DOMESTIC HOMICIDE REVIEW

East Sussex Safer Communities Partnership

Executive Summary of the report into the murder of Henrietta (Adult E)
August 2015

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Contents

Executive Summary

1.1 The Review Process

1.1.1 This summary outlines the process undertaken by East Sussex Safer Communities Partnership domestic homicide review panel in reviewing the homicide of Henrietta who was a resident in their area.

1.1.2 The following pseudonyms have been in used in this review for the victim and perpetrator to protect their identities and those of their family members:

- Victim: Henrietta
- Perpetrator: Peter .

1.1.3 Henrietta was killed by her former partner Peter, with whom she had recently separated, in late August 2015 at her home address leaving two young children who were 3 years and 12 months at the time of her death. Henrietta was 20 years old at the time of the homicide and Peter 21 years old. Both were White British.

1.1.4 Peter stood trial in July 2016 after pleading not guilty to the murder. The jury found him guilty and he was sentenced to life with a minimum tariff of 24 years.

1.1.5 The process began with an initial meeting of the East Sussex Safer Communities Partnership on 8th October 2015, when the decision to hold a domestic homicide review was agreed. All agencies that potentially had contact with Henrietta and Peter and their children prior to the point of death were contacted and asked to confirm whether they were involved with them.

1.2 Methodology and Contributors to the Review

1.2.1 Requests for a 'Summary of Involvement' (SOI) with Henrietta and/or Peter were sent to 27 agencies in East Sussex using the local Multi-Agency Risk Assessment Conference (MARAC) network. It was also considered helpful to involve those agencies that could have had a bearing on the circumstances of this case, even if they had not been previously aware of the individuals involved.

1.2.2 Of these, 16 agencies reviewed their files and notified the review that they had not been involved with Henrietta or Peter. Therefore, these agencies were <u>not</u> asked to complete an Individual Management Review (IMR). These included:

- East Sussex County Council Adult Social Care.
- East Sussex Fire and Rescue Service (ESFRS).

- Eastbourne Borough Council Housing.
- Hastings Borough Council Housing.
- Kent, Surrey and Sussex Community Rehabilitation Company (KSS CRC).
- Lewes District Council Housing.
- Surrey and Sussex Multi-Agency Public Protection Arrangements (MAPPA).
- National Probation Service (NPS).
- The local specialist domestic abuse service (provided in East Sussex by Change, grow, live (CGL), which is a delivery partner in 'The Portal[1]).
- The local domestic violence refuge service (provided in East Sussex by Refuge[2]).
- The East Sussex Drug and Alcohol Recovery Service, STAR (provided in East Sussex by Change, grow, live (CGL).
- Wealden District Council Housing.

1.2.3 11 agencies notified the review that they had been involved with Henrietta and/or Peter, and IMRs were requested from these organisations (of these two organisations completed combined IMRs across service areas, including East Sussex County Council (ESCC) Children's Social Care and East Sussex Health Care Trust (ESHT) Acute and Community Services).

1.2.4 All IMRs included chronologies of each agency's contacts with the victim and/or perpetrator over the Terms of Reference time period from the start of their relationship in 2009 to date of the homicide in late August 2015.

[1] The Portal is a partnership of leading Sussex Domestic and Sexual Abuse Charities – including RISE, Survivors' Network and CGL – and provides a single point of access and helps victim/survivors of domestic and sexual violence and abuse to find advice and support in Brighton & Hove and East Sussex. For more information go to http://www.theportal.org.uk

[2] For more information go to http://www.refuge.org.uk/

1.2.5 Although information was included about the children in the IMRs from Children's Social Care (CSC) and Health Visiting, this was only provided for the purpose of context, where necessary, to the agency's contact with Henrietta and/or Peter. The panel agreed that it was not necessary to analyse agency contact directly with the children.

1.2.6 Members of staff not directly involved with Henrietta, Peter or any family members undertook the IMRs.

1.2.7 IMRs were received from:

- Affinity Sutton (registered social housing provider).
- East Sussex County Council (ESCC) Children's Social Care - Early Help, Targeted Youth Support and SWIFT Specialist Family Support.
- East Sussex Health Care Trust (ESHT) Acute and Community Services (Health Visiting/Family Nurse Partnership and Maternity Services).
- Home Works (a housing and homelessness service Home provided by Southdown and commissioned by East Sussex County Council[3]).
- Primary care services.
- Sussex Partnership NHS Foundation Trust (SPFT) (the local mental health service).
- Sussex Police.
- Victim Support.

1.2.8 On the whole, the IMRs provided were comprehensive and the analysis supported the findings. Following comments, questions and suggestions some IMRs were redrafted and once complete, were comprehensive and high quality.

1.2.9 An IMR was not requested from Rother District Council Housing, based on their minimal contact with Henrietta. However, based on the information that the Council provided, an additional IMR was requested from a Social Landlord (Affinity Sutton) as Henrietta was a tenant of Affinity Sutton.

1.2.10 An IMR was also requested from the General Practice. As there was a significant amount of contact by staff within the General Practice, the IMR was completed by a member of staff acting on

[3] For more information go to http://www.southdownhousing.org/housing-support/home-works-east-sussex

behalf of the Eastbourne, Hailsham and Seaford (EHS) and Hastings and Rother (HR) and High Weald Lewes Havens (HWLH) Clinical Commissioning Groups.

1.2.11 Additional information was sought from Victim Support to gain further insight into their arrangements with the police, support offered and the detail of the referral pathway and services provides. This was facilitated by the Office of the Sussex Police & Crime Commissioner (OSPCC), which commissions this service locally, which was greatly appreciated.

1.3 The Review Panel Members

1.3.1 The Review Panel members and Independent Chair were:

Name	Job Title	Organisation
Carol Redford	Operations Manager, Safeguarding Development Team	East Sussex County Council.
Carol Studley	Partnerships and Community Safety Coordinator	Rother District Council.
DCI Ali Eaton	Safeguarding Investigation Unit, East Sussex Division	Sussex Police.
Debbie Barnes	Designated Nurse Child Safeguarding	Eastbourne Hailsham and Seaford (EHS) and Hastings and Rother (HR) and High Weald Lewes Havens (HWLH) Clinical Commissioning Groups.
Gillian Field	Designated Nurse Adult Safeguarding James Rowlands	Eastbourne Hailsham and Seaford (EHS) and Hastings and Rother (HR) and High Weald Lewes Havens (HWLH) Clinical Commissioning Groups.
James Rowlands	Strategic Commissioner (*Partnership Lead*)	Joint Domestic, Sexual Violence & Abuse and Violence against Women & Girls (VAWG) Unit – Brighton & Hove and East Sussex.
Micky Richards	Director	Change, Grow, Live (CGL).
Nicky Spiers	MARAC Development Officer	Joint Unit – Brighton & Hove and East Sussex.
Nicole Jacobs (*Independent*	CEO	Standing Together Against Domestic Violence (STADV)

Independent Chair)		
Sara Jones	Business Manager Victim and Witness Service	Office of the Sussex Police & Crime Commissioner (OSPCC).

1.3.2 The Review Panel met a total of four times, with the 1st panel meeting date on the 17th December 2015 and the final one on the 14th October 2016. Subsequently the Review Panel provided electronic feedback on drafts of the report in January and March 2017.

1.3.3 The Independent Chair wishes to thank everyone who contributed their time, patience and cooperation to this review.

1.4 Contact with the family and perpetrator

1.4.1 The Independent Chair met with Henrietta's sister who gave input in to the review in March 2017. The Independent Chair wishes to thank Henrietta's sister for her insight for this review and for reviewing the final draft. The final draft is much improved and is more significant due to her input. Henrietta's sister was given the HO leaflet related to DHRs as well as the leaflet for AAFDA.

1.4.2 The Independent Chair sent her first initial letter to Peter via the prison post-trial on the 11th October 2016. No response or confirmation of receiving this letter was received from the prison or Peter. In the meantime, the probation representative on the panel informed the Independent Chair that Peter was interested in being involved in the review. The Independent Chair then sent another letter via the prison governor to Peter on the 15th December 2016. The Independent Chair met with Peter on the 14th February 2017 and his views are incorporated in this review.

1.5 Independent Chair of the DHR and Author of the Overview Report

1.5.1 The Independent Independent Chair of this DHR is Nicole Jacobs, CEO of Standing Together Against Domestic Violence, an organisation dedicated to developing and delivering a coordinated response to domestic abuse through multi-agency partnerships.

1.5.2 *Independence:* The Independent Chair has no connection with East Sussex Safer Communities Partnership or any of the agencies involved in this case.

1.6 Terms of Reference for the Review

1.6.1 At the first meeting, the Review Panel shared information about agency contact with the individuals involved, and as a result, established that the time period to be reviewed would be from 2009 to the date of the homicide in late August 2015. This includes the period of time when Henrietta and

Peter began their relationship to the date of her murder by Peter. Agencies were asked to summarise any relevant contact they had had with Henrietta and Peter outside of these dates.

1.6.2 *Key Lines of Inquiry*: The Review Panel considered both the "generic issues" as set out in 2013 Guidance and identified and considered the specific issues related to the age of both Henrietta and Peter, their young family and their prior experiences with services.

1.7 Summary of Chronology

1.7.1 Henrietta was known to be a dynamic, fun-loving, intelligent person who was an exceptional mother, daughter and friend. The domestic abuse suffered from Peter was known by Henrietta's family and friends. There were overt disclosures of both physical and emotional abuse. However, they were not described as "domestic abuse" and the risks to Henrietta in the process of her separation from Peter were not known or fully understood by her family and friends.

1.7.2 Henrietta and/or Peter were known to primary and acute trust health services, and early help in Children's Social Care, but their contact was either focused on support for injuries, general health services or services focused on their children. Issues relating to domestic abuse were not discussed or detected in many of the health-related settings.

1.7.3 Sussex Police were called on two occasions. One related to a disturbance during a small party and no crime was alleged and none was detected. The second incident took place in the weeks before the murder and resulted in Peter being charged with Common Assault to Henrietta and Occasioning Actual Bodily Harm to her friend. Peter was held overnight and Henrietta was referred to Victim Support.

1.7.4 The Police incidents triggered referrals to, and assessment by, Children's Social Care and some ongoing support offered to Henrietta from health services. There were some administrative errors which resulted in lack of contact with Henrietta but overall, when contact was made, the domestic abuse was not substantively discussed or addressed with Henrietta by Children's Social Care.

1.7.5 The second police incident also triggered a referral of Henrietta to Victim Support to offer support for the domestic abuse she was experiencing. Victim Support successfully contacted Henrietta but in this early stage in her separation with Peter, Henrietta stated that she did not require ongoing support.

1.7.6 Due to police incidents and complaints by neighbours, Affinity Sutton was made aware of the disturbance and potential domestic abuse but they recorded and dealt with the incidents as anti-social behaviour which led to warning letters and some intervention with Henrietta but none which addressed or discussed support for ongoing or potential domestic abuse.

1.8 Key issues arising from the review

1.8.1 **Sussex Partnership NHS Foundation Trust (SPFT)** While the boundaries and purpose of the Police and Court Liaison and Diversion Service (PCLDS) are acknowledged, it seems that the fact that the charge, or the context of the charge, is unknown presents a challenge for domestic violence and abuse cases. If in part of the Level 1 comprehensive risk assessment there is a question to assess if there is any evidence to suggest that the person could cause harm to others, but the PCLDS does not have information about the domestic violence and abuse allegedly perpetrated by the person in custody, this is a clear oversight as such information would aid part of the purpose of the assessment. In the case of Peter, the response to this question was recorded as unknown. Had Peter been directly asked about the context of his offending and previous mental ill health, he may have described it as having been due to relationship problems (and with a trained PCLDS professional this may well signal a cause for concern in relation to domestic violence abuse).

1.8.2 The primary focus of the referral is in relation to determining if the person in custody is a risk to him/herself but PCLDS colleagues also state that an additional purpose is to determine if there are unmet needs of the offender. It seems that in Peter's case an unmet need would have been the stress he was demonstrating due to the breakdown in his relationship with Henrietta. Peter was given helpline information for mental health but was not provided with specific information related to support for those who are experiencing relationship breakdown and / for whom there may be a concern that they are perpetrating domestic violence and abuse.

1.8.3 **The East Sussex Safer Communities Partnership** Considering learning for the wider partnership, if Peter had disclosed relationship problems, it may have been appropriate for professionals to provide information on sources of help and support. There is a national helpline that Peter could have been signposted to for confidential support and advice (the Respect Phoneline)[4] and professionals should be aware of this information and it is not clear that is always the case.

1.8.4 Services to address and work with men using, or at risk of, using violence and abuse are limited locally. The local structured programme is the Building Better Relationships (BBR) programme; in East Sussex this is provided by the Kent, Surrey and Sussex Community Rehabilitation Company (KSS CRC) and is for those offenders with an Accredited Programme Requirement. In addition, East Sussex County Council Children Services have developed a joint offer with KSS CRC to extend this programme to include men with children. However, there is no local community based

[4] The Respect Phone line is a confidential and anonymous helpline for anyone concerned about their violence and/or abuse towards a partner or ex-partner. more information go to http://www.respectphoneline.org.uk/

programme to which Peter could have referred at the time if he had wished to address his behaviour and that remains the case at the present time.

1.8.5 **Acute Services, East Sussex Healthcare NHS Trust (ESHT)** The East Sussex Healthcare NHS Trust services have a duty of care to provide care within local and national policy and guidance. There is an occasion when professional curiosity within the A&E staff should have been adopted.

1.8.6 On 7th January 2012, there is documentation relating to Henrietta having a 'fall down the stairs' and sustaining a head injury. The entry fails to provide adequate information surrounding the incident. Henrietta initially presented at A&E where she was assessed briefly and transferred immediately to the obstetric team as she was 18 weeks pregnant. It could be that the midwife assumed thorough background information had been gained from A&E; however, this did not happen as demonstrated by the fact that the ASF was not updated. There is no further evidence of follow-up conversations about the incident between specialties.

1.8.7 Peter then attended the same A&E the 23rd January 2012, 2 weeks after Henrietta's attendance. He described taking an overdose due to the end of his relationship following an argument. He disclosed this at the A&E Triage. He had a mental health assessment and was given advice on discharge. There is no record of the details of the argument, such as whether it involved domestic violence. This was potentially a missed opportunity.

1.8.8 Thinking of these two attendances together one may easily make assumptions about the links between the two but the A&E staff would have little to link the two individuals to each other unless told. They were not married and did not have the same surname and did not mention each other to A&E staff. However, both attendances merited some further exploration as to whether or domestic abuse was a factor for these patients and if so, what support could be offered or signposted.

1.8.9 **Maternity Services, East Sussex Healthcare NHS Trust (ESHT)** The maternity care provided to Henrietta during two pregnancies is viewed as quality obstetric care, which provided the positive outcome of safe delivery of her two sons. Henrietta support systems were recorded as good and she was described as a happy, well-adjusted mum. During the period of care for the pregnancy of Henrietta's first child, an ASF was in place due to Henrietta's age. Safeguarding supervision within midwifery had not commenced at that point. Contact by ASM was requested but no documentation is present to establish if contact was made.

1.8.10 There are two occasions when the professional curiosity of the midwives should have been adopted. On 7th January 2012, there is documentation relating to Henrietta having a "fall down the stairs" and sustaining a head injury. The entry fails to provide adequate information surrounding the incident. Henrietta initially presented at A&E where she was briefly assessed. It could be that the midwife assumed the details of the situation thorough background information that had been

gained from A&E. It would have been appropriate to update the Additional Support Form in this instance. There is no further evidence of follow-up conversations about the incident.

1.8.11 On 22nd March 2014, Henrietta took self-discharge from the unit as she was upset and unable to stay due to childcare issues at home. A discussion about the family set-up and the source of her concerns would have provided an opportunity to disclose issues that may have been occurring.

1.8.12 During her second pregnancy Henrietta accessed care on six occasions for issues such as reduced foetal movements; increased foetal movements and abdominal pain. The ESHT guidelines for 'identification and disclosure of domestic violence for women using maternity services' identify repeated contacts for non-specific issues as a prompt to consider if abuse is occurring. There is no reflection of practitioners considering the issue of abuse - if this had been disclosed an Additional Support Form could have been generated to avoid documentation within the handheld notes.

1.8.13 The booking, ASF, delivery and discharge information was routinely shared with the GP and Health visitor in Henrietta's first pregnancy. The ASF was not generated for her second pregnancy and closer working relationships within midwifery and health visiting may have provided a seamless service of support, particularly during Henrietta's second pregnancy.

1.8.14 **Primary Care Services** In October 2011, Henrietta attended and reported to be pregnant, ante-natal examination conducted and GP referred to Midwifery services. There is no documented discussion with Henrietta regarding relationship status or the father of the baby.

1.8.15 During a midwifery assessment Henrietta disclosed historic cannabis use, this is contained within a summary sent to the practice but there is no evidence of this being discussed between the GP and Henrietta nor any discussion documented with regards to any current or historic drug use by her partner/father of the baby.

1.8.16 In January 2012, a discharge summary is received from Accident and Emergency (A&E) detailing Henrietta attending with abdominal pain following a fall, there is no documentation within the records of this being explored or discussed with Henrietta when she attended the surgery.

1.8.17 In January 2012, correspondence is received regarding Peter's attendance at A&E following an intentional overdose in the context of relationship issues. Peter was also reviewed by Sussex Partnership Foundation Trust (SPFT) Psychiatric Liaison Team in A&E who also wrote to the surgery detailing their involvement and assessment.

1.8.18 Peter attended the surgery in February 2012 reporting stress within his relationship; the records do not document further discussion of the nature of the stresses within the relationship nor reference any details of his partner.

1.8.19 Consultation/attendances at the surgery from this date forward regarding Henrietta, Peter or their children are routine in nature and relate mainly to ante-natal care, post-natal care and routine immunisation of the children.

1.8.20 There are no documented disclosures of domestic abuse within the records. While it is true that there were no disclosures by Peter or Henrietta using the term domestic abuse, the above-mentioned details present clear indications that it would have been appropriate and correct to ask about difficulties or worries about their personal relationship which may have resulted in disclosure of domestic abuse.

1.8.21 It is acknowledged that this GP surgery has a large number of patients and linking Henrietta and her care to Peter and his care would not be likely or expected; however, it would be possible to expect that even a brief intervention or reference to support would be appropriate given the incidence of domestic abuse in general and that there would be literature in the GP surgery.

1.8.22 **East Sussex Healthcare NHS Trust (ESHT), Community Services** All contacts with the family were completed as per the health visiting service specification at that time, with the exception of the six-week visit following Harris' birth. Henrietta received a more intensive service because of the Goodstart Programme for her first child. This meant she had two ante-natal visits and eleven post-natal group sessions. She always presented as a capable, caring parent who engaged well with the service.

1.8.23 Health visitors knew less about Peter. What they did know is mostly from Henrietta's reports. Peter was seen on one visit only (the very first ante-natal visit). This 'invisibility' of fathers is not unusual and is well-documented from serious case reviews both locally and nationally (NSPCC, 2015). Peter was largely invisible despite being the father. The consensus in the literature is that fathers are underused as a source of support for their children.

1.8.24 There may have been an assumption that Peter was unable or unwilling to attend visits as the couple were not living together and he was reported to be working.

1.8.25 In this case there is nothing to suggest that Peter presented any risk to Henrietta or his children and the opportunities to discuss this with Henrietta were appropriately taken. Henrietta received a universal health visiting service and engaged well. There is nothing to suggest that staff missed opportunities to deliver care for Henrietta or her children. The staff delivered care in line with policies and service specifications.

1.8.26 It is not documented if there was a missed opportunity after the incident on 10th December 2013 when there was a contact by the ESCC Integrated Screening Hub (ISH) regarding an MOGP1 from Police. This was the incident when the police had been called when there was arguing and cannabis use at the flat where Henrietta lived. Noted good practice is that the Health Visitor ensured that Henrietta was visited after this incident. Henrietta reported the incident as a "one-off."

The detail of Henrietta's conversation with the Health Visitor was not noted and it may be that safety-netting advice was given. It is an important learning point for Health Visitors (as well as all frontline professionals) that these opportunities are critical so that patients know the range of services offered in Sussex should they ever need it. Often survivors of domestic abuse do not know there is independent support and advice beyond that of statutory services.

1.8.27 **East Sussex Healthcare NHS Trust (ESHT), Maternity Services** There is also a clear deficit of documented acknowledgement concerning the presence of Peter. It is recognised as a failure of services to identify and adopt professional curiosity regarding men around the family in previous serious case reviews. Henrietta's maternity records do not reflect the state of her relationship and her family dynamic.

1.8.28 This review reflects an ongoing pattern of findings related to the invisibility of fathers in both national and local findings. A Serious Case Review, a result of the deaths of two children (Child J and Child K)[5], was commissioned by the East Sussex Local Safeguarding Children Board in December 2011 and states, "opportunities were missed to develop a fuller picture of what was going on and what standards of parenting were available from both mother and father … and this would have been assisted by a fuller assessment process...". The actions are overseen, and progress monitored, by the Local Safeguarding Children Board's Case Review Group.

1.8.29 **Sussex Police** The incident on 27th November 2013 was a non-violent domestic incident with a strong suggestion of drug abuse. The first response of the police was appropriate and the correct recording and completion of the MOGP1 and DASH RIC was done with the correct level of risk assessed at that time. An intelligence report was submitted. The only history markers on the address related to two separate previous occupiers. With regard to this incident the tag of "Domestic Abuse" was rightly added to the serial however a history marker should have been added given Henrietta's age (aged 19), the fact that she was a young mother with a 1-year-old child who had experienced a domestic argument alongside the suspicion of drug use around the child. A key lesson related to this is that the vulnerability of victims and children must be considered on each occasion and the level of risk assessed accordingly.

1.8.30 The incident on 2nd August 2015, which was a violent domestic incident where Henrietta and Male 1 were assaulted and the new definition of Domestic Abuse was in force. The first response and actions taken were appropriate with Peter being arrested. No Further Action (NFA) was taken with regard to the ABH to Henrietta's friend and Peter was cautioned for Common Assault to Henrietta and subsequently released from custody. However, given the responses Henrietta gave to some of the DASH RIC questions such as:

[5] http://www.eastsussexlscb.org.uk/professionals/serious-case-reviews-2/

- That she felt intimidated when Peter shouted at her.
- Their recent separation.
- Peter's constant texts.
- The fact that she had young children.
- Peter's jealousy and past offending.

Coupled with the previous incident on 27th November 2013, and the officer completing the SCARF clearly stating in the 'child to notice section' that specific risk factors were young children - the risk should have been assessed as 'medium' and not 'standard'. An assessment of 'medium' would have resulted in an automatic notification to the specialist domestic abuse service provided by CGL.

1.8.31 Henrietta's statement does not detail what her relationship with Peter was like. Effective victim questioning/interviewing of the victim as a result of the responses to the DASH RIC questions may have led to her disclosing a previous incident she had told her family about, where Peter tried to strangle her.

1.8.32 Whilst positive action was taken, given the above, a Domestic Violence Protection Notice (DVPN) could have been considered. More time spent in taking Henrietta's statement would not only have provided details of their relationship but would have been another opportunity to probe further in light of the responses she gave.

1.8.33 The SCARF is a form that is used as a vehicle for NICHE and has multi-agency sections. NICHE is a police database in Sussex used to record all crime and intelligence reports. What must be borne in mind is that partner agencies will not have access to statements etc. and therefore the Child to Notice and DASH sections must contain comprehensive information. Attention to detail is critical to enable other agencies to make informed decision/s on courses of action that may or may not be taken.

1.8.34 However, of the five members of staff involved in the paper trail for the incident on 2nd August 2015, only two of them had attended the mandatory training for first responders. Whilst every effort has been made to ensure that first responders attend the mandatory training a number of members of staff have not attended and attendance on the Domestic Abuse workshop training is voluntary.

1.8.35 **East Sussex County Council (ESCC) Children Social Care** There were three issues identified in relation to CSC during this review.

1.8.36 The first was an acknowledgement that Youth Support Team did not manage to contact Henrietta when she disclosed being "kicked out" of her home with a child when 17 years old. Whilst best practice might suggest greater professional curiosity; in recording the baby's details, exploring the reasons behind them being "kicked out" and contacting Rother District Council to double check

contact details. The expectation would have been that Henrietta would make contact again but a learning opportunity with this review and with other related reviews is that reflection is required as to how to properly engage young people. The Single Point of Advice (SPOA) would now be responsible for this contact and would link efforts back to the continuum of need.

1.8.37 The issue identified related to the instance when Henrietta's referral from the police to CSC following police attendance at her home was lost due to an administrative error. Whilst no system is infallible, the service needs to ensure that the administrative processes are as robust as possible to avoid omissions and errors. If the SCARF referral had been appropriately actioned the retrospective view of professionals at CSC is that it would have been at a low level of concern and Henrietta's reaction to a further assessment and/or contact with CSC cannot be known.

1.8.38 Lastly, at the meeting on 28th January 2014 the Health Visitor reported that she had written asking for a meeting on the 29th of January. There is no record of any further discussion of the family at a TAF meeting. At that time, it would have been expected that the case would be reviewed at a further meeting. A review did not take place on the 4th February 2014, as the TAF administrator did not add the case to agenda and although there was a regular administrator for the Town 1 meeting, at times one of the other two administrators would cover.

1.8.39 There have been significant developments in the early help services alongside all contact being screened by the SPOA to make a judgment as to whether early help or CSC are necessary. TAF has now been replaced with Early Help Meetings and notes from these meetings now have a record.

1.8.40 The panel discussed the process of assessment during the period of time between receiving an initial referral from the police on 28th November 2013 and the Practice Manager decision on 5th December 2013. There was screening activity during this time. However, the process has already been improved by instituting SPOA and there is active audit work in place in relation to this new assessment process.

1.8.41 The retrospective view of the Operations Manager responsible for Duty and Assessment Teams is that the triage decision would have been to locate the SCARF referral at Level 2 on the Continuum of Need. Early Help is provided with Level 3 and enhanced serviced are provided with Level 2. The rationale for this decision is based on the fact that Henrietta had engaged with a DASH risk assessment and was supporting a prosecution of Peter. The Review Panel and the Independent Chair conceded that this decision could have gone either way depending on the professional judgment of the decision maker. Given the history of Peter, this case may well have been assessed by another practitioner as Level 3.

1.8.42 **Victim Support** Henrietta was referred to Victim Support two days after the police incident. This referral came to Victim Support on a Tuesday and the attempt to reach her was not until Friday.

The contract with Victim Support is to offer support within 48 hours which did not happen in this case.

1.8.43 At the time, Victim Support did not have access to the Police DASH RIC information so would make a call to a victim without this information. Firstly, this means that the staff member had a limited picture of the circumstances in the case. Secondly, where a victim was successfully contacted, they would be asked to complete the DASH RIC again instead of allowing Victim Support to build upon the picture of risk that the police have started. It would be better practice to share the DASH RIC with Victim Support to enable a more seamless approach.

1.8.44 It was also unclear if given a more accurate picture of risk at the time of the referral, if this would have allowed for Victim Support to use their professional judgment in terms of risk. Henrietta was recently separated for the first time with very small children and other risk factors at play such as jealousy, recent violence, the mental health and previous violence and substance misuse of Peter and escalation. Henrietta was stating she was surprised by the actions of Peter over past weeks. It would heavily depend on the conversation and concerns of Henrietta but it could be that Henrietta's risk assessment might have changed to a higher concern for her immediate safety and that of her children. It is clear that the referral arrangement did not allow for professionals at Victim Support to get off to the best start with the information they were given.

1.8.45 Records indicate that the National Centre for Domestic Violence (NCDV) number was provided to Henrietta and not the National Domestic Violence Helpline.[6] The NCDV provides a free, fast emergency injunction service to survivors of domestic violence. During Henrietta's contact with Victim Support Henrietta had indicated that "everything is settled down now." Providing information on injunctions would therefore be unlikely to be the most appropriate offer; in contrast providing more general information about the National Domestic Violence Helpline and local specialist services would have been more appropriate.

1.8.46 In addition, it was practice at the time that the police were not informed if a victim did not engage with the Victim Support service.

1.8.47 **Affinity Sutton** They addressed the initial complaint related to arguments as per their antisocial behaviour policy and as such, the Housing Officer did what would be expected as per that policy. This did not recognise the context which could have indicated domestic abuse and neither did it trigger a child safeguarding referral. Henrietta was reported to have been screaming at 3:30 am to "pack your bags and leave." It may have indicated to the Housing Officers that the noise was related to a relationship breakdown. The letter to address the 'anti-social behaviour' could well

[6] The Freephone 24 Hour National Domestic Violence Helpline, run in partnership between Women's Aid and Refuge, is a national service for women experiencing domestic violence, their family, friends, colleagues and others calling on their behalf. The Helpline can give support, help and information over the telephone, wherever the caller might be in the country. For more information go to http://www.nationaldomesticviolencehelpline.org.uk

have served to silence Henrietta by thinking that she was perceived to be a problem whereas by referring to the DA policy, it may have provided an opportunity to determine if Henrietta required support or signposting to services.

1.8.48 Following the second complaint letter, Henrietta contacted her Housing Officer to deny the noise between her and a male stating it was more likely her shouting at her son and that she would adjust her behaviour. As no further complaints were received from the complainant, no further action was taken. Again, this may have been an opportunity to signpost or offer support related to relationship breakdown. Nor did the no further action consider the impact on the children and therefore a referral to CSC, which in turn may have elicited more information regarding domestic abuse. As Henrietta was young and this was her first tenancy, it may have been that she was attempting to ensure that the Housing Officer did not think Peter was living with her due to a perception that she would be required to let Affinity Sutton know if there were changes to those residing at the flat. Henrietta's sister reinforced the notion that she may well have been concerned to "be in trouble" with the housing provider.

1.8.49 These incidents were logged as a 'tenancy issue' which means that review of a housing manager was not required. These issues should have been noted as domestic abuse or a possible cause for concern' should have been explored so that the context of the disturbance was accurately noted. It may have been that Henrietta would not have sought help from the Housing Officer but regardless of this, it would have been an appropriate time to express concern and highlight services and support.

1.8.50 Affinity Sutton does not regularly receive information from the police if a crime has taken place at their property. This was the case in early August 2015 when it was a neighbour who happened to report the police incident to the Housing Officer. The Housing Officer demonstrated appropriate curiosity to make enquiries with the police but did not take further action. Given this incident again indicated a relationship breakdown it may have been appropriate to consider proactively offering support and advice.

1.8.51 There were missed opportunities to offer support and signposting to domestic abuse services which are rooted in the lack of expectation and relevant support from Affinity Sutton to expect its employees to understand domestic abuse as separate from anti-social behaviour and to consider more subtle forms of help seeking and giving. The individual Housing Officer did what was expected of her and was proactive and quick in her reactions to Henrietta and others. However, she was not encouraged, supported or trained to think differently about domestic abuse.

1.8.52 **East Sussex Safer Communities Partnership and the Office of the Office of the Police & Crime Commissioner** The referral pathway at the time of Henrietta's referral in early August of 2015 left victims of domestic violence abuse exposed to potential pitfalls in their offer of support. If a victim was assessed by the police to be high or medium risk, they were referred to the local

specialist domestic abuse service. For those deemed to be standard risk, they were referred to Victim Support. There is no referral pathway for victims who come to the attention of the Police where there is "non-crime." Henrietta's sister felt strongly that as her Henrietta would have benefitted from a proactive phone call in the week after the case had been closed by Victim Support or No Further Actioned by the Police. She felt that additional effort could be made to try to engage people in situations where the whole situation or risk level is unclear.

1.9 Lessons learned and lessons to be learned

1.9.1 **Sussex Partnership NHS Foundation Trust (SPFT)**

Consideration to issues related to risk assessment outlined above were included in the SPFT's serious incident notification, which was a parallel review. Although the subsequent review was downgraded from a serious incident review the findings were as follows. These are therefore the single agency recommendations for SPFT:

- The training that the PCLDS service receive may not fully equip them to deliver global assessment of risks with patients who have a history of serious offending and specialist Be Aware and Respond to Abuse (BARTA) or RESPECT training in this area may have improved the risk formulation in this case
- An enhanced screening format may have highlighted future risk more effectively
- PCLDS staff should routinely document the alleged offence as part of the assessment to enable other professionals to have an awareness of patients' previous contact with criminal justice system.

1.9.2 East Sussex Safer Communities Partnership should explore if there are any improvements that could be made to link those using, or at risk of, using violence and abuse with national helplines such as the one run by RESPECT as a possible link to support and advice at what could be a critical time. All front-line providers should be reminded of or made of aware of this provision of service at a minimum.

1.9.3 The East Sussex Safer Communities Partnership should review the provision of community based support for those using, or at risk of, using violence and abuse who are not able to access programmes through existing statutory provision.

1.9.4 The East Sussex Safer Communities Partnership should ensure multi-agency training is on offer so that agencies have the skills to encourage reporting of DA and staff can build up the necessary rapport with clients quickly and in particular young clients. This should incorporate local work done to help improve engaging young people in services.

1.9.5 There is a developing focus in East Sussex related to ensuring that professionals are able to provide appropriate 'safety-netting advice'. Identified areas of work include the development of online, downloadable tools including new guidance for professionals, as well as the development of self-help and safety planning tools for victim/survivors.

1.9.6 The East Sussex Safer Communities Partnership should ensure that the development of online, downloadable tools for professionals and victim/survivors and their families are developed as planned.

1.9.7 While it is clear that individual agencies and services offer safeguarding and DA training, in many instances these programmes of training are not offered on an ongoing basis. For this reason and due to the fact that front line workers benefit from training with others from various services and organisation, the provision of multi-agency training should be prioritised. Further, this training should be reviewed to ensure it adequately includes information and skills building to engage perpetrators of abuse. This would help address the "invisibility" issues outlined in this review.

1.9.8 The LSCB runs several domestic violence and abuse training courses. A thematic training review has recently been completed, with new training being rolled out across East Sussex with an extension to staff working with adults. This will include both e learning, but also a two-day course accessible to staff working with both adults and children focused around Adopting a Whole Family Approach to Domestic Abuse and Promoting Safety.

1.9.9 The Safer East Sussex Team is also rolling out targeted training on the use of the DASH RIC and the MARAC process locally.

1.9.10 **Acute Services, East Sussex Healthcare NHS Trust (ESHT)**

Mandatory training for all A&E staff in safeguarding procedures including domestic abuse is in place. This has resulted in a greater awareness and response to identifying and safeguarding adults and children where domestic abuse is suspected or confirmed.

1.9.11 Although not relevant for this case, it is worth noting that the MARAC process is now actively engaged with by ESHT; Paediatric Liaison are sharing information regarding A&E attendances and alerts are placed on the E-searcher systems so that staff are able to identify patients at risk of domestic abuse.

1.9.12 Safeguarding supervision is now embedded in paediatric practice within East Sussex Healthcare NHS Trust. Reflective practice, professional curiosity and awareness have increased. Doctors and nurses need to conscientiously consider whether Domestic Abuse is a factor when adults and children attend A&E, even when there is not an alert on systems and to have greater professional curiosity.

1.9.13 The following recommendation was made within the Individual Management Review for Acute Services which would address issues identified in the previous section:

- A&E staff require greater professional curiosity regarding accidents that occur in women who are pregnant as this is known to be a highly vulnerable period.

1.9.14 **Maternity Services, East Sussex Healthcare NHS Trust (ESHT)**

Mandatory training for all midwives and maternity support workers within ESHT has included a session on domestic abuse on two occasions, mostly recently in 2014. This has resulted in a greater awareness and response to identifying and safeguarding women where domestic abuse is suspected or confirmed. MARAC referrals have increased and the alert placed on the Euroking/E3 systems for women heard as victims of domestic abuse increases early identification. There should be a review of staff training requirements since 2014 and action taken to address the possible need for refreshed or further training as the training in 2014 is now three years ago.

1.9.15 Safeguarding supervision is now embedded in midwifery practice within East Sussex Healthcare NHS Trust. Reflective practice, professional curiosity and awareness have increased. Practitioners need to conscientiously move away from the reporting of 'all well, no concerns', to be replaced by a meaningful engagement with women and supporters, demonstrating active listening and responsive reaction.

1.9.16 During the first pregnancy when an ASF was in place, it was not easy to update and include new issues that occurred during the pregnancy. In December 2014, the maternity system was upgraded from Euroking K2 to E3 which has enabled midwives' greater ability to update an ASF. This has resulted in increased number of updated ASFs within the unit.

1.9.17 Ongoing effort and focus to maintain the progress outlined in the above points must be maintained to ensure that frontline staff and practitioners remain supported and up to date in relation to domestic abuse practice and training.

1.9.18 The following recommendation was made within the Individual Management Review for Maternity Services:

- To ensure that on all occasions when a woman is seen with a physical injury or multiple presentations with non-specific concerns that the healthcare professional exercises professional curiosity and asks the question about domestic abuse.

1.9.19 **Hastings and Rother Clinical Commissioning Group**

During 2016, Hastings and Rother Clinical Commissioning Group (CCG) Healthy Hastings & Rother Programme are piloting a service targeted at reducing health inequalities arising from domestic violence which will be in Hasting and St. Leonard's areas only. These pilots aim to improve identification, response and the use of appropriate referral to specialist services for people affected by domestic violence in health settings. While the activity delivered as part of this pilot will

be provided by CGL, it will be aligned to the delivery of the wider specialist service provision in East Sussex delivered by The Portal. With reference to ESHT, this includes a Health Independent Domestic Violence Advisor (HIDVA) within A&E at the Conquest Hospital and (where appropriate) other delivery options for example the Maternity Unit and genitourinary medicine (GUM) clinic.

1.9.20 The development of a HIDVA is recognized as good practice nationally and the responsible commissioner (Hastings and Rother Clinical Commissioning Group) should work with the lead commissioners for specialist services (East Sussex County Council, Safer East Sussex Team) and providers (the East Sussex Healthcare NHS Trust and specialist services) to evaluate the impact of the HIDVA pilot and, if it is successful, sustain and embed this provision locally.

1.9.21 **Eastbourne, Hailsham and Seaford Clinical Commissioning Group and NHS High Weald Lewes Havens Clinical Commissioning Group**

If the HIDVA pilot is successful other Clinical Commissioning Groups in the county should review the findings in order to consider its wider rollout in other Acute Settings across East Sussex.

1.9.22 **Primary Care Services**

It is confirmed that literature on domestic abuse is currently provided at this surgery.

1.9.23 Given the findings related to GPs in relation to domestic homicide reviews[7] and other research and guidelines including the NICE Guidelines for domestic abuse, GP surgeries should do all they can to be domestic abuse aware and to link to local Safeguarding training and practice in relation to domestic abuse. All GPs should have materials in public spaces for their patients to access.

1.9.24 Level 3 Child safeguarding training is provided by the CCG and is available within the surgeries, delivered by the named GP for Safeguarding Children; this training includes information on domestic abuse. All clinicians are able to receive this training including Health Care Assistants. There is also training available on-line via various sites including Kwango, Skills for Health and e-learning for health. Adult Safeguarding training is not currently delivered to the same degree but there are evolving discussions if this will change.

1.9.25 There is very clear guidance for health staff regarding Child Safeguarding training and this is described in the Intercollegiate Guidance. Similar guidance for Adult Safeguarding Training is due to be published by NHSE and is expected to be very similar.

1.9.26 Adult Safeguarding training for Primary Care is not currently delivered by the CCG, however this may change. Primary Care staff can access adult safeguarding training via Kwango or Skills for Health and e-learning for health.

[7] Domestic Homicide Review (DHR) Case Analysis, Report for Standing Together, Nicola Sharp-Jeffs and Liz Kelly, June 2016

1.9.27 The CCG have arranged, in conjunction with the Safeguarding Adults Board, for some training to be delivered to Primary Care. Six sessions were held in 2016. These sessions include domestic abuse and advice to access The Portal.

1.9.28 The following recommendations were made within the Individual Management Review for Primary Care Services:

- Consideration should be given within Primary Care to:
    - Increased professional curiosity with regards to presence of partner and other family members and dynamics of those relationships.
    - Increased professional curiosity when patients present with non-specific symptoms that may be indicative of DVA.
    - Routine screening regarding DVA during Primary Care consultations.
    - Increased awareness and recognition of potential indicators of DVA and knowledge of referral routes.
    - Signposting in surgery waiting areas to DVA services in the locality.
- Designated nurse Safeguarding Adults will engage with primary care colleagues to promote awareness of local domestic abuse resources, signposting to services and training opportunities available.

1.9.29 **East Sussex Healthcare NHS Trust (ESHT), Community Services**

There is ongoing work to improve engagement of fathers within ESHT Community Services. The ESHT Health Visitor Service does encourage involvement of significant males and they are welcome at post-natal groups. There is some literature that has been developed specifically for fathers, some staff work flexibly to meet the needs of working parents and staff are aware of the Local Safeguarding Board course on involving males / information from Serious Case Review Briefings and have access to a document produced by the Named Nurse Community which gives brief safeguarding advice on inclusion of men in a 'top ten tips format'.

1.9.30 However, these measures are not yet part of a consistent, co-ordinated approach across the community service and throughout ESHT. Ongoing work which includes workshops from the Named Nurse/Deputy Named Nurse and work with the clinical leads is planned for 2016 to embed the practice of including significant males in the assessment, planning and delivery of optimum health care support for children.

1.9.31 **East Sussex Healthcare NHS Trust (ESHT), Maternity Services**

The following recommendation was made within the Individual Management Review for Maternity Services:

- To increase professional awareness of men/other people within a family, particularly for women with an identified vulnerability and document this.

1.9.32 **Sussex Police**

They are responsible for policing Sussex and in keeping with national policy and guidelines adhere to the Code of Ethics, which sets the national standards for all staff within the organisation and was created by the College of Policing to put into writing what the police service have long worked to: the highest levels of professional standards.

1.9.33 The chief officers of Surrey and Sussex fully support the introduction of The Code, which has been created to support the difficult judgments and complex choices the service make every day as police officers, members of staff and volunteers.

1.9.34 In tandem with The Code, The National Decision Model (NDM) is the primary decision model for the police service. It replaces all decision models previously used. Dynamic use of the model provides a framework within which to assess and understand what staff deal with, recognise threat, harm and risk, provide clarity in relation to what staff want to achieve and then respond accordingly within a clear legal framework.

1.9.35 The Code further re-enforces this by reminding staff that decisions made must be consistent with its principles and standards of behaviour, are ethically and legally sound and in accordance with an evidence-based decision-making process.

1.9.36 In the context of Domestic Abuse and Child Protection there are policies and clear guidance for staff.

1.9.37 In September 2013, Her Majesty's Inspector of Constabulary (HMIC) was tasked by the Home Secretary to conduct an inspection on the police response to Domestic Abuse. Specifically, the effectiveness of the police approach to domestic violence and abuse, focused on the outcomes for victims and whether risks were adequately managed and to identify lessons learnt on how the police approach this and to make recommendations in relation to their findings.

1.9.38 The HMIC report was published in 2014 under the title 'Everyone's business: Improving the police response to domestic abuse'. Following on from this they also published the result of their inspection of individual Police Forces and published their reports. Regarding Sussex Police this is entitled 'Sussex Police's approach to tackling domestic abuse'.

1.9.39 A number of recommendations were made ranging from a review of training and raising levels of knowledge for call handlers, first responders, secondary investigators, the level of risk, acting upon the recommendations of DHR's and problem profiling. All these recommendations have been/are in the process of being addressed.

1.9.40 For example, from January 2015 to Summer 2015 mandatory training was carried out for first responders focusing on the definition of domestic abuse, responsibilities of the first responder, emphasis on the identification of risk, established risk factors regarding the victim, suspect and children and the National Decision Model, so called Honour Based Violence and firearms.

1.9.41 There is still more work to be done to ensure the HMIC's recommendation recommendations are fully implemented, such as responsibility for ensuring that training is up to date and the continued roll out of Domestic Abuse training.

1.9.42 Following on from this in November 2015 Domestic Abuse Workshops were commenced for secondary investigators, primarily aimed at Divisional Investigation Teams, which a number of SIU officers are now attending given the amalgamation of Child Protection Team and Adult Protection Team.

1.9.43 Sussex Police have taken a robust approach to raising awareness, knowledge and training regarding Domestic Abuse and there is also a wealth of information and guidance on the force intranet and e-learning however all Domestic Abuse training should be mandatory.

1.9.44 The following recommendations were made within the Individual Management Review for Sussex Police which would address the issues identified in the previous section:

- Statements from victims of Domestic Incidents should contain details of their relationship history.
- First Responders should use effective victim questioning/interviewing of the victim to gather comprehensive information to enable accurate completion of the DASH and ask probing questions where the victim clearly states there is controlling, coercive etc. behaviour. This will also assist with identifying the correct level of risk.
  Not only will this give a clear picture of the relationship but will also assist with the identification of level of risk.
- Staff to be reminded to continue taking positive action in arresting offenders and to ensure that a DVPN/DVPO is considered for all cases.
- Staff to be reminded about the referral process to NCDV for applications of non-molestation orders.
- All current Domestic Abuse training should be mandatory for First Responders, Secondary Investigators, relevant Specialist Units and teams.
- Supervisors and Specialist Officers should ensure that they review all the material collated as part of the investigation to ensure that the level of risk has been correctly assessed.
- This should include National Centre for Applied Learning Techniques intranet training that is widely available to all staff.

- Staff that have not completed mandatory training must take personal responsibility to ensure they complete this as part of their CPD. To include officers that have transferred department/s or missed the first round of training.
- Supervisors and Specialist Officers should ensure that they review all the material collated as part of the investigation to ensure that the level of risk has been correctly assessed.

1.9.45 **East Sussex County Council (ESCC) Children Social Care**

The following recommendations were made within the Individual Management Review for Children Social Care which would serve to improve the aforementioned issues identified:

- MASH and TAF administrative processes and systems should be informed by any learning from this DHR.
- The specification and monitoring of the new integrated Health Visiting and Children's Centre service should be informed by any learning from this DHR.
- Staff to be reminded of the need to check the accuracy of family names, details and contact numbers.
- SCARF referrals should be recorded on the adults as well as the children's electronic casefiles for future reference.
- Details of the children of young people referred to the service should be recorded as well as the parent.

1.9.46 **Victim Support and Sussex Police**

Both have improved some of their operational procedures since the time of Henrietta's murder. For example, Victim Support return all non-engaged referrals to the police via a daily email template to the Officer in Charge so that he/she is aware if a survivor has not engaged with the Victim Support service.

1.9.47 Victim Support have also agreed provide more localised support information via Safe: Space. This will be an important improvement for victims. Victim Support will provide this information via text and email where there is consent to do so.

1.9.48 The following recommendations were made within the Individual Management Review for Victim Support which would help address issues identified in the previous section:

- To receive the DASH RIC from Sussex Police to enable the service to have a more accurate picture of risk prior to contact with standard risk victims (this will also allow Victim Support to more accurately identify Medium and High Risk Cases which should be referred to Specialist Domestic Abuse Services).
- To inform Sussex Police if a victim does not engage with the service

- Review the information provided about the sources of help and support locally, including the National Domestic Violence Helpline and local specialist services.

1.9.49 The Police and Crime Commissioner should ensure that as part of regular contract monitoring reviews, ensure that victims are contacted within agreed timescales and are given up to date and accurate information related to local and national services.

1.9.50 The Police and Crime Commissioner and the East Sussex Safer Communities Partnership must continue to address and support the referral pathway for victims who come to the attention of the police, namely these entities must address the gap in service provision for victims assessed to be at medium risk where there is a "non-crime."

1.9.51 **Affinity Sutton**

The following recommendations were made within the Individual Management Review for Affinity Sutton which would address the issues identified in the previous section:

- All neighbourhood housing officers are reminded that any incidents that are reported to them directly, that fall under ASB or domestic abuse procedures, are logged accordingly.
- The Antisocial Behaviour Procedure is amended to say; if the ASB complaint includes domestic arguing, the investigating officer should consider and investigate whether there is domestic abuse and document in their investigation what they have done and the outcome of this investigation. If domestic abuse is suspect, then they should refer to the Domestic Violence Policy and Procedure for guidance.

1.9.52 Affinity Sutton has delivered an initial phase of training for Neighbourhood Housing Officers on distinguishing ASB from domestic abuse and to enhance knowledge of local referral pathways. Further, national roll out of this training is being planned for spring to summer 2017. .

1.9.53 Given the learning from this review related to this individual housing provider, the fact that there is an East Sussex Operational Group for housing, the Independent Chair and panel felt this would be an effective and practical forum where the learning related to housing could be reviewed and extended to other housing providers in East Sussex.

1.9.54 There are also ways in which housing providers can engage with the local processes for safeguarding assurances such as the Section 11 audits done by the Local Safeguarding Children's Board and via the use of the Safeguarding Adults Board Strategic Assurance Tool. Currently, housing providers do not engage in these processes. The East Sussex Operational Group for housing should consider integrating these practices.

1.9.55 The Independent Chair applauds the initiative already taken by Affinity Sutton in beginning to address recommendations 12 and 13 (below) in early 2017.

1.9.56 All single agency recommendations noted in this section will be recorded in the Action Plan for Single Agency Individual Management Review Recommendations. This document is used locally to monitor progress against any single agency recommendations identified during the review process.

1.10 Conclusions

1.10.1 The murder of Henrietta resulted in the loss of a bright and vibrant daughter, sister, mother and friend is devastating. Peter is singularly responsible for this act.

1.10.2 However, this review concludes that the invisibility of fathers to community and family services remains an issue. This indicates that even though this issue has been included in prior Serious Case Reviews in the local area, progress has not been made to sufficiently address it. If more services had known and interacted with Peter, it may well have opened more opportunities to understand the situation of this young family and to address their needs.

1.10.3 For situations where there is known domestic abuse, or indications of it, referral pathways and the relevant processes must be scrutinised and inconsistencies and inadequacies must be prioritised and addressed. To ensure a coordinated community response to domestic abuse, these systems must be audited, discussed and inadequacies must be addressed or survivors of abuse will fall through these gaps. There is some work to do to address the referral pathways for all survivors who come to the attention of the Police. In particular, the feedback from Henrietta's sister should be addressed to carefully consider how services are described to victims and how they are proactively offered. Similarly, there must be increased knowledge and confidence, as well as service provision, in relation to perpetrators so that they can be held accountable and supported to change their behaviour. Areas are requiring professionals to identify perpetrators but to do this safely there must be both training and relevant services to enable this.

1.10.4 And, as with many reviews, there must be continued momentum to train and provide tools (such as safety netting) to ensure that professional curiosity and identification of domestic abuse is fostered in all settings. This is particularly true in relation to healthcare settings where there is opportunity to engage with both the victim and the perpetrator and the wider family. It is likely the place of earliest intervention.

1.10.5 Clearly there is some work to build on locally about enhancing the range of front line services attempting to engage young adults and this may well include their views and experiences of services which may have negatively shaped their attitudes or distorted their understanding.

1.10.6 The role of housing in the early identification of domestic abuse merits highlighting; Affinity Sutton is not alone is its lack of identification of domestic abuse and its mislabelling of this as anti-social behaviour. There are national standards of practice for domestic abuse in housing settings and all

housing providers should adhere to these standards as they will have many tenants in a similar situation to Henrietta.

1.10.7 Importantly, it is not only professionals who require support and information about domestic abuse. Both Peter and Henrietta were surrounded by family and friends advising them and supporting them in the day, weeks and months before the murder of Henrietta. These family and friends knew much more accurately the situation and feelings of Henrietta. However, more needs to be done to ensure that family and friends know pathways to support and when to encourage engagement with services, particularly in cases of first and recent separation.

1.10.8 The Independent Chair is encouraged by the East Sussex Safer Communities Partnership, the leadership of members from this DHR panel, and her discussions with Affinity Sutton that the issues raised in this review are already being addressed. There is strong evidence that the following recommendations will be acted on and monitored robustly as has been the case in previous DHRs. The family of Henrietta feel heartened by this as well and wish to remain informed of the progress on the following recommendations.

1.11 Recommendations

1.11.1 The recommendations below are multi-agency recommendations arising from the review which should be acted on and initial reports on progress should be made to the East Sussex Safer Community Partnership quarterly. Recommendations should be considered alongside other similar reviews and findings.

1.11.2 These are in addition to the single agency recommendations identified in individual IMRs. The Single agency recommendations will be recorded in the Action Plan for Single Agency Individual Management Review Recommendations. This document is used locally to monitor progress against any single agency recommendations identified during the review process

1.11.3 It is the expectation that all agencies involved in this review or the wider East Sussex Safer Community Partnership will share the learning from this review as widely as possible and will incorporate its findings into existing learning and development frameworks.

1.11.4 **Recommendation 1: The East Sussex Safer Communities Partnership** Review pathways so that victims of domestic abuse incidents (not just crimes) are offered a referral to a domestic abuse specialist service.

1.11.5 **Recommendation 2: Office of the Police and Crime Commissioner and the East Sussex Safer Communities Partnership:** Review the current commissioning arrangements for standard risk victims, identifying how to ensure that all victims are able to access help and support from a domestic abuse specialist service and consider how these services are communicated and offered in keeping with the findings of this review and input from Henrietta's sister.

1.11.6 **Recommendation 3: East Sussex Safer Communities Partnership** Explore if there are any improvements that could be made to link those using, or at risk of, using violence and abuse with national helplines such as the one run by Respect as a possible link to support and advice at what could be a critical time. All front-line providers should be reminded of or made aware of this provision of service at a minimum.

1.11.7 **Recommendation 4: East Sussex Safer Communities Partnership** The East Sussex Safer Communities Partnership should review the provision of community based support for those using, or at risk of, using violence and abuse who are not able to access programmes through existing statutory provision.

1.11.8 **Recommendation 5: Hastings and Rother Clinical Commissioning Group** Work with the lead commissioners for specialist services (East Sussex County Council, Safer East Sussex Team) and providers (the East Sussex Healthcare NHS Trust and CGL specialist service) to evaluate the impact of the HIDVA pilot and, if it is successful, sustain and embed this provision locally.

1.11.9 **Recommendation 6: Eastbourne, Hailsham and Seaford Clinical Commissioning Group and NHS High Weald Lewes Havens Clinical Commissioning Group** If the HIDVA pilot is successful, review the findings in order to consider its wider rollout in other Acute Settings across East Sussex.

1.11.10 **Recommendation 7: Hastings and Rother Clinical Commissioning Group** Work with the lead commissioners for specialist services (East Sussex County Council, Safer East Sussex Team) and providers (specialist services) to evaluate the impact of the IRIS pilot and, if it is successful, sustain and embed this provision locally.

1.11.11 **Recommendation 8: Eastbourne, Hailsham and Seaford Clinical Commissioning Group and NHS High Weald Lewes Havens Clinical Commissioning Group** If the IRIS pilot is successful review the findings in order to consider its wider rollout across East Sussex.

1.11.12 **Recommendation 9: Office of the Police and Crime Commissioner** As part of regular contract monitoring reviews, ensure that victims are contacted within agreed timescales and are given up to date and accurate information related to local and national services.

1.11.13 **Recommendation 10: East Sussex Safer Communities Partnership** Ensure that the development of online, downloadable tools for professionals and victim/survivors and their families are developed as planned which will build on the Safety Netting work developed to date.

1.11.14 **Recommendation 11: Sussex Police and the Office of the Police and Crime Commissioner** Continue to improve the referral pathways for victims in contact with the police who are deemed to be a standard risk so that adequate information is shared, the consideration of the victim's experience of intervention and support is fully considered and the safety of the victim is prioritised for both crime and non-crime domestic abuse incidents.

1.11.15 **Recommendation 12: Affinity Sutton** Ensure the IT systems at Affinity Sutton and processes are able to delineate domestic abuse as separate from other tenancy issues or anti-social behaviour to allow for repeat incidents or concerns to be easily understood.

1.11.16 **Recommendation 13: Affinity Sutton** Enhance provision of training to include more distinct modules on domestic abuse and to ensure that contracts with ASB action reflect the domestic abuse policy and procedures and to include this review in training to ensure that child safeguarding concerns are appropriately addressed.

1.11.17 **Recommendation 14: Affinity Sutton** Identify how to disseminate information to tenants about the support available to those who experience abuse at home.

1.11.18 **Recommendation 15: East Sussex Housing Operational Group** Review the findings relating to Affinity Sutton, in particular the general need to take a proactive approach to identifying domestic abuse and not conflating it with anti-social behaviour, and seek assurance in relation to the standard of practice by other housing providers.

1.11.19 **Recommendation 16: East Sussex Housing Operational Group** Review practice related to the minimum standards for housing providers such as those promoted by the Domestic Abuse Housing Alliance[8] (endorsed in the national VAWG strategy).

1.11.20 **Recommendation 17: Safeguarding Adult and Children's Board** Ensure that housing providers are engaged within the local processes for assurance, including the Safeguarding Adults Board Strategic Assurance Tool and Local Safeguarding Children Board Section 11 audits to ensure that safeguarding practice is monitored and addressed.

[8] For more information go to http://www.peabody.org.uk/resident-services/safer-communities/domestic-abuse/daha