias, they are in the position to challenge their assumption about a victim and their family, understand the victim's story (and it has been noted that Emma's voice was not heard) and therefore provide the support they need based on evidence and sound decision making.

21.1.47 Listening to the Voice of Emma:

21.1.48 Emma faced many challenges in her life and several agencies identified that they did not hear Emma's voice. Professionals in WSCC CSC and WSCC Education did not engage with Emma to listen to what was happening in her life, to fully understand her lived experience. If agencies had spoken with Emma with curiosity, they may have built up a holistic picture of what Emma was experiencing in her own words, her aspirations and her concerns.

21.1.49 Any of the agencies supporting Emma could have tried to listen to Emma's voice and therefore it is important that professionals are reminded to be professionally curious when supporting vulnerable children and adults. This will enable professionals to have a more holistic approach in providing support to the victim.

21.1.50 The DHR Panel welcomes the finding of the Ofsted monitoring letter October 2022, which states that WSCC CSC puts the child's voice at the heart of what they do.

21.1.51 Continuity of Care:

21.1.52 Research by Standing Together DHR Case Analysis (Sharp Jeffs and Kelly 2016) has identified that GPs are often the only stakeholder that consistently engages with a victim and perpetrator. Emma was involved with several GP practices whilst in Sussex and the various GP practices were dealing with the problem they saw at the time. If Emma had one or two GP's rather than several there would have been the opportunity to listen to Emma's voice and better understand her transition from vulnerable child to a vulnerable adult. The DHR identified that when Emma did have continuity for example the nurses who supported the smoking cessation programme Emma attended, she built up a relationship and described her anxieties.

21.1.53 The DHR Panel endorse the GP recommendations which will address continuity of care as detailed in the agency recommendations. (8.2.3)

21.1.54 Ensuring the practice of a routine enquiry about domestic abuse is embedded in the policy and practice of agencies:

21.1.55 This DHR has identified that there were some apparent missed opportunities to make a routine enquiry with Emma about domestic abuse (whether this was about Ben or other males that Emma may have been in a relationship with). A lack of routine enquiry was noted by the CCG IMR author, and the DHR Panel were unclear and therefore asked for clarification if routine enquiry was part of

CGL's policy and practice and the Sussex Community NHS Foundation Trust. Policy and practice confirmed, and details included in 5.1.12 giving assurance that routine enquiry is embedded in CGL and Sussex Community NHS Foundation Trust practice.

21.1.56 Lack of routine enquiry by GP practices is a common thread in many DHRs and GP practices are independent businesses and therefore the ICB cannot enforce a GP practice to make a routine enquiry about domestic abuse. The ICB can reinforce through safeguarding training with GP practices the benefit of a routine enquiry about domestic abuse. As already identified in 5.1.12 GPs are often the best placed professional to make a routine enquiry around domestic abuse as they are a universal service used by most people.

21.1.57 The DHR Panel have included a recommendation for the ICB/General Practice to ensure that a domestic abuse routine enquiry is embedded in GP consultations with patients as detailed in paragraph 8.2.3.

21.1.58 Use of Victim Blaming language in agency records:

21.1.59 This DHR did cover an extensive period of Emma's life, with agency records being received from 2013. Within the IMRs there is language used which blames the victim for their behaviour and what they are experiencing. The DHR panel accepts that there has been significant improvement and knowledge around recording of domestic abuse and a better understanding of the trauma a victim is experiencing, this review provides an opportunity to remind professionals about appropriate/inappropriate language when discussing/recording details about a victim of domestic abuse. Safer West Sussex Partnership will be sharing information and promoting learning across local partnership boards, including victim blaming language and practice as part of a wider piece of work arising from the Domestic Abuse Commissioner's Office Health Action Learning Together research.

22. DHR Recommendations

23. Local

23.1.1 **Recommendation One:**

23.1.2 Safer West Sussex Partnership to provide training to a wider cohort of professionals on the Homicide Timeline, which will be in addition to either overarching or individual agencies domestic abuse training on all types of domestic abuse.

23.1.3 Ownership: Safer West Sussex Partnership

23.1.4 **Recommendation Two:**

23.1.5 Review the professional bias training offer for professionals in West Sussex and identify any gaps and ensure training is provided. (A comment, this is also about culture, reflective supervision to challenge decision making).

23.1.6 Ownership: Safer West Sussex Partnership

23.1.7 **Recommendation Three:**

23.1.8 SWSP and district and borough councils in West Sussex raise awareness to the wider community on local housing support for victims of domestic abuse.

23.1.9 Ownership: Safer West Sussex Partnership and district and borough councils

23.1.10 **Recommendation Four:**

23.1.11 SWSP to raise awareness with health /police social care and voluntary sector on the impact of the Domestic Abuse Act 2021 and housing support for victims of domestic abuse.

23.1.12 Ownership: Safer West Sussex Partnership

23.1.13 **Recommendation Five:**

23.1.14 SWSP and Sussex Police to raise awareness of the Domestic Violence Disclosure Scheme (DVDS) also known as Clare's Law.

23.1.15 Ownership: Safer West Sussex Partnership

23.1.16 **Recommendation Six:**

23.1.17 Acute health care to develop a domestic abuse strategy for acute care in West Sussex which complements and support the strategic aims of SWSP.

23.1.18 Ownership: Sussex University Hospitals NHS Foundation Trust

23.1.19 **Recommendation Seven:**

23.1.20 CCG (Now Sussex Integrated Commissioning Board) and Sussex University Hospitals NHS Foundation Trust to identify resources to provide an IDVA in the acute health care setting to provide equality of service across Sussex.

23.1.21 Ownership: Sussex University Hospitals NHS Foundation Trust

23.1.22 (To note; IDVA posts have been identified and these will be sited within WORTH services to enable health provision to be effectively integrated).

23.1.23 **Recommendation Eight:**

23.1.24 SWSP to review and monitor the impact of Pan Sussex Housing Strategy Support for domestic abuse victims and seek assurance that the support is being implemented across West Sussex.

23.1.25 Ownership: Safer West Sussex Partnership

23.1.26 **Recommendation Nine**:

23.1.27 Safer West Sussex Partnership will ensure that the multi-disciplinary learning is shared at the West Sussex Domestic and Sexual Violence and Abuse (DSVA) Steering Group.

23.1.28 Ownership: Safer West Sussex Partnership

23.1.29 **Recommendation Ten:**

23.1.30 Safer West Sussex Partnership to request that the West Sussex Safeguarding Children's Partnership (WSSCP) reviews what support is available to mothers following care proceedings/post adoption in recognition of the potential for increased risk and vulnerability and whether this meets current and ongoing needs of this cohort of vulnerable mothers.

23.1.31 Ownership; Safer West Sussex Partnership and West Sussex Safeguarding Children Partnership

24. Individual Agency Recommendation/ actions:

24.1.1 **West Sussex Children Social care:**

- If the threshold for an Initial Child Protection Conference has been met when a young person becomes pregnant and it is evident that they do not have the support of their family or there is evidence that they are vulnerable at risk of Child Exploitation, substance use etc, an assessment should be completed, ideally prior to the birth so that a multi-agency safeguarding plan will be in place that will support both the young person and the baby.
- When it becomes apparent that a first-time parent is unable to meet the needs of their child appropriately or consistently and the Local Authority are of the view that it is not safe for the child to be in the sole care of their parent, a strategy discussion should be convened, in order that multi agency consideration can be given to how best to support the parent and safeguard the child.
- When there is evidence that a young person is at risk of exploitation and is frequently going missing, Strategy Meetings are to be held in line with the WSCC CSC processes and partnership safety planning for the young person should commence, which includes a referral to the Youth Homeless Prevention Team for 16–17-year-olds at risk of homelessness.
- The DHR Panel would also recommend that a copy of the DHR is kept on Emma's baby's care file so that they have the option of reading it when they are older. WSCC CSC to ensure support is provided to during this process, if needed.

24.1.2 **West Sussex County Council - Education:**

- West Sussex County Council Education has implemented local practice, including the Keeping Children Safe in Education (KCSiE) 2015 which provides statutory guidance for schools on how they should undertake their safeguarding duties, which includes the introduction of a curriculum which covers relationships and sex education.
- West Sussex County Council Education has developed support for Designated Safeguarding Leads in schools including training, tool kits and a support network.

24.1.3 **General Practice** (The CCG/ICB IMR author requested that the recommendations be clearly identified as the responsibility of General Practice):

- Creation of a short universal safeguarding template for recording safeguarding concerns for general practice notes, which can be utilised by general practice and other agencies. Recording notes with consistency of coding of the entries to appear in the summary and to be pulled out and highlighted with further episode entries.
- Digitalising the GP record. NHS digital are working on digitalising the whole patient record.
- Sharing of risk assessments from external agencies with GP practices.
- A named clinician to support a family when identified as vulnerable.

24.1.4 The DHR Panel would also recommend that GPs and health professionals working in health settings ensure that routine enquiry about domestic abuse is embedded into policy and practice.

24.1.5 **Sussex University Hospitals NHS Foundation Trust:**

- Domestic abuse strategy to be developed which will include IDVA/navigator, alert flagging system for adults on patients' administrative system, body mapping, clinical photography for preserving evidence.
- An overarching Domestic Abuse Strategy Policy to be formulated and implemented for the Trust. The strategy to reflect the Domestic Abuse Act 2021.

24.1.6 **Arun District Council Housing:**

- Where an applicant for the housing register indicates that they are homeless, the case should be referred for a full housing assessment interview to take place.

25. Appendix One

Safer West Sussex Partnership (SWSP)

Domestic Homicide Review

December 2021

Terms Of Reference vrs 2 updated 7 Dec 21

1. This Domestic Homicide Review (DHR) is being conducted in accordance with Section 9(3) of the Domestic Violence Crime and Victims Act 2004.

2. This legislation places a statutory responsibility on organisations to securely share confidential information, which will remain confidential until the panel agrees the level of detail required in the final report for publication.

3. The DHR will strictly follow the SWSP DHR protocol, which is based on Home Office DHR guidance.

4. The statutory purpose of the DHR is to:

    a. Establish what lessons can learned from the domestic homicide regarding how the local professionals, agencies and organisations worked individually and together to safeguard the victims of domestic abuse.
    b. Identify clearly what those lessons are, both within and between agencies and organisations, how they will be acted on, and what will change as a result through a detailed Action Plan.
    c. Apply these lessons to service responses including changes to policies and procedures as appropriate.
    d. Prevent domestic homicides where possible in future through improved intra and inter-agency responses for all domestic abuse victims and their children.

5. The agreed timeframe for information to be secured and reviewed is for the period 6 December 2011 - 13 May 2018 (Emma Victim) and 18 November 2007 -13 May 2018 (Ben perpetrator) unless there have been significant events prior to this. Significant events will include engagement due to mental health, other noteworthy medical issues and other wellbeing issues.

6. The DHR will not seek to apportion blame to individuals or agencies from the information it receives. However, it is recognised that other parallel procedures (e.g. SCR, IOPC (Independent Office for Police Conduct) referral, and internal agency disciplinaries) may use information from the DHR process to support their investigations.

7. The Panel notes that the DHR process may be suspended as necessary to avoid the risk of activities prejudicial to criminal proceedings. (Criminal investigations against Ben concluded in June 2021 when he was convicted of murder).

8. In addition, the following areas will be addressed in the Individual Management Reviews (IMRs) and through wider enquiries:

    a. Awareness and understanding of professionals and the wider community of the potential presence of coercive control and how this may have impacted on the behaviour of Emma and Ben.
    b. Consideration of any equality and diversity issues that appear pertinent to Emma and Ben e.g. Femicide, men and women's roles in society, for example Ben did not accept any criticism of his behaviour.
    c. Whether there were any barriers experienced by Emma or her family / friends in seeking support from professional service providers?
    d. Whether there were any barriers experienced by professionals / agencies in offering support services to Emma?
    e. To consider any agencies or wider community groups that had no contact with Emma and her family and whether helpful support could have been provided e.g. specialist domestic abuse services and if so, why this was not accessed? E.g. housing/welfare benefits
    f. Identification of any training or awareness-raising requirements required to ensure a greater knowledge and understanding of the impact of domestic abuse and availability of support services.
    g. Impact of drug/ alcohol issues on the wellbeing of Emma and Ben?
    h. Possible impact of trauma and possible neglect in Emma's childhood which may have impacted on her wellbeing and whether professionals/practitioners considered Emma's childhood experiences when assessing Emma's needs and support?
    i. What support Children's social care provided to Emma, post adoption of her child.
    j. To consider previous domestic abuse by Ben in his relationships and any interventions by agencies.
    k. The impact of homelessness and access to welfare benefits for Emma including the difficulties of CSC and other agencies trying to contact Emma as she had no fixed address.
    l. To consider any previous convictions and risk factors for Emma and Ben.

9. The Panel will critically evaluate and approve the Overview Report, Executive Summary and Action Plan produced by the Independent Chair at the end of investigation prior to it being passed to the chair of SWSP, which will own the Report and implementation of the Action Plan.

10. As actions and lessons are identified, the Chair will notify the relevant agencies/ local safeguarding boards so that the implementation, monitoring and review of actions can be commenced as soon as possible.

11. These Terms of Reference may be varied by the DHR Panel as new information emerges.

12. Media: All agencies involved can confirm a review is in progress once the CCB criminal investigation has been completed, but no information to be divulged beyond that.

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Ms. Lynne Abrams
Chair of the Home Office QA DHR Panel
Interpersonal Abuse Unit
2, Marsham Street
London
SW1P 4DF

22 February 2024

Dear Ms Abrams,

Thank you for your letter, dated 15 January 2024, in respect of the Domestic Homicide Review report for Emma submitted by West Sussex Community Safety Partnership, and which was considered by the QA Panel on the 13 December 2023.

The Quality Assurance Panel has made suggestions for revision prior to publication and we would like to take this opportunity to comment on each of these, and ensure that the Home Office is assured that there is a record of our response to these; these are set out below but also need to be read in conjunction with the revised version of the report, which we have attached for your reference, and which has highlighted changes.

Areas for final development:

• Consideration needs to be given on how to improve the response to DA, either through training, further system developments by named GPs or support from an ICB designate team. This is borne out of Section 7.9 "Lack of routine enquiry by GP practices is a common thread in many DHRs and GP practices are independent businesses and therefore the ICB cannot enforce a GP practice to make a routine enquiry about domestic abuse".

This was highlighted in the agency section at 9c. In response to this we can also confirm that a programme of training has been rolled out to GPs and practices over the last twelve months. The focus of this training is to raise domestic abuse

awareness, highlight the impact on a victim-survivors mental health, support in identifying and responding to disclosures, asking the question (professional curiosity), identifying high risk indicators and referral to MARAC. A combination of this training, alongside GP's receiving police SCARF reports has resulted in an increase of information being shared into MARAC, and in referrals into both MARAC and WORTH high risk domestic abuse services. The ICB is also exploring with named GPs how to further embed training to ensure continued professional curiosity and practice on seeking and responding to disclosure.

• The equality and diversity section is very brief. Consideration should be given to expanding this.

This has been expanded and is highlighted within the report attached.

• Emma had multiple vulnerabilities and was well known to statutory and third sector organisations. However, there was no joined up approach to support her care and the support needs of a young person transitioning.

Significant information regarding this is included within the report which had identified that the transitioning was not as good as it should have been. However, there is a much improved system in place now. This is acknowledged at the start of your letter to SWSP, which identifies how local systems and services can work together to support young people transitioning and adults experiencing multiple disadvantages.

• Some pertinent information, such as a visit to A&E in which facial injuries were sustained, requires specific details on the facts surrounding the visit. The report would benefit from including more information on what happened on that occasion.

This has been expanded.

• There is some wording that could be perceived as victim blaming and the CSP may wish to consider rewording as it appears to place responsibility on the victim not to be harmed:

- 3.3.4 – '..that if Emma continued to place herself at further risk a child protection investigation may have to take place.'

- 3.5.6 – 'Concerns were raised about Emma placing herself in vulnerable positions..'

- 4.2.4.4 – '..there was no documented analysis of accumulating potentially risky behaviours..'.

- 5.17.3 – '..she was involved in risky behaviours..' (again at 6.2)

The language above was extracted from agency records dating back up to 2013 in some cases. More detail about victim blaming and victim blaming language has been included within the report. The Independent Chair and the West Sussex County Council, Community Safety Lead Officer have written to agency leads involved in this review to request that they remind all professionals in

their organisation about the appropriate use of language when referring to a victim of domestic abuse.

3.8.4 – it would be helpful to explain what a MOGP1 (child to notice) is.

This has been explained.

• The Action Plan is helpfully RAG rated but there are no completion dates and actual outcomes included. Many of the actions set out what has been done, rather than what will be done.

The action plan contains completion dates and where there are not completion dates this is because a number of the actions were identified throughout the review process and progressed prior to submission. The action plan is currently under review to assess completion and progress.

• The report is considered to currently contain a number of typos which will need to be rectified before it is published. Some reformatting is also required in places.

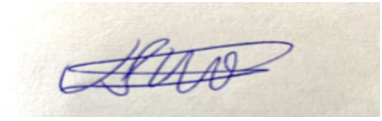
A review of all spelling, grammar and format has been completed.

• The report does not state when the CSP received notification of the death, when the CSP decided that a DHR would be undertaken, or when the Home Office were notified of the intention to undertake a DHR. It would be helpful if this information could be included.

This has been included.

The Safer West Sussex Partnership looks forward to receiving the Home Office response in due course. If possible we would to request a refreshed letter confirming agreement to publish as we would prefer not to publish the letter dated 15 January 2024.

Yours sincerely



Jim Bartlett

Head of Community Safety and Wellbeing, Communities Directorate, West Sussex County Council