FENLAND
Community Safety
Partnership

Domestic Homicide Review:

Overview report:

Death of Ben

December 2018

Independent Author: Mr Jon Chapman

Contents:

1. Introduction

1.1 This review is initiated by the homicide of Ben, who was stabbed and killed by his partner Amy. This occurred during a violent attack by Ben upon Amy. At the time of his death Ben was 39 years of age and Amy was 46 years of age. In any review it is important to try to understand the victim and this important perspective is often given by those who were close to them, the family and friends. In this case Ben's mother, sister and son all met the author and discussed the case. They did not wish to meet the panel.

1.2 Ben was the oldest of four children. He grew up not knowing his father who left the family home before he was born. When he was aged 5, he was involved in a very serious car accident and spent over 6 months in hospital. It was believed that Ben would not survive his serious injuries. Although Ben recovered, his mother was told that he had a mental age below his years whilst he was at senior school. Ben is described, by his mother, as a 'normal' child and teenager.

1.3 Ben had a number of relationships over the years and was the father to 5 children and one other child who he treated as his own. His mother would say that there was turbulence in the early relationships, but no more than you might expect. More recently Ben formed a relationship with Amy, and they moved in together. Amy had two children when their relationship started, these were Child A and Child B. Amy was not, in fact, the biological mother of these children but assumed the role of mother as a result of a Child Arrangement Order, previously arranged whilst she lived in a different area, this was not known to other family members.

1.4 Ben's family would describe Amy as a strong character, they were aware that both Ben and Amy drank alcohol every day and this, on occasions, fuelled conflict in their relationship. Both were involved in the use of controlled drugs, which they would take at home. There was a period when Ben was estranged from Amy and during this time Ben's family would say that to a large extent Ben was able to manage his alcohol and drugs use much better and was seeking support from services for this.

1.5 The Ben's family say that both Ben and Amy 'were as bad as each other'. Amy would know how to aggravate Ben and would do this regularly, which caused tension and discord in their relationship, which the children were exposed to.

1.6 Ben's mother was aware that there had been violence in the relationship and recounts an example in Christmas 2017, when there was a very heated argument between Ben and Amy during which they went upstairs. When Amy returned, she had marks and bruises on her face which Ben's mother assumed Ben had caused.

1.7 An insight for the review author and panel into the children's lived experience has been taken from the accounts given by the children following Ben's death. The children witnessed drug taking and excessive drinking by the adults at the address. There was evidence of neglect both in the care and living conditions afforded to the children. There was also physical abuse by assault and by being locked in the address by both Amy and Ben. The children witnessed domestic abuse between Amy and Ben, with both parties assaulting one another.

2. Timescales for completion

2.1 This report was commissioned by the Fenland Community Safety Partnership (FCSP). This statutory partnership brings together several agencies with the aim of reducing crime, disorder and anti-social behaviour across the Fenland area of the County of Cambridgeshire.

2.2 The tragic death of Ben occurred in December 2018. The death was reported and referred by the police to the Fenland Community Safety Partnership on in January 2019. The death was also referred to the HM Coroner.

2.3 The chair of the FCSP determined that a domestic homicide review was necessary in accordance with the 2016 Home Office statutory guidance for multi-agency domestic homicide reviews. Statutory agencies were duly notified of the requirement to identify and secure relevant material.

2.4 At the DHR panel meeting held in March 2019, the Independent Chair clarified that although efforts would be made to complete the review process in a timely manner, that an extension beyond six months would be likely and chose to notify the Home Office of a possible delay, given the circumstances of the ongoing criminal investigation, and the need to seek information across a number of counties and health areas.

2.5 The DHR panel discussed what was known at that time from the initial agencies trawl of information, the meeting did not identify any urgent matters for action but noted that there was likely to be some learning to be achieved. Importantly, the identified safeguarding issues involving the two children in this case, Child A and Child B, were already being appropriately addressed by respective agencies.

3. Confidentiality

3.1 The findings of this review are confidential. Information is available only to participating officers/professionals, their line managers and the respective agencies commissioning professionals. The report has included pseudonyms where necessary to protect the identity of the individual(s) involved. The pseudonyms were selected by the author after consultation with the family.

The review is owned by the Fenland Community Safety Partnership.

4. Terms of reference

4.1 The critical dates for this review have been designated by the panel as to reflect the background of domestic abuse within the lives of Ben and Amy. This has included significant historical information to contextualise the sometimes, complex relationships. However, the chair has asked agencies to ensure that the matters are both relevant and contextual.

4.2 The purpose of this DHR is to:

a) Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims.
b) Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result.
c) Apply these lessons to service responses, including changes to inform national and local policies and procedures, as appropriate.
d) Prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity.

4.3 The further specific areas that this review would like to address are:

a) To what extent was the misuse of alcohol an issue in this DHR
b) What extent were the children affected by the domestic abuse in the household

Therefore, timescales for this review will be from 1st January 2011 extending to 28th December 2018.

5. Methodology

5.1 This overview report has been compiled based on the comprehensive Individual Management Reviews (IMRs) prepared by authors from the key agencies involved in this case and other relevant agency information, where IMR's have not been required. Each IMR author is independent of the victim and family of the victim, and of management responsibility for practitioners and professionals, whom have been involved in this case.

5.2 The overview author has also fulfilled a dual role and has chaired the panel meetings in respect of this domestic homicide review process. This is recognised as good practice and has ensured a continuity of guidance and context for the review. There have been a number of useful professional discussions arising and the panel meetings have been referenced and minutes taken appropriately for transparency. The author has made himself available for

contact by professionals involved in this review throughout the duration of the review process.

5.3 In support of the information received from agencies, the author has sought to engage with the family of Ben and Amy. Ben's family have been able to discuss the review following the prosecution decision. Amy who was on bail for some considerable time, despite repeated requests, including the offer of obtaining independent advocacy, has declined to speak to the review author or any other panel member.

5.4 It is important that this Domestic Homicide Review has due regard to the legislation concerning what constitutes domestic abuse which is defined as:

Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members, regardless of gender or sexuality. This can encompass, but is not limited to, the following types of abuse: psychological, physical, sexual, financial, and emotional.

5.7 The Government definition also outlines the following:

Coercive behaviour is an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim.

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

5.6 Section 76 of the Serious Crime Act 2015, created a new offence of controlling or coercive behaviour in an intimate or family relationship. Prior to the introduction of this offence, case law indicated the difficulty in proving a pattern of behaviour amounting to harassment within an intimate relationship.[1] The new offence, which does not have retrospective effect, came into force on 29th December 2015.

5.7 It is important to clarify that this review is not about who is culpable, but how do we learn to prevent domestic abuse in the future and learn the lessons from what has occurred in cases such as this.

6. Involvement of family, friends, work colleagues and community

6.1 Unexpected deaths are tragic not just for the family, but also for friends, and this can also extend into the local community and neighbourhood. This perspective may also extend to work colleagues and the nature of the tragedies may endure through children and their lived-in experience.

[1] The Statutory Guidance cites the following cases - Curtis [2010] EWCA Crim 123 and Widdows [2011] EWCA Crim 1500.

6.2 The Home Office leaflets providing information for those affected by domestic abuse and the process of such reviews have been provided to family members and the accompanying letter emphasised the opportunity and encouragement for those individuals to participate in this review process. Seeking and hearing individual's voices may enlighten services concerning issues that may not have been addressed within the terms of reference. The review has also highlighted the opportunity for them to obtain advocacy support.

6.3 Specifically, an independent specialist advocate has been engaged to seek a pathway to communicate to the children, for their voices to be heard in a suitable environment. This perspective also ensured that the police homicide investigation was not compromised.

6.4 Key matters pertaining to individuals are addressed in the respective body of this report, but it is acknowledged by the review that they are survivors of this tragic episode, not least the family of the deceased and this review should be regarded as a way forward in identifying and supporting others who may have similar needs. Obtaining individual and sometimes personal views may also identify intervention opportunities for agencies in future and similar cases.

6.5 Ben's family agreed to be part of this review once the decision on prosecution had been made. They declined to be part of the process during the panel stages, due to their part in the criminal justice process, but were updated by the police family liaison officers. The findings and the report itself have been discussed with them. The perpetrator of the review, Amy, has been contacted on several occasions through various agencies and as mentioned above has declined to be part of the review. The Crown Prosecution Service made the decision that, in this case there was not a realistic chance of a conviction, due to the likely defence of self-defence and therefore the prosecution against Amy was withdrawn.

7. Contributors to the review

7.1 The following agencies have contributed to the review: Each of the agency authors is independent of any involvement in the case including management or supervisory responsibility for the practitioners involved. The review panel has extended requests to the relevant services and agencies within the other areas.

- East Anglian Ambulance Service Trust (EAAST)
- Cambridgeshire Constabulary
- Cambridgeshire and Peterborough Clinical Commissioning Group – on behalf of involved GP Practices
- Cambridgeshire and Peterborough Foundation Trust (CPFT)
- Queen Elizabeth Hospital NHS Trust, Kings Lynn
- Fenland District Council Housing Services
- Inclusion/CGL Drug and Alcohol Services
- Cambridgeshire County Council, Children's Services
- Head Teachers of Children's school
- Cambridgeshire Education Authority

- Cambridgeshire County Council Adult Safeguarding
- Cambridgeshire and Peterborough Independent Domestic Violence Advisor (IDVA) services

8. Review Panel members

8.1 The following individuals and agencies comprise the DHR panel or have acted in an advisory capacity to the panel and independent chair.

Name	Agency	Role
Deidre Reed	Independent domestic abuse advisor to panel	Operational IDVA Manager
Mandy Geraghty	Independent domestic abuse advisor to panel	Refuge Service Manager
Selina White	Independent Advisor on substance misuse	Safeguarding Lead CGL
Tracey Martin Sarah Gove	Fenland Housing	Lead Housing Officers
James Bambridge Laura Koscikiewicz	Cambridgeshire Constabulary	Review Officer Head of Public Protection
Paul Collin	Cambridge and Peterborough NHS Foundation Trust (CPFT)	Head of Adult Safeguarding
Julia Cullum	Cambridgeshire County Council	Domestic Abuse and IDVA service
Carol Davies/Linda Coultrup	Cambridgeshire and Peterborough Clinical Commissioning Group	Designated Nurse/ Lead Nurse Safeguarding Adults
Caroline Sexby	East of England Ambulance Service NHS Trust	Safeguarding Lead
Jerry Green Tracey Denny	Queen Elizabeth Hospital Kings Lynn	Safeguarding Leads
Chris Meddle	Cambridgeshire County Council	Senior Leadership Advisor Education Services
Alan Boughen	Fenland District Council	Community Safety Partnership / Manager
Helen Duncan	Cambridgeshire County Council and Peterborough City Council	Head of Adult Safeguarding/Principal Social Worker
Jitka Kohoutova	Cambridgeshire County Council and Peterborough City Council	Team Manager Children Services

Jon Chapman	Independent	DHR Chair and report Author

9. Panel Chair and author of the overview report

9.1 The Independent chair and overview author, Mr Jon Chapman, is provided by RJW Associates.

9.2 He is a retired senior police detective and senior investigating officer. He was formerly the head of the Public Protection Department of the Hertfordshire Constabulary. He is also the Independent Chair of several Child Safeguarding Practice Reviews. He has extensive experience in partnership working within safeguarding environments and authoring Serious Case Reviews. He also has significant experience in conducting Domestic Homicide Reviews, MAPPA reviews and other safeguarding practice reviews having both chaired and authored numerous reviews across the country.

9.3 Mr Chapman and RJW Associates have no connection with the Fenland Community Safety Partnership, other than the provision of case reviews.

10. Details of any parallel reviews

10.1 An investigation was commenced by the Cambridgeshire Constabulary in December 2018, which then became a homicide investigation when Ben died. The death of Ben was reported to HM Coroner in accordance with Coronial Law.

10.2 A post mortem conducted shortly after the death of Ben, concluded that the death was attributable to injuries that Ben appeared to have sustained in the incident in December 2018, however, pathology also identified that the deceased had another chronic disease, which may possibly have contributed to his death.

10.3 Following case papers being submitted to the Crown Prosecution Service it was concluded that if the case proceeded to trial it was unlikely that the Crown could rebut the defence of self-defence. In these circumstances there was not a realistic prospect of conviction and therefore no prosecution continued against Amy for the offence of murder.

10.3 Her Majesty's Senior Coroner for the district, Mr David Heming, has also been notified of the domestic homicide review process. An Inquest has been opened and adjourned pending a full hearing at a date to be notified. The review author is cognisant of the fact that the review process may assist the Coroner in concluding those Inquest proceedings. HM Coroner will therefore be given access to this overview report and will be kept informed as to the progress of the review.

10.4 In respect of the two children, cared for by Amy, there are current proceedings within the Family Court which are being managed by Cambridgeshire County Council Children's Services.

11. Equality and diversity

11.1 Both Ben and Amy were white British and had resided in England since birth.

11.2 The author is satisfied that the IMR authors and the DHR Panel have addressed, where appropriate the protected characteristics under the Equality Act 2010 and in accordance with the terms of reference. Specific comment is made accordingly within the report narrative where appropriate in respect of those characteristics which are,

- Age
- Disability
- Gender reassignment
- Marriage and civil partnership
- Pregnancy and maternity
- Race
- Religion or belief
- Sex
- Sexual orientation

11.3 Ben, although involved in an accident in early life, was not diagnosed with any disability or mental health conditions. Both Ben and Amy abused substances, alcohol and controlled drugs. Ben at times did seek support for his substance misuse. The panel considered how these aspects may have affected their access to services.

11.4 When considering the circumstance of Ben's death, it is more usual for females to be killed by male partners. Of the 270 female victims of domestic homicide from March 2016 to March 2018, the suspect was male in 260 cases (96%). (ONS, 2019)

12. Dissemination

12.1 A copy of the report will be disseminated to all agencies identified as being involved in the case, as listed in section 7, for consideration of their involvement and appropriate reflection and action. The report will also be shared with the Cambridgeshire Police and Crime Commissioner as well as the Cambridgeshire Domestic Abuse Sexual Violence Partnership. An anonymised version of the report will be published on the Fenland Community Safety webpage which can found on the website of Fenland District Council.

13. Background

13.1 The circumstances are, that on an evening in December 2018, around 9.30pm, Ben and Amy were involved in a violent domestic incident at their home address. Amy sustained several injuries in the incident and the violence resulted in Ben being stabbed with a pair of scissors by Amy, whereby he sustained wounds to his neck and chest.

13.2 Ben was taken to hospital by ambulance, suffering a cardiac arrest shortly afterwards. He was admitted to the critical care unit, where his condition continued to deteriorate over the next few days resulting in his family consenting to the withdrawal of his life support. He passed away, having not recovered consciousness.

13.2 Amy was arrested, and in interview she stated that she was a victim of domestic abuse by Ben. She told officers that they normally got on well, the exception being when he consumed alcohol and a consequence of which he would frequently become violent. She stated that on the day of the incident he had drunk about two thirds of a bottle of vodka and started pushing her around, so she went upstairs to get away from him. He followed her and began to violently assault her, by punching her repeatedly to the face and head. She was thrown to the floor and he continued to assault her. She picked up some scissors and lunged at him, as he was trying to strangle her. She thought he was going to kill her. She was just trying to get him off and stop strangling her. The assault stopped when Child A screamed at him. Child A's sibling, Child B, who was out of the house at the time, returned home and called the police.

13.3 When the incident was reported to the police, they discovered that Amy had substantial bruising to her face, which required hospital treatment and which she stated was caused by Ben.

13.4 At the beginning of December 2019, following case papers being submitted to the Crown Prosecution Service a decision was made that there would be no charges proffered against Amy in relation to Ben's death on the basis that the prosecution felt that they would be unable to rebut the defence of self-defence.

14. Chronology

14.1 Both Amy and Ben had been involved in several relationships before they met, with Amy also being involved in a relationship with another man, since they had met.
In so far as the commencement of the relationship between Ben and Amy is concerned, this is believed to have started during the latter part of 2015.

14.2 Family close to Amy have provided information that Amy had a history of abuse from men she was in relationships with, where she was the victim of both physical violence and controlling behaviour. It is said, by some of Ben's family, that many of the arguments were around Ben's excessive drinking and fuelled by drug taking by both Ben and Amy.

14.3 There were several, domestic related incidents involving Ben with his previous partners and also for Amy and her partners at the time. These are outside of the timeframe of this review as determined by the panel. They are referenced to provide context of where the incidents occurred and an indication of similar facts but will not be examined in detail. Primarily, incidents will be examined from 2011 onwards.

Chronology relating to Ben

14.4 Ben has, as has already been stated in this report, resided in other areas of the UK within the agreed review period. He has, prior to 2011, been in relationships with different women.

14.5 Ben was born in the London area. He has resided in several locations across the country and those include Lincolnshire in 2006/7, West Mercia in 2012 and Cambridgeshire in 2016. Members of his immediate family reside in both Cambridgeshire and Norfolk. Ben has no criminal convictions or cautions, although he was arrested on three occasions, once in 2007 and twice in 2016. Each of those arrests was for alleged domestic assault. He has five biological children, but none of them have had any recent contact with him.

14.6 In January 2012, a report was made to West Mercia police by Laura who stated that she was in a relationship with Ben and she had 'learning difficulties' which she claimed were 'caused' by Ben during an argument. This was referred to social care, but no other action was taken.

14.7 In March 2012, West Mercia police report that during an adult protection meeting concerning risks to Laura, it was reported that she had been seen with bruises, inflicted by Ben. Ben had reportedly thrown items at her. Laura had agreed to be placed in a women's refuge in order to separate from him but wasn't at the time able to make any formal complaint of assault. It transpired that having been found accommodation at a refuge by social services, she left and returned to be with Ben.

14.8 In May 2012, in a report by West Mercia police, Laura had returned to live with Ben, it was reported that she had wanted to give him another chance. She had since become fearful of further domestic violence, although not disclosing that any had occurred at that time. Even though it was her accommodation, she was fearful of asking him to leave. This was reported to her family worker, who in turn alerted the police, who attended and advised Ben to leave the accommodation, which he did.

14.9 Between September and October 2012, in a report from West Mercia police, it was noted that Laura, who had been in a relationship with Ben for about ten months, was pregnant with his child. Laura had disclosed to her mother, that she was fearful of Ben's temper and he would throw things around the house and threaten to harm himself. She told her mother that she wanted to leave the relationship.

14.10 In the latter part of October 2012, West Mercia police reported that Laura had left Ben after a 'domestic' at the beginning of that month and had then resided with her

mother. She had then returned to Ben, fearful that her child would be taken into care. Laura and the child were identified as being at risk due Ben's violent behaviour and abuse.

14.11 On the 13th December 2012, Ben attended his GP reporting that he had been abusing alcohol both currently and historically. Ben had been advised by his key worker to seek medication for his cravings and his physical reaction to alcohol abuse. He was prescribed medication and a follow up appointment for testing.

14.12 In June 2014, in a report from West Mercia police concerning Laura and Ben, it is recorded that their '*child 'E' had been taken into care due to the volatile relationship between the parents*.' Laura was in fact expecting their second child imminently and wanted to leave the relationship due to her fear for the unborn child. Laura did not disclose any specific incidents, however she wanted to break away from him.

Chronology relating to Amy

14.13 Amy was born in Cambridgeshire and has resided in both Cambridgeshire and another area. Amy has also been in several relationships within the review period. She is known to services, (which has been confirmed in particular from records held by the police) by a number of different surnames. The reason for her changes of name appears to link to or reflect her relationship at that time. The police IMR author comments that her frequent 'change' of surname has made it difficult to accurately and chronologically assess her full involvement and contact with the agencies. At least eight different surnames have been used by Amy. On occasions Amy appears to have provided different surnames for no apparent reason. She has two children of her own, both of whom are adults. Amy has two other children in her care, Child A and Child B.

14.14 Amy has come to the notice of the police on several occasions, principally as a victim of domestic abuse involving her respective partners. She has a criminal record for assault in 2007, which was not domestically related.

14.15 In February 2014, Cambridgeshire police received a report of a domestic incident, involving Amy and her partner Mark. Mark had reportedly taken an overdose of medication and alcohol. Officers assessed the risk (to Amy) as high on the Domestic Abuse, Stalking and Harassment (DASH)[2] risk assessment. Two children were recorded as being within the household, believed to have been Child A and Child B, although both were identified with different surnames to Amy.

14.16 In May 2014, following an argument with Amy, Mark had attempted to hang himself and was discovered by Amy who prevented him from serious injury. He was taken to hospital and discharged himself, returning to her home where he caused damage after she refused to allow him in. Police attended, detained Mark, although no action was taken against him. On the resulting DASH report, the children (again recorded with different

[2] Domestic Abuse Stalking and Harassment – DASH – tried and tested checklist of questions for victims to understand and standardise the level of risk.

surnames) are referenced on this occasion as niece and nephew. In fact, it was the case that Amy was not the biological mother for Child A and Child B or related in any way. The case was referred to the IDVA service but despite a number of contacts Amy did not wish to engage with the service.

14.17 In early August 2014, Mark contacted police concerning his 'ongoing problems with Amy'. Mark alleged that Amy was causing distress to his daughter, whom, although of adult age, had a mental capacity of a young child. This incident was recorded, not as domestic occurrence, but that Mark was concerned that Amy was attempting to get him to breach his bail conditions.

Chronology relating to Ben and Amy

14.18 In the latter part of 2015, Ben and Amy formed a relationship although it would appear that Ben was still also involved with Laura.

14.19 On 29th April 2016, Ben visited his GP practice concerning his drug and alcohol dependence. He wanted to stop drinking but was advised to reduce his consumption slowly on a weekly basis, rather than stop abruptly[3]. He was referred to alcohol services.

14.20 In early July 2016, Laura reported a domestic incident occurring between her and Ben. They had both been drinking and Ben accused her of flirting with other men as they walked back to their home. He head-butted her and she sustained facial injuries. Ben was arrested but denied the offence, stating that the injuries were sustained when Laura fell off her bicycle. No further action was taken due to insufficient evidence. A DASH risk assessment recorded the risk as medium; this was later re-assessed as high, and a referral was made for the case to be heard at the Multi Agency Risk Assessment Conference[4] (MARAC). The case was not processed from the Multi-Agency Safeguarding Hub (MASH) to MARAC for six days. The IDVA service was involved with Laura and safety planning and liaison with Children Services was undertaken. The IDVA service attempted to make contact with Laura but were unable to do so as Laura was moving between areas.

14.21 In July 2016, Ben attended his GP practice in respect of his alcohol misuse. He had been referred by inclusion services advising him to seek medication and support for his mood swings. Ben reported that he "*gets angry and feels low*". He was provided medication and vitamin supplements. Ben stated that he had not been drinking for three weeks.

14.22 In early August 2016, Laura reported that Ben had attacked her whilst under the influence of alcohol. He was allegedly jealous of her 'new friend' and during the incident, it

[3] Alcohol use disorders; diagnosis and management of physical complications. NICE Guidance 2010. (Accessed 12th October 2020)
https://www.nice.org.uk/guidance/cg100/chapter/Recommendations#acute-alcohol-withdrawal

[4] Multi Agency Risk Assessment Conference (MARAC) - is a victim focused information sharing and risk management meeting attended by all key agencies, where high risk cases are discussed, and actions taken to address the risk.

is alleged that he put Laura in a strangulation hold. Ben was arrested; however, no further action was taken against him. This incident was assessed as medium risk and referred to the IDVA service.

14.23 There is family information to say that October 2016 was a particularly turbulent time in Amy and Ben's relationship. This was attributed to both Amy and Ben using cocaine. There were arguments on a daily basis culminating in a substantial dispute at the end of October where Ben was pushed down the stairs and he responded by holding Amy by the throat against a wall and Amy slapping and punching Ben.

14.24 In November 2016, Ben contacted a health professional at his GP practice. The record indicates; *"Spoke to [Ben] who does not want to speak to me so put his partner on the phone with his consent I spoke to her. [Ben] is drinking a lot of alcohol and his behaviour is getting worse, he is very angry*". Professionals persuaded Ben to attend in person, and he did so later that day and he confirmed that he had not been under the community alcohol services as was thought to be the case and was drinking excessively and having anger issues. He was referred to alcohol support services and given prescription medication.

14.25 In February 2017, Cambridgeshire Constabulary received a report of a 'domestic disturbance' at Amy's home address, in a call purporting to be made by Amy, although no words were spoken by the caller. When officers attended, they were told by the occupants, that there had been a party and things were 'boisterous'. However, the attending officers did not obtain any details of those present. The attending officers reported that there were no offences, and no referrals were made.

14.26 There is an incident that is of direct relevance to the children (Child A and Child B) within Amy's household. This is not however, related to domestic abuse, but is contextual to the safeguarding issues herein.

14.27 This recorded incident, in May 2017, is in a report by the primary school Child A attended. Child A had not been seen at school for more than a week and there had been no parental contact with the school. School staff attended Amy's home and were unable to see either Amy or Child A. A third person (female) was present who was not apparently related to either Amy or Child A. The premises were reported to be in a *"very poor condition*" both internally and externally with *"rubbish everywhere".* The school attempted other lines of communication with Amy but were unable to speak to her. Two days later a phone call was made by the school to the home, it was answered by a child with an adult instructing the child to end the call. The school were so concerned that they referred those concerns to the police, who raised an incident for a prompt (as soon as possible) attendance.

14.28 A police officer attended Amy's address later that day and spoke with Amy who advised the officer that Child A had a *"medical issue*". The attending officer recorded that there was no safeguarding concern but had taken 'a quick look' around the premises. The information was passed back to the school accordingly by the attending officer. The police IMR identifies though that the time spent by the officer at the location was only three minutes.

14.29 In early July 2017, the school and educational welfare lodged information before the local Magistrates in respect of Child B's poor attendance record. The parents (Amy and Ben) failed to appear in response to the information as laid and were fined.

14.30 In early May 2018, Ben was seen by the local alcohol and drugs inclusion service. He stated that he was experiencing auditory hallucinations and had been doing so since he was 2 years old. He stated that these would trigger his aggression and that he would frequently react first and think later. He felt he was unable to separate the triggers when he was drinking alcohol. He alluded to suicidal ideations and previous self-harm. He indicated that he had not spoken to his GP about his anxiety and depression and did not wish to take medication or engage in any treatment at that time.

14.31 Ben indicated that his partner Amy, whom he lived with, was allegedly undergoing treatment for spinal cancer. Also, in the home were two children. Ben did identify that there had been a physical altercation (although he did not disclose the severity) at Christmas when he was under the influence of alcohol. There was no police involvement and he stated that he and Amy talked about it and resolved the issue. Ben was insistent that the children were not witnesses to this and had no knowledge of the incident.

14.32 Ben stated that the children want for nothing and are well cared for. He did note that he was concerned that Child A was "getting an attitude" and believes that his stopping alcohol use was one means to reducing this issue.

14.33 Ben had been in treatment previously with Inclusion Services in 2016. He stated that he was not able at that time to make changes, so dropped out of treatment, but he was now ready to make changes in order to become alcohol free. His current alcohol consumption levels were self-admitted as being at 2 cans of lager and 2.5 litres of cider, daily. He was signposted to group therapy but indicated his anxiety of being within a group and that he would respond better with one-to-one support.

14.34 Ben engaged well with the alcohol inclusion service, attending seven from a total of fifteen sessions before his engagement tailed off. The key worker described him as 'open and likeable'. His dis-engagement would have coincided with the breakdown of his relationship with Amy.

14.35 In May 2018, Ben was admitted to hospital suffering from chest pains that had become increasingly worse over the previous 3 days but had been present for some 2 months. His medical history declaration indicates that he admitted to consuming 6 litres of cider and a bottle of vodka daily, although when seen by a doctor he stated that his consumption was several cans of alcohol daily. He was discharged following assessment for cardiorespiratory exercise test in June 2018, but Ben did not attend that appointment.

14.36 In August 2018, one of Amy's dogs bit a neighbour's child, although there is no indication that any formal action was taken. It is a matter of fact, that there were a significant number of dogs at the address. There is an inference that the small house was unsuitable for the significant number of dogs that were present.

14.37 In September 2018, a fire was reported outside Amy's address. A mattress was set alight outside of the premises, which caused some slight fire damage to the exterior of the premises. Nobody was injured in this incident; however, it is noted that Amy's partner, whom was with her when the fire occurred, was now Paul. Amy stated that she believed that the fire had been started deliberately by her former partner, Ben, who had moved out of the home 3 to 4 weeks previously and since then he had been bombarding her with messages, following her and attempting to force friends to encourage her to contact him. There was no evidence to link Ben to the offence although it is noted that although the arson crime was reported, Ben was not traced and interviewed. However, the most significant element to this reported incident was not the arson report itself, but the fact that Amy chose to disclose an assault on her by Ben some nine months previously when officers returned to investigate the fire the following day. It is of note that she confirmed that she was in a relationship with Paul, who was living at the address.

14.38 Amy stated that she was at home on Christmas Day 2017, with Ben, his mother, and her children. A verbal disagreement between the three adults took place following Ben confronting his mother. This caused Amy to intervene and separate them. Following this Amy went upstairs only for Ben to follow her, where he then confronted her and assaulted her, allegedly causing a broken nose. Ben then left the address and despite Amy being advised by Ben's mother to contact the police, she didn't. Photographs were taken on a mobile phone of her injuries at the time. She did not seek medical attention. Ben returned very early the next morning and after being refused entry by Amy, he threatened to set fire to the front door.

14.39 This was recorded as a crime of assault. However, Ben's mother was not seen, nor were the children assessed as possible witnesses. The crime was filed as a common assault, for which the time limitation for prosecution is just 6 months from the date of the actual assault. It was deemed therefore, that the crime could not be progressed, and Ben was not interviewed about the allegation. The photographs of injuries to Amy purporting to be those sustained on that date were retained. These photographs have been viewed by the DHR chair and the panel, it is clear to them that Amy had sustained an injury, allegedly caused by Ben. They also bear a striking similarity to those injuries sustained by Amy in the December 2018 incident.

14.40 Amy's GP records indicate that the practice received notification of domestic violence in the household arising from the incident reported in September 2018. Children's Social Care records also indicate that they received the same referral.

14.41 In mid-September 2018, Children's Social Care made a visit to the family home to see the children in view of the recent DASH risk assessment and referral, which included the arson attack, as a single agency enquiry. Both children were seen but made no disclosures regarding concerns. The referral shared concerns that the children were present and appeared to be scared of the previous partner, believed to be Ben. The referrer also shared that the children were often seen spending time and staying in neighbouring homes.

14.42 In October 2018, Children's Social Care (CSC), were notified of domestic violence involving Paul and Amy. Later in October CSC again visited the family to see the children and both were seen, again there were no disclosures made and the discussions formed part of the same Children Services assessment.

14.43 In October 2018, Paul contacted Cambridgeshire Police stating that he had been punched and bitten in an assault on him by Amy. Amy then came to the 'phone making a counter allegation and further calls were received from a neighbour and from Child B, who stated that Paul had broken into the house. Paul was arrested, however no prosecution ensued. A Multi-Agency Safeguarding Hub (MASH) referral was made by the police and records show that Amy's GP received a MASH safeguarding referral on the same date.

14.44 Just over a week later, on 13th October 2018, police officers attended a reported disturbance at Amy's address. On attendance Amy informed officers that there was no dispute, but she was struggling with the recent deaths of her brother and sister and that Ben was there assisting Amy in coping with her issues. In short, Ben was back in the household within a week of Paul having left. Neighbours indicated that there had been no disturbance, however it was established that Amy was on the phone to mental health services at the time and for that reason officers chose to alert other agencies by making an adult at risk referral for Amy as opposed to a DASH referral.

14.45 At the end October 2018, the single agency assessment was concluded by CSC. There was confusion over whether the assessment was focusing on the previous relationship with Ben and the historical assault or the current relationship with Paul. Amy indicated that she had since ended the relationship with Paul and on this basis the assessment was closed. Wider consideration to the continuing pattern of domestic abuse in relationships and the impact on the children was not given. Amy accepted that professionals had concerns about her partner, and she was advised of accessing Clare's Law[5] to gain information about his offences. Amy advised CSC that she had worked with the police to ensure that her previous partner does not return to the home and had formulated a safety plan for Child A and Child B. There is no indication that CSC considered a disclosure under the 'Right to Know' of the Domestic Violence Disclosure Scheme.

14.46 CSC reported that Child A was being referred to CAMH[6] for assessment. Both children were reported to have witnessed the behaviour between Amy and Paul and neighbours also supported this perspective. However, both Child A and Child B were spoken to, but made no disclosures or mentioned anything that was worrying them at home. Amy indicated that she had a large support network and that there were many people that her children could speak to if they were worried about anything.

14.47 In November 2018, Ben's mother, contacted Cambridgeshire Police with concerns for the welfare of Ben, his partner and children. This appears to have stemmed from an incident that followed on from the Christmas Day in December 2017, when Ben assaulted Amy and

[5] Clare's Law – Domestic Violence Disclosure Scheme - https://www.cambs.police.uk/information-and-services/Domestic-abuse/Clares-law

[6] CAMH – Children and Adolescent Mental Health

which, since that time, his mother had not spoken to him. The mother had seen Ben in the town centre, and he had approached her in a threatening and confrontational manner, causing a member of the public to intervene. Ben was seen by officers but denied any wrong-doing and as his mother would not support any action, the incident was closed. On the same day, it is alleged that Ben caused some damage to another member of his family's home, which may possibly have linked into the earlier incident involving his mother. There was no evidence against Ben and the matter was closed without further investigation.

14.46 In December 2018, the incident that led to Ben's death occurred. Amy's account of the incident was that she was being attacked by Ben and being beaten about the head and body and retaliated by striking out with scissors in her hand.

15. Overview

15.1 In creating a timeline of Amy's relationships in the 12 months leading up to the tragic events of December 2018, it is of note that Amy entered into a relationship with Paul in the latter part of 2018. Following an incident of arson at Amy's address, which Ben was suspected of, although this was never substantiated, Amy disclosed a serious assault on her by Ben, occurring the previous Christmas. In October 2018, Paul made allegations that he'd been bitten and punched by Amy. It transpired that Paul had broken into the house and assaulted Amy. Paul was arrested but no proceedings followed, after communication with the Crown Prosecution Service. On the termination of the relationship with Paul, Amy renewed her relationship with Ben. Agencies, particularly children services, were confused when dealing with referrals as to whether they concerned Ben or Paul.

15.2 What was known by agencies and professionals about Ben and Amy? There is apparent evidence and information from a range of agencies that identify that Ben was the perpetrator of a number of instances of domestic violence against his former partner Laura. Laura was victim on a number of occasions both within Cambridgeshire and prior to that within West Mercia. In that respect, there is significant similar fact evidence against him, which identifies some similarity within his behaviour, linked to the consumption of alcohol.

15.3 The Independent Domestic Violence Advisory service (IDVA), report that Ben was known to their service, as a perpetrator, and had been discussed at the Multi-Agency Risk Assessment Conference (MARAC) in respect of Laura. At that time Laura was in fact resident just over the Cambridgeshire County boundary in Norfolk.

15.4 The case was heard at MARAC in July 2016. It was established that they had been in an abusive relationship for some 6 years and had 2 children, whom were in care of their grandmother out of the area and had been placed in her care by the local children's services. In August 2016, Laura had reportedly returned to Cambridgeshire and it appeared that she had reconciled with Ben and she was living at the same address as him. The Cambridgeshire and Peterborough IDVA service made efforts to contact Laura, however they were unable to secure an engagement with her and closed the matter, with no further contact being made.

15.5 East of England Ambulance Service NHS Trust have confirmed that their only contact with Ben and Amy was because of the emergency call in December 2018, responding to the reported stabbing incident. They confirm that both Amy and Ben were conveyed to the nearest accident and emergency department, where both received treatment accordingly.

15.6 A key issue in examining the family in an overall context, is how Amy came to look after both Child A and Child B and that a considerable number of professionals believed, and had no reason not to, that Amy and Ben were the parents of the children, which of course they were not. Where this left professionals, is somewhat of a moot point as had they been aware of the tenuous relationship, they may have been more alert to considerations around safeguarding. Why this information was not shared with education services on transfer of the children into County is not known.

15.7 The GP practice for Amy does not identify any disclosures by her of domestic abuse throughout her medical history. Although there is no evidence that Amy was asked about domestic abuse. Importantly, the record confirms that she did not receive any treatment in December 2017 for any injuries that would be potentially associated with Ben. The only recognition of domestic abuse within Amy's record is from the DASH referral in October 2018, in respect of the December 2017 incident. There were a number of contacts by Amy with the GP's practice post the awareness of the DASH referral and it would have been natural and good practice to follow up with an enquiry regarding domestic abuse and the current position with her relationship.

15.8 The fact that Amy used different surnames (eight different surnames were identified as used by her in the review period) did not, as was initially envisaged, conceal any significant information about Amy. In summary, this appears to be a pattern by her that is not intended to deceive or conceal behaviour but moreover appears to be an idiosyncrasy of her lifestyle.

15.9 Cambridgeshire Children's Services engaged with Amy and the children in September 2018, (arising from the December 2017 report in respect of Ben) and then again in October 2018 (arising from the report involving Paul). The CSC IMR author does, however, make an observation, that there was no assessment made in September from the visit but that the case remained open. The case was then closed following the latter incident involving Paul. Effectively this meant that the future risk for the children in respect of Amy's relationships was not considered, however the children's voices were heard concerning their apparent fear of Amy's partner. The assumption is that this was Ben, but no name was recorded within the assessment. Effectively, the relationship between Amy and Ben was assumed to have been over and that relationship was not effectively explored. There remained confusion over the relationship at this time.

16. Analysis

16.1. Impact of Domestic Abuse on the Children

16.1.1 There is strong evidence that the children lived with domestic abuse as a factor in their lives. They were also exposed to other adverse experiences such as drug taking and the

excessive use of alcohol by their carers. This impacted on their development and school attendance. This is confirmed by other family members.

16.1.2 A real concern for Child A was their poor rate of attendance at school. Several letters were sent, meetings arranged, and referrals made up to the date of the incident in December 2018. Most of these appear to have been ignored by Amy and Ben. Child A's attendance did not improve until they became a Looked after Child (which was after the death of Ben). However, the school did follow Local Authority and Education Welfare Service guidance and protocols to follow up on this in the appropriate way.

16.1.3 During Child A's time at Primary School, staff had no awareness of any parental issues relating to Ben's alcoholism, depression, anxiety or anger management. They were unaware that support was in place for him or that there was any multi-agency involvement in the form of the Drug Counselling Team or the Inclusion Drug and Alcohol Team. It also appears that the school had no idea that there had been Social Care involvement, or that Amy suffered depression and allegedly had cancer. In fact, the Primary School had not been made aware at any point that Child A was subject to any kind of Child Arrangement Order via another area or that the people presenting as her parents were not in fact the biological parents. This information did not come to light for the school until after the fatal incident in December 2018.

16.1.4 The Primary School reports that both Amy and Ben always presented well when staff saw or spoke with them and they referred to themselves as Child A's 'Mum and Dad'. Amy regularly collected Child A from school, although not punctual but nevertheless did collect them and they were always happy to see her. After a time, Child A's sibling, Child B began collecting them from school, walking home together with Child B's friends. Child A appeared to be equally happy with this arrangement.

16.1.5 Child A rarely talked about Ben, referring most often to 'Mum and Child B' during general discussions. Neither Amy or Ben attended parents' evening or came to school events. Primary School staff did not identify any signs of Domestic Abuse.

16.1.6 By the time Child B began attending secondary school in February 2016, Child B had already attended at least five other schools in two counties.

16.1.7 At the time of transfer to secondary school, the school were not informed of any concerns relating to Amy or Ben, their physical and mental health, support from other agencies or their 'actual/non-biological' relationship to Child B. They were also unaware of input from Social Care or that Child B was subject to any kind of Child Arrangement Order. Like at the primary school, staff had no reason to believe that both Amy and Ben were not Child B's biological Mother and Father. Similarly, they were 'in the dark' with regards to any Domestic Violence, until it being brought to their attention at the point of the MASH referral made in September 2018 concerning the December 2017 alleged assault on Amy by Ben.

16.1.8 As with Child B's sibling, a significant concern for Child B was around the very poor attendance at school. A full range of attendance letters were sent to the parents (Amy and Ben), home visits were made, meetings set up and ultimately a court summons was issued.

Throughout, Amy and Ben ignored these communications and Child B's attendance became worse.

16.1.9 In September 2018, the Cambridgeshire MASH Team called the school in relation to a referral about Amy's alcoholism and her relationship with the male in the home. The Local Authority Designated Safeguarding Lead contacted school staff regarding Child B's presentation and engagement and it was reported that they were in school at that time, looking relaxed, happy and well dressed. Had the schools been more informed regarding the challenges the carers faced they would have been better placed to support the children.

16.1.10 The CSC IMR is clear that domestic violence (DV) guidance was not followed by their practitioners, there was no DV risk assessment, no capacity to change assessment with a clinician and no direct work with the children around their experiences of DV. The review notes, in addition, that there was in general terms, a lack of a multi-agency approach. There was no child in need planning and a lack of exploration of the children's lived in experience.

16.1.11 When looking at the wider picture there has been little, if any, joined up activity or where any single agency has raised concerns about Amy and the children that could have been addressed by more incisive partnership working. Amy and the children lived in a household that was frequently affected by domestic abuse and the children were undoubtedly affected by living within such an environment.

16.1.12 The schools were not routinely notified of domestic abuse incidents attended by the police; this was also common in other cases at the time. This issue has now been resolved by the introduction in Cambridgeshire of an Operation Encompass[7] based process, which links schools to the police to ensure information regarding domestic abuse is appropriately shared.

16.2. To what extent was alcohol a factor in this DHR

16.2.1 There is clear evidence that Ben relied on alcohol and had done so since at least 2012. On various occasions Ben did seek support to address his alcohol reliance. The GP practice for Ben identifies his apparent constant struggle with alcohol misuse and his need for support for his addiction. Ben was signposted and referred to community services, Ben did not appear to fully engage with that support throughout.

16.2.2 This reliance on alcohol and the damage that it caused is also highlighted by his family. In November 2018, Ben contacted his GP and disclosed that he felt angry and lost control when drinking. The GP practice initially spoke to a female partner of Ben's before speaking to Ben. The practice arranged to see Ben face to face and referred him to alcohol services, which was good practice but there was no exploration by the GP practice into the impact of his alcohol on those around him and if this manifested in any abuse. The timing of this call to the GP and the fact that Ben appeared to be supported by Amy is significant as it follows a long period of turbulence in their relationship. This may have been a joint attempt

[7] Operation Encompass - https://www.operationencompass.org/
(accessed 8th March 2021)

to address one of the factors which caused dispute in their relationship and significantly affected Ben's behaviour.

16.2.3 Although Ben appears to have opened up more to the Inclusion services about his behaviours, any actual admission of domestic abuse was not made by him, nor did he ever make any admissions to his GP, other than he had 'anger issues'. It is recognised that this should have been explored further.

16.2.4 Ben and Amy were often in conflict and this conflict turned into violence perpetrated by Ben on Amy, this conflict and ultimately violence was often exacerbated by Ben's use of alcohol. This typology of violence is categorised as violent resistance (Johnson 2008[8]). This research identifies that alcohol plays a significant part in the commission of violence. In 40% of cases the violent incident is a single occurrence but in the remainder of cases there is chronic often escalating violence.

16.2.5 There is clear evidence that Ben wished to address is alcohol intake, seeking support from his GP and then the alcohol inclusion service, where his engagement was positive. Ben acknowledged that he acted first and only considered the consequences later. He was unable to identify the triggers for his anger and was not sure whether he had anger issues. Ben did disclose some adverse childhood experiences and trauma, which may have impacted on his substance misuse.

16.2.6 Although the alcohol inclusion sessions considered the safeguarding of the children Ben cared for, there is no evidence that any potential issues of domestic abuse were explored. This is despite the fact that Ben disclosed the incident in December 2017, and it being rooted in alcohol use, although he significantly minimised the severity of the incident. Interestingly on one of his sessions, Ben asked if his partner could accompany him in the future sessions, this was not permitted as the key worker was only able to see one person. This may have been Ben attempting to create an opportunity to explore alcohol use and the effect on his relationship.

16.2.7 Ben did not seek support for his abusive behaviour, but should he have wished to reach out as a person who wanted to address this, the provision of services in Cambridgeshire would have been limited. There was at the relevant time, no access to a programme for men who wish to address their abusive behaviour, unless this is through Probation Services upon conviction or through Children Services in support of the children. This limited provision continues to be the situation currently. This is acknowledged on the Cambridgeshire and Peterborough Domestic Abuse and Sexual Violence Partnership website.[9]

16.2.8 There is little doubt that Amy was a repeat victim of domestic abuse at the hands of a number of different partners. In the case of both Ben and more recently with Paul, alcohol

[8] Johnson, M.P. (2008) A Typology of Domestic Violence: Intimate Terrorism, Violent Resistance, and Situational Couple Violence. The Northeastern series on gender, crime, and law. Lebanon, New Hampshire, US: UPNE

[9] Cambridgeshire and Peterborough Domestic Abuse and Sexual Violence Partnership website (online accessed 20/10/20) - https://www.cambsdasv.org.uk/website/perpetrator_issues/176007

misuse has played a significant part in those relationships, and there is a clear inference that both the December 2017 assault on Amy and the December 2018 incident, were predicated by Ben and that the abuse of alcohol by him was a key factor.

16.2.9 Whilst this review acknowledges that the key subject of this review is Ben because he died in the incident, there can be little argument that Amy had suffered domestic abuse from Ben in the previous 12 months, and professionals were not curious enough throughout to raise concerns about her and address the abuse that was happening to her.

16.2.10 A previous DHR, case of Irena April 2017, identified the necessity for professionals to recognise and act on the signs of alcohol abuse and coercive control in relationships. This recommendation should be re-visited to understand what work has been undertaken and the effectiveness of it.

16.2.11 There were two recorded incidents where Ben is accused of strangling partners during domestic incidents, Laura in August 2016 and Amy in October 2016. This is also the account given by Amy when she stabbed Ben, that she was being strangled. There is significant evidence that non-fatal strangulation is an important risk factor. This has been recognised after some determined campaigning and will become a specific recognised offence because of an amendment to the Domestic Abuse Bill and was announced on 1st May 2021[10].

16.2.12 In examining the referrals made concerning domestic violence, there does appear to have been good communications between the agencies when DASH referrals were made by the police. Although, in the incident in September 2018, where there was a mattress fire at Amy's address and she suspected Ben, a DASH assessment should have been completed. Amy also disclosed that she had been texted and followed by Ben. A DASH assessment would have put more multi agency focus on the incident. The incident should also have been more tenaciously followed up with interview and accounts from Ben.

17. Conclusion

17.1 There are several issues to consider in line with the terms of reference which specifically relate to the children in Amy's care. This is an important consideration, given that they undoubtedly witnessed incidents within the household involving Amy and Ben but also other individuals with Amy.

17.2 One of those issues is the lack of apparent knowledge and understanding by services within Cambridgeshire, that both children, Child A and B, were not Amy's biological children. Whilst this may not be a unique occurrence and the panel discussed this issue in some

[10] Domestic Abuse Bill amendments - https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/965820/Lord_Rosser_DA_Bill_Letter_01.03.21.pdf
(accessed 8th March 2021)

depth, there is a danger that assuming a biological parent/child relationship exists could lead to all safeguarding concerns and potential concerns not being fully considered.

17.3 Child A's poor attendance at primary school in April into May 2017, highlighted concern that both the school and the police visited Amy's home to make enquiries as to Child A's welfare, albeit separately. The school noted that the home was in a "*very poor condition*", however there was no mention of this in the later police visit. Critically however, there were no referrals made to Children's Services by the school or the police which, given the circumstances, was an omission on the part of both services. Although the police IMR indicates that the officer attending the incident had '*no concerns'*, the fact that a visit was made in specific response to concerns raised by the school and there were opposing views, a safeguarding referral should have been made by both the school and the police. The police IMR indicates that just some 3 minutes attendance time was taken by the attending officer to the report. This must have been a superficial visit and lacked proper professional curiosity.

17.4 The Cambridgeshire County Council Children's Services IMR does also highlight that in reviewing their records of the family, there was not a multi-agency approach throughout. At no time was there any child in need (CIN) planning and the children's lived experiences were not captured. The author of the IMR from Children's services states; *"In my view Children Social Care could have explored the relationship of [Amy] and [Ben] more. We could have considered [Amy's] future partners and the effect on the children who were displaying behaviours of living in a DV household".*

17.5 The serious assault on Amy allegedly inflicted by Ben in December 2017 went un-reported until some nine months later, in September 2018. By this time, the police quite correctly recorded the alleged assault as a crime. However, as there was seemingly no independent medical evidence for Amy having suffered a broken nose and no other witnesses were seen by the investigating officer, the matter was closed as the time limitations for what was deemed to be a 'common assault' is limited to six months from the date of the offence. Photographs of Amy's injuries had been taken and a DASH risk assessment was completed. Both the police IMR author and the panel expressed a view that whether this was 'time barred' was a decision that should have been taken by the Crown Prosecution Service, bearing in mind the level of injury clearly seen on the photographs. Pre-judging the outcome before the case was fully investigated resulted in a premature closure of the investigation. The recording of the offence as a common assault limited the period for prosecution and then limited the action that could be taken. Had the crime been recorded as an assault occasioning actual bodily harm, which the evidence supported, there would have been no such limitations. The panel agreed that domestic assaults should be recorded according to legal thresholds as opposed to police charging standards.

17.6 There have been several occasions when the police's attendance at incidents involving Amy at her home address have not presented a fully informed set of circumstances. Police officers are frequently on the front-line in the recognition and identification of safeguarding concerns and it is imperative that officers are confident of whom they are communicating with and who are present within a household, in particular when the inference is of domestic abuse and children are known or understood to be present. With the recognition

of the risk presented by non-fatal strangulation previously recorded incidents of domestic abuse should be considered when undertaking risk assessments.

17.7 Substance misuse, in particular Ben's alcohol use, was a significant factor in this case. Although Ben sought and was given support there was never any holistic consideration of what the impact of this was on those closest to Ben.

17.8 Looking at what life was like in that family from the agency reports, the review author is unable to state that there was ever an incisive or clear view of what the family environment was like at Amy's home. No single agency has been able to present a perspective of this, which leaves significant gaps in knowledge and understanding. It is apparent that several agencies have made comment concerning the individuals, but this has tended to be at a particular time, rather than observations looking at the wider context and gaining a clearer understanding of the underlying issues.

18. Lessons to be learned

18.1 Agencies should ensure that where referrals take place to other statutory agencies for safeguarding concerns involving children that an individual safeguarding referral is made to Children's Services. This will ensure that Children's services are able to make an independent assessment of the information as a whole.

18.2 This review is far from unique in respect of how professionals have on occasions lacked professional curiosity. This is not peculiar to any single agency as each statutory agency has failed to display this at different times. Amy's and the children's situation did not initiate any coordinated multi-agency approach. For example, the serious assault on Amy by Ben in December 2017 went un-reported for some nine months, the seriousness of that allegation was recognised, although the matter was filed by the police without effective action. A more enquiring approach would have established circumstances to initiate a referral at that time to MARAC using professional judgement.

18.3 What is not clear, is which agencies knew of the 'arrangement' for Amy to have care of both Child A and Child B. There certainly appears to be a complete lack of information shared by the external local authority to Cambridgeshire. Amy informed the IDVA service in 2014 that the children were hers from a previous relationship. Police and IDVA service records thereafter indicate that Amy had parental responsibility for the children but at no stage was the parental situation enquired into or clarified. The sometimes, complex relationships of Amy and the lived experiences of the children have therefore not been identified fully to key agencies, where the background information about them may have triggered additional questions to be raised and agency referrals made.

18.5 Good recognition of concerns by the Inclusion service to child safeguarding in May 2018 following disclosures made by Ben was identified, discussed with managers, and passed to Children's Services. This was regarding the 'physical altercation' and concerns in respect of alcohol abuse being witnessed by Child B. These concerns could have extended to the exploration of potential abuse or conflict in the relationship.

19. Recommendations

1. The Fenland Community Safety Partnership should ensure that they compile a list of all agencies that are operating or can provide domestic abuse services within their area. They should make this list available to their partnership, so agencies are aware of what services are available to support victims of domestic abuse and that victims are appropriately referred to them.

2. The Cambridgeshire and Peterborough Domestic Abuse Partnership should consider what the offer is to those who subject others to domestic abuse or coercive behaviour and want support to address their behaviour.

3. The Fenland Community Safety Partnership should seek assurance from Cambridgeshire Children Services and Cambridgeshire Constabulary that: -
   - Appropriate cases are referred to MARAC.
   - That high-risk cases coming into MASH are referred in a timely fashion.

   From Cambridgeshire Children Services
   - That where cases of domestic abuse are discussed at safeguarding meetings that IDVA services are represented where possible.

4. The Fenland Community Safety Partnership should seek assurance from Cambridgeshire Children Services.
   i) that when Domestic Abuse and its damaging effects are recognised, that there is an effective assessment undertaken and effective multi-agency plan put in place to support children according to the risk being presented when thresholds are met, in particular those identified as high and medium risk.

   ii) that record keeping in similar cases, includes within the narrative sufficient detail to ensure it is clear who the perpetrator of the domestic abuse is.

5. The Fenland Community Safety Partnership should seek assurance from Cambridgeshire Constabulary that the recording and investigation of domestic abuse offences is appropriate to be able to support and sustain a prosecution and will not be limited by statutory limitations, as was the case with the December 2017 assault and that the following investigation is effective.

6. The Fenland Community Safety Partnership should write a practice note to make all agencies aware of the provisions of the Domestic Abuse Disclosure Scheme and ensure that due consideration is given to it when there are previous instances of domestic abuse. Further awareness should be considered to coincide and complement the Domestic Abuse Bill 2020.

7. The Fenland Community Safety Partnership should consider convening with their partners a practitioner event across the Fenland area for professionals and agencies using this case to highlight the effect of alcohol and coercive and controlling behaviour and domestic abuse.

8. The Fenland Community Safety Partnership should seek assurance from Cambridgeshire County Council Education Safeguarding Team that they have or will provide advice that at the student intake process, it includes an enquiry as to the status of the parent/carer/guardian and to establish if there are any care or guardianship orders in place.

9. The Cambridgeshire Clinical Commissioning Group should brief health practitioners that when they identify or are informed about substance misuse and/or anger management issues, in a patient, this should trigger professional curiosity regarding the potential for domestic abuse in the household.

10. Fenland CSP and County DASV Partnership should ensure the impact of alcohol and its links to domestic abuse still forms part of any awareness raising events and they reflect current best practise and provides practitioners with the tools to identify alcohol related domestic abuse and the ability to sign post perpetrators to appropriate support services

11. The Fenland Community Safety Partnership should be assured that where CGL Drug and Alcohol Services receive a disclosure regarding domestic abuse that a referral is made to domestic abuse services.

12. The Fenland Community Safety Partnership should work with the Domestic Violence Strategic Partnership to highlight the risk of non-fatal strangulation and use this case to initiate training and awareness of the new offence and how this will feature in risk assessment.