Cheltenham Strategic Leadership Group

Domestic Homicide Review

Into the death of Lucy and her unborn child, Sarah

Independent Chair Deborah Jeremiah

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Overview Report
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Tribute to Lucy and Sarah from their family

Lucy will always be remembered by her family and friends for her huge personality and radiant smile. She was a young girl who loved life and always had time for others. Her baby will always be the little girl who would have been welcomed into our lives and loved very much. We take some comfort from knowing that she rests in peace with her mummy.

Tribute to Lucy from her close friend

Lucy had a great sense of humour and was fun to be with. She loved fashion and took a lot of care over her appearance and was very pretty and petite. It is still hard to believe she is gone but I will always remember her lovely smile and the fact that she made me laugh.

1 Preface

1.1 This domestic homicide review (DHR) examines the circumstances surrounding the death of a 16 year old girl, Lucy and her unborn child (Sarah). Lucy was 24 weeks pregnant when she was strangled by her 18 year old boyfriend, Daniel. Daniel was Sarah's father. It should be noted that pseudonyms are used throughout this report.

1.2 The Independent Chair and Review Panel express deepest and heartfelt condolences to Lucy's family and friends for their loss. Only they can truly comprehend the pain and distress caused by Lucy's death and her daughter, Sarah. We have endeavoured to give Lucy a voice in this review and capture the richest learning possible from this dreadful tragedy. What has emanated from this review has been a deep reflection by all concerned on how we work with young people who find themselves in unhealthy and violent relationships at a vulnerable age and how we can all work with young people who become victims but also those who become perpetrators.

1.3 The Panel's thoughts are also with Daniel's parents in recognition that they cared for Lucy, giving her a home at one point and that the fact that they have seen their son given a long jail-term. Lucy's death has had a tragic impact on both families.

1.4 The Independent Chair would like to thank the Review Panel for the huge patience, time commitment and thoughtful consideration for this review. This was in the face of having a dual role for a parallel Serious Case Review (SCR). The latter review was also required given that Lucy was under 18 when she died.

1.5 The Independent Chair would also like to thank frontline professionals from a range of organisations and agencies who have cooperated and assisted with the review as well as those staff who supported the review from an administrative perspective. The issues have been complex and have touched on a number of the bigger challenges we face today as a society to keep our young people safe and in healthy and happy relationships.

1.6 A glossary of terms used is at **Appendix One.**

1.7 The review has been led by an Independent Chair who has no association with the professionals or organisations concerned and who has been trained in the process prescribed by the Home Office to conduct such reviews.

1.8 The review process follows the Home Office Multi-Agency Statutory Guidance on the Conduct of Domestic Homicide Reviews (as amended in December 2016). Domestic Homicide Reviews (DHRs) came into force on the 13th April 2011. They were established on a statutory basis under Section 9 of the Domestic Violence, Crime and Victims Act (2004). The Act states that a DHR should be a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by:

a. A person to whom he/she was related or with whom he/she was or had been in an intimate personal relationship or;

b. A member of the same household as him/herself; held with a view to identifying the lessons to be learnt from the death.

1.9 The purpose of a DHR and the Review Panel is to:

- Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims;
- Identify clearly what those lessons are both within and between agencies; how and within what time scales they will be acted on, and what is expected to change as a result.
- Apply these lessons to service responses, including changes to policies and procedures as appropriate; and identify what needs to change in order to reduce the risk of such tragedies happening in the future; to prevent domestic homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working.

1.10 One of the main features of this review is how professionals and agencies understand domestic abuse for young people and how this may emerge and in what form.

Scope of the review

1.11 The review places a particular focus on the period from 10th October 2011 to the date of Lucy's death on 5th April 2014. That is not to say that earlier information is not included where this might provide important context for the review.

1.12 A timeline of events is included to highlight the sequence of key events and responses in Section 13.

1.13 A key feature of this review is that it involved two teenagers and the Terms of Reference reflect this. Working with teenagers has its own set of challenges. The Review Panel wished to consider how agencies, statutory and non-statutory, can work more effectively with this age group. It was identified at the outset that this DHR had great potential to shed light on how agencies respond to some of the challenges which arise including:

- Domestic abuse including coercive control between or involving those under-18 years of age. This is a relatively new developing area;
- The challenges of engaging with teenagers and their expressions of autonomy;
- An understanding of the wider risks to teenagers;
- How best can agencies support teenagers understanding what constitutes healthy and unhealthy relationships;
- How best to effectively engage teenagers within current safeguarding systems where domestic abuse is an apparent risk.

2 Summary

2.1 This overview report considers the single and multi-agency responses to Lucy and the risks posed to her before her death on 5th April 2014. Lucy was 16 when she died. She was subjected to a fatal assault by her partner, Daniel on 2nd April 2014. Lucy was pregnant at the time of her death and Daniel was found guilty of her murder on 3rd October 2014 and given a life sentence.

2.2 The Home Office Statutory Guidance advises that where practically possible a DHR should be completed within 6 months of the decision made to proceed with the Review. For legitimate and logistical reasons as set out below the criminal proceedings and the SCR took primacy. The SCR report was finalised in June 2016. This was published on 12 July 2016. The DHR report was submitted to the Home Office in March 2017 and comments received in October 2017.

2.3 The DHR was formally commissioned by the Cheltenham Strategic Leadership Group in August 2014 following a scoping meeting on 31st July 2014. This was followed by a meeting to confirm the Review Team and Panel in September 2014.

2.4 The criminal trial concluded in October 2014. Neither SCR nor DHR commenced in earnest until the trial was concluded so as not to prejudice the criminal proceedings and to manage sensitivities around disclosure of information and also professionals who were both witnesses at the trial but who would also need to input into the DHR. It was appropriate to give the family time and space following the criminal trial and this was a high profile murder widely reported. The trial was naturally a harrowing experience for the families as the exact circumstances of how and in what circumstances Lucy came to her death, emerged.

2.5 The DHR panel met on 8 occasions specifically for the DHR and the final meeting was on 1st September 2016. There was also a ninth Panel meeting post Quality Assurance on 1st December 2017. The Individual Management Reviews (IMR's) were requested after the process of conversations with frontline professionals was concluded for the SCR. This was in an attempt to avoid duplication in seeing frontline professionals. The conversations and integrated chronology were concluded in January 2015. The final IMR was received in August 2015.

2.6 The Review Team for the SCR were also the Review Panel for the DHR and the group met on further occasions purely to progress the SCR. Where at all possible information was shared.

2.7. Cheltenham Strategic Leadership Group has been kept updated as to progress throughout with sound links with the Gloucestershire Safeguarding Children Board. It has taken some time to agree the DHR action plan as a result of deliberations around roles and responsibilities and whom would be accountable for the various elements in a changing landscape to local government. Those issues have now been resolved and clarity provided.

2.8 This DHR has therefore been concluded later than the 6 months' timescale.

3. Confidentiality

3.1 Prior to publication details of the review and findings have been kept confidential. A great deal of confidential data has been considered and shared during the course of this review but with the appropriate agreements and understandings as to the security and confidentiality of that information. This has taken into account that some information has concerned a victim who is under 18 and this has been managed in liaison with Lucy's parents.

3.2 The findings of this DHR were restricted to participating officers/professionals, their line managers, the family of the victim and the perpetrator, until after the DHR was approved for publication by the Home Office Quality Assurance Panel.

4. Purpose, Scope and Terms of Reference

4.1 The purpose and scope of the review are set out in the terms of reference for this review which can be found at **Appendix Two.** The proposed terms of reference were shared with Lucy's family and they contributed to the final terms of reference and their questions have been included. Daniel's family came forward to contribute to the review but later on in the process.

5. Methodology

5.1 This review is guided by:-

- The processes outlined in the Home Office Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews
- Learning from other Domestic Homicides Reviews and Serious Case Reviews of child death/vulnerability across the UK
- The cross-government definition of domestic abuse (April 2013).

5.2 This report emanates from various sources of information gathered from sources detailed at **Appendix Four** which also includes research references.

5.3 The IMR authors were provided with and followed the IMR template from the Home Office guidance as well as a checklist of what makes a good quality IMR. There was also a presentation delivered on the overarching process for the DHR.

5.4 The review has kept to the prescribed DHR Home Office process but also aligned to a SCR which was conducted using a different approach and methodology. However the integrity of the analysis for the purpose of the DHR has been maintained.

6. Family Background and Involvement

6.1 A genogram was provided for the DHR but has not been replicated to maintain confidentiality. It will be apparent from this report who the main family members are and the part they played in Lucy's life.

Family composition and pseudonyms used:

- Victim - Lucy aged 16 at the time of her death in April 2014;
- Perpetrator, Lucy's partner - Daniel, aged 18 at the time of Lucy's death;
- Unborn child – Sarah;
- Lucy's mother – Heather;
- Lucy's father – Paul;
- Heather's partner – Mark;
- Maternal grandmother – Hilary;
- Maternal grandfather – John;
- Best Friend – Hannah.

6.2 Family and friends' perspectives, experiences and input are conveyed throughout the report.

6.3 Information from the families was gathered after a careful introduction to the various family members explaining the process and encouraging them to participate. Regard was given to the very helpful advice and guidance contained in the Advocacy After Fatal Domestic Abuse[1] and Home Office leaflet for families and this was provided to further aid the family's understanding of a DHR and inform them of support.

6.4 This review also used the principles of family involvement as contained in the research[2] for involving families to ensure a sensitive, structured and well prepared approach for initial contact, negotiation, information gathering and feedback throughout. In this review the Chair and Review Panel maintained an on-going dialogue with the family and also with those supporting them.

6.5 It was also possible to speak to one of Lucy's closest friends, Hannah and that was of immense assistance to understanding Lucy as a person, her personality and her hopes for her future as well as the challenges faced by young people when they have knowledge that one of their peers is at risk. This young person showed a great deal of courage to come forward and assist on what are still very painful memories.

6.6 Lucy's grandparents also kindly inputted. Heather and Lucy were accommodated and supported by Hilary and John at various times as Lucy grew up. She grew up in a large house with a large garden to play in. As she grew up, she was parented by her grandparents as circumstances dictated. While Hilary and John did not seek to have parental responsibility for Lucy they admit that they did a lot of the practical caring for Lucy, as Heather was limited in what she could do and manage as she had periods of being mentally unwell.

6.7 Hannah told the review that Lucy worried a lot about her mother and really wanted to live with her full time ideally and hoped that one day her mother would fully recover. Hannah went on to say that sometimes Lucy felt close to her mother but that at other times the relationship was more difficult and she felt she did not have a close adult in her life to whom she could confide. Hannah was sure that Lucy would not have told Heather everything about her relationship with Daniel as she would have worried about the impact upon her mother's health. Hannah described Lucy as drifting between her mother, her grandparents and her dad over some years but Lucy always had money and nice things. Lucy was small and petite and liked to be well groomed and look good. She liked hair extensions, make up and to have nice nails and she would go to the salon and have treatments.

[1] www.aafda.org.uk

[2] Morris,K.,Brandon,M and Tudor,P. (2012) A Study of Family Involvement in Case Reviews: Messages for Policy and Practice BASPCAN ISBN 13 978 085358 287 8

6.8 During the course of the review Heather and Paul expressed most strongly that they felt very unsupported by some services and consider that those working on a day to day basis with Lucy did not have the experience or qualification to manage what they saw were many risks to her wellbeing. This included her risky behaviours which increased as she passed through her teens; the relationship with Daniel which they identified as unhealthy and harmful, to such an extent that they did not feel they could protect Lucy. Her situation was also complicated by a pregnancy at a young age. This was in the context of Lucy being an older child with her own views, wishes and presumed autonomy.

6.9 Although Daniel's parents did not witness any assaults nor observe any injuries to Lucy they do not excuse his actions. In a meeting with Daniel's family, it was clear that they too have been devastated by what has happened to Lucy, Sarah and their son. This has also had a huge impact upon their family.

6.10 The DHR Chair and Review Panel would like to thank both families for their time and thoughtful approach in assisting this review. Their input has been invaluable. Daniel has not inputted into the DHR given concerns for him and this was not been pursued further.

7. Contributors to the Review

7.1 Contributors to this review include the Review Panel with their consideration and deliberations on the information being brought forward to the review. The Review Panel also had the added benefit of information from discussions with the 29 front-line professionals involved with Lucy and Daniel from the SCR. This meant that the Review Panel had rich information from these 29 frontline professionals directly as well as the content of IMR's. Those frontline professionals and staff are listed below:-

Support Co-ordinator	Independent Housing Provider
Support Co-ordinator	Independent Housing Provider
Social Worker 1 (SW1)	Children's Social Care Referral and Assessment Team
Team Manager	Children's Social Care Referral and Assessment Team
Social Worker 2 (SW2)	Children's Social Care Children and Families Team
Student Social Worker (SSW)	Children's Social Care Children and Families Team
Team Manager	Children's Social Care Children and Families Team
Family support Worker	Children's Social Care Diversion and Placement Support Team
Family Support Worker	Children's Social Care Diversion and Placement Support Team
Chair	Children's Social Care Child Protection Conference Chairs' Team
Community Midwife	Gloucestershire Hospitals NHS Foundation Trust
Teenage Pregnancy Midwife 1	Gloucestershire Hospitals NHS Foundation Trust
Teenage Pregnancy Midwife 2	Gloucestershire Hospitals NHS Foundation Trust
School Nurse	Gloucestershire Care Services NHS Trust
Sexual Health Nurse Advisor	Gloucestershire Care services
Counsellor	Teens in Crisis +
GP1	GP Practice
GP2	GP Practice
Case Responsible Officer, NEETs	Gloucestershire Youth Support
Case Responsible Officer, Housing	Gloucestershire Youth Support
Team Manager	Children's Social Care 16+ Team
Social Worker	Children's Social Care 16+Team
Police Constable (PC1)	Gloucestershire Constabulary
Police Constable (PC2)	Gloucestershire Constabulary
Detective Sergeant	Gloucestershire Constabulary
Pastoral Support Worker	School
Designated Safeguarding Lead	School
Mental Health Support Worker	2gether NHS Foundation Trust
Care Co-ordinator	2gether NHS Foundation Trust

7.2 The Review Panel did not seek the expert advice or opinion of any other specialist during the review as all questions were answered by members of the review panel, IMR authors or frontline professionals. While this review concerns a victim under 18, there was expertise on the panel well able to consider the interface of managing domestic abuse in the context of child safeguarding systems. There were also some members on the Review Panel whose roles revolve around the management of domestic abuse and the development of local and regional strategies in the national context.

8. Domestic Homicide Review Panel

8.1 The members of the Review Panel are set out below:-

Deborah Jeremiah	Independent Chair
Strategy and Engagement Manager	Cheltenham Borough Council
Named Nurse Safeguarding Children	Gloucestershire Care Services NHS Trust
Deputy Director Nursing, Designated Nurse	Gloucestershire Clinical Commissioning Group
Service Leader Safeguarding	Gloucestershire County Council - Children and Young People's Social Care
Safeguarding Children Development Officer	Gloucestershire County Council Education
Divisional Nursing and Midwife Director; Women & Children's Services Named Nurse Safeguarding Children	Gloucestershire Hospitals NHS Foundation Trust
Detective Sergeant	Gloucestershire Public Protection Bureau
Domestic and Sexual Violence Coordinator	Gloucestershire Public Protection Bureau
Business Manager	Gloucestershire Safeguarding Children Board
Operations Manager	Gloucestershire Youth Support Team
Housing Contracts Manager	Home Group
Safeguarding Lead/Named Nurse Safeguarding	2gether NHS Foundation Trust

8.2 The Review Panel consisted both of agencies that had involvement with Lucy and Daniel and also those who had wider knowledge of working in the field of domestic abuse and had specific responsibilities around this. Individual Management Reviews (IMR's) were also provided from those agencies who had involvement with Lucy and Daniel:

- Gloucestershire Care Services NHS Trust
- Gloucestershire Clinical Commissioning Group (primary care-GP)
- Gloucestershire County Council - Children and Young People's Social Care
- Gloucestershire County Council Education
- Gloucestershire Hospitals NHS Foundation Trust
- Gloucestershire Public Protection Bureau
- Gloucestershire Youth Support Team
- Home Group
- 2gether NHS Foundation Trust

8.3 The chronologies were shared with an aligned SCR and an integrated chronology produced and used for both processes. It is from this integrated chronology that the timeline in this report emanates.

8.4 The IMR's were produced as requested and the Chair and Review Panel wish to thank the authors for these and for attending the panel meetings to present the IMR's and answer questions from the panel. On request some authors produced further information to sit behind the IMR's and to clarify where necessary. The timing of requesting the IMR's was set to also allow the SCR process to progress.

9. Parallel Processes

9.1 As previously mentioned, as well as being considered for a DHR, this case was also taken to the Safeguarding Children Board's Serious Case Review sub-group on 22nd April, 2014 due to this involving the death of a child for consideration of a SCR.

9.2 Following consideration by the sub-group, it was agreed that the circumstances of the child's death fully met the criteria for an SCR as set out in Chapter 4 of Working Together to Safeguard Children, 2013.

9.3 The SCR started at the same time as the DHR after the criminal case was concluded. There has been a close interface between both reviews as they shared a common review panel.

9.4 There was some deliberation and communication with the Department of Education (who oversee SCRs) and the Home Office (who oversee DHRs) as to whether one review and report would suffice. However the Independent Chair of the Gloucestershire Safeguarding Children Board was informed that two reviews would be required particularly as the selected methodology for the SCR differed in nature and process to that used for a DHR. It was therefore agreed in July 2014 that two reviews would be necessary and panels and an Independent Chair were sought. The subsequent letter (attached) from the Home Office following QA dated 9th October 2017 does not fully acknowledge this directive and a number of other comments did not reflect the report submitted. This has been brought to the attention of the Home Office. There has also been subsequent clarification from the Home Office on points made around detail of the perpetrator and the use of pre-2016 DHR guidance as this DHR was drafted prior the current guidance. The Home Office has now clarified on 22nd November 2017 they are satisfied that all Quality Assurance criteria for the report have been met. They also made the following comments:
"The Panel was very grateful to you for carefully considering the issues they raised and for providing additional clarity in relation to a number of points.

The Panel is satisfied that all matters have now been addressed and would like to thank you and your colleagues for your participation in the process and for the considerable work that you have put into the report in this case."

9.5 The SCR report whilst emanating from the same set of facts as the DHR presents the learning from a systems perspective lifting the facts away from the case specific into more generalised findings, while the DHR remains case specific and uses Individual Management Reports (IMRs) to look at single-agency and multi-agency learning as the main source of information.

9.6 To seek to enhance both reviews, information and data has been shared as much as possible. There is also a strong commonality for the review in that the main objective for both reviews is to learn lessons and to prevent further violence and deaths in the future. Further, the close working between Cheltenham Strategic Leadership Group and the Gloucestershire Safeguarding Children Board has been a positive factor and useful in looking at domestic violence where the victim is under 18, as in this case.

9.7 An inquest into Lucy's death was held on 13 October 2014 and concluded that the verdict was "Other-murder".

10. Equality and Diversity

10.1 The review adheres to the Equality Act 2010. All nine protected characteristics were considered by the panel and none specifically apply to Lucy. Lucy was pregnant with Daniel's child when she died and she was vulnerable and was essentially a child expecting a child. There were no other equality factors relevant.

11. Dissemination

11.1 Each of the panel members, the Chair and members of Cheltenham Strategic Leadership Group have received copies of the final report. An offer was made to share the final report with both Lucy's and Daniel's families but this offer was declined.

11.2 All relevant family, friends, staff and professionals have had the opportunity to comment on actual or potential criticisms in the report.

11.3 The content of the Overview Report and Executive Summary is anonymised to protect the identity of the victim, perpetrator, relevant family members and others. This has been a high profile matter and has attracted national media interest. Both Lucy and Daniel's family were consulted with as to the publication date of this review.

12. Background Information and Overview

12.1 Lucy was raised by a number of members of her family as her parents separated when she was a toddler. Her mother, Heather started to have mental health problems when Lucy was aged around three. Heather continued to have enduring mental health problems which sadly impacted upon her ability to parent Lucy consistently. Lucy moved around as she grew up between Heather, her father, Paul and maternal grandparents, Hilary and John.

12.2 Lucy was raised as an only child but had a half-sibling as Paul had an older child from an earlier relationship. Paul played a part in Lucy's life despite the breakdown of the relationship with Heather. Both Lucy and Heather were supported by Hilary and John and they helped Lucy financially and practically.

12.3 Lucy had a disrupted secondary education and attended a number of schools in the independent sector and at state schools. She often stated she did not feel she fitted in, particularly in the independent schools she attended. In her early teens she started to have emotional difficulties and her behaviour became more challenging. She increasingly came into conflict with her family as she sought to resist their direction and control.

12.4 As a result of Lucy's increasingly challenging behaviour and concerns about her resilience and self-harming, she was referred at the age of 13 to the Child and Adolescent Mental Health Services which is now called Children and Young Peoples Service (CYPS). There were to be numerous referrals to mental health services and this is explored fully later in this report in the context of her health pre and post relationship with Daniel. She also came to the attention of the police due to an incident at a party and also in connection with an allegation of assault she made against John. This allegation was considered to be unfounded and did not progress to any charge.

12.5 The relationship with Daniel was Lucy's first serious relationship and started when she was 15. Lucy's school friend says that Lucy liked the fact that he was two years older and she quickly became besotted with him. Lucy had connected with him initially through a mutual friend and they started to communicate with each other on Facebook. The relationship between Lucy and Daniel appeared straightforward and unproblematic initially, though is described by friends and family as becoming intense fairly quickly. The relationship became sexual in nature within weeks though her friends believe Lucy denied this to her family and her GP. Lucy started visiting her GP at regular intervals with non-specific abdominal pain and urinary symptoms. In all but one visit to the GP Lucy was accompanied by her mother.

12.6 Lucy's family started to have concerns about her relationship with Daniel because they believed that Daniel had a gambling problem and was taking Lucy's money. They also claimed that Daniel was smashing Lucy's mobile phones and exerting other controls over Lucy. They started to fear for Lucy in the relationship and tried to draw her away as they saw the relationship as unhealthy. Paul believed that Daniel had stolen from his home when he let Lucy stay there when he was on holiday. He told Lucy she was welcome back but not Daniel.

12.7 Lucy started to distance herself from her family and close friends. Her close friend, Hannah described Lucy as communicating less often and her view was that the relationship with Daniel had become volatile with lots of arguing. Daniel was noted to be loving one minute and then very derogatory toward Lucy at other times. However Hannah says that Lucy was in love with Daniel and saw a future with him as someone she could build a family unit of her own.

12.8 Lucy's family were offered some support from services involving mediation, a parenting programme and some targeted support later on but this did not come to fruition as they declined to engage with the support available.

12.9 The first formally recorded physical assault by Daniel was on the 31st October 2013 which was also around the time Lucy thought she may be pregnant. A member of the public found her distressed in the street and the police were called. Lucy initially described a previous incident to the police where Daniel had physically hurt her in the past. She said she had been with him for around 9 months. Daniel was persistently texting and ringing Lucy when the police were in attendance with her and by the time she was collected by her grandparents she was minimising the seriousness of the incident. The professional response to this and other incidents are fully explored later in this report. Daniel was arrested in connection with this incident but released without charge. Lucy had said she did not want to press charges but rang the police the next day having changed her mind. However that message did not get through and no further action was taken.

12.10 Following the October 2013 incident and until her death agencies, including Children's Social Care, were working with Lucy and her family. A social worker had started an Initial Assessment under child safeguarding processes after the assault. However when the social worker became absent with ill-health the case was not re-allocated. The assessment was not completed for three months. This should have been completed in 10 days in accordance with the process at the time and this is considered later in this report.

12.11 The main focus for Children's Social Care was primarily around the risk to Lucy because of her housing situation. Lucy and the professionals working with her considered her to be homeless. Her family told us subsequently that they had wanted Lucy to go into care and away from her home town out of reach from Daniel as they felt they could not protect her. It was in this context that they were unable to accommodate her and she presented as having nowhere to stay. Lucy's relationships with her family had become very strained as a result of these factors though she did stay in touch intermittently with Heather throughout.

12.12 Lucy wanted to continue her pregnancy and be given accommodation to live with Daniel. Lucy was 15 so she was referred to the Teenage Pregnancy Midwife. That midwife had concerns around Lucy self-harming and referred her to Children and Young People (emotional wellbeing and mental health) Service (CYPS). CYPS had already been involved with Lucy historically and had assessed her to be in need of cognitive behavioural therapy (CBT). However the wait for that service was lengthy and instead Lucy was referred to a counselling service Teens-in-Crisis. The counsellor saw Lucy at school but she attended sporadically as her school attendance had dropped.

12.13 Efforts by Children Social Care to support Lucy in finding appropriate accommodation with her family or elsewhere (including foster-care) were not successful and when she reached 16, Lucy moved in with Daniel and his family. His parents cared for Lucy and her attendance at school improved and there appeared to be some stability in her life.

12.14 Lucy had a strong rapport with a member of the Pastoral Support Staff at school but did not share any difficulties she was experiencing in the relationship with Daniel. The school were very supportive of Lucy continuing her education throughout her pregnancy and considered her a bright pupil who could go onto Higher Education. Lucy was noted to have a black eye at school but said she had walked into something, injuring herself. School were concerned about Lucy and had regular meetings about her from late 2013 onwards. It was at a meeting in January 2014 that they were informed that Daniel had assaulted Lucy in the previous October.

12.15 Daniel's parents felt they had no choice but to take Lucy in but say they really noticed a change in Daniel when Lucy became pregnant. They consider he was perhaps unable to deal with the prospect of becoming a father. They told the review that they were unaware of any violence or control in the relationship though agreed that the relationship was very intense. They said they had no contact with any agencies who were involved with Lucy but they did contact Paul to say that Lucy should be with her own family.

12.16 During this time, Lucy visited Heather occasionally. On one occasion, Heather walked in while Lucy was changing at her home and saw severe bruising on Lucy's torso and legs. Heather told the review that she reported this to Children's Social Care (though social care did not have a record of this report). Lucy's friends also noted changes. Lucy was wearing loose fitting clothes, no make-up and had changed a great deal. Previously she was always a very well-groomed young woman and took great pride in her appearance.

12.17 Lucy remained known to several agencies who were actively working with her under child safeguarding frameworks. Children's Social Care drew up a Child in Need plan in respect of Lucy in March 2014. The student social worker who was working actively with Lucy also discussed a safety plan with her. Latterly Lucy's unborn child, Sarah, was made subject to a Child Protection Plan and it was considered at that time that Lucy's needs would be adequately managed under the same plan. Daniel attended the Child Protection meeting with Lucy and he said the October 2013 incident was a one-off and admitted he had an anger issue. At this conference Lucy's family were not invited so they were not present to feed in information they knew, as Lucy did not want them present. Although there was knowledge of the assault upon Lucy by Daniel a 'split conference"[3] was not considered.

[3] This is where an individual may be excluded from the child protection conference for fear that their presence may prejudice the conference, inhibit information sharing, disclosures or the person be disruptive or present a risk to others in some way. Part of the conference will therefore be held excluding that person. The decision to manage a child protection conference in this way is one for the Chair of the child protection on the merits.

12.18 The interface between the professional response in the context of domestic abuse and children safeguarding is analysed later in this report. Particularly pertinent is the response to behaviours of coercive control.

12.19 After an incident at Daniel's home Lucy left to go back to live with her mother where she lived until her death. Lucy expressed that she wanted some space and was afraid that her baby would be taken into care if she was with Daniel. Daniel did try and contact Lucy by phone and also came to Heather's house but Lucy chose to cut communication with him. Heather told a member of the Review Panel that Lucy was upbeat about the future and was starting to take care of herself again and was looking forward to being a mother.

12.20 Lucy was permitted to go into school after morning registration as she was experiencing morning sickness. On her way to school on 2nd April 2014, Lucy was intercepted by Daniel and she went to Daniel's house. There, Daniel strangled her with a scarf.

12.21 The jury at the trial were told Daniel left Lucy dying. He then went to a betting shop to check on a bet. As he left the house Daniel's sister was arriving home and she found Lucy was on the floor unconscious and unresponsive. Daniel's sister called an ambulance immediately.

12.22 Lucy was taken to the Emergency Department where she presented in cardiac arrest. She was admitted to critical care. A scan showed hypoxic brain injury due to lack of oxygen. A foetal heart beat was present. She was 24 weeks pregnant. On examination bruising was noted to the right eye, abrasions to the left temple, together with old bruising to her right arm and left thigh.

13.23 The foetal heart rate deteriorated and foetal death was confirmed on 3rd April 2014. A female stillborn baby, Sarah, was delivered at 24 weeks gestation on 4th April. Lucy's condition deteriorated and brain stem death was confirmed. Lucy was extubated and died on 5th April 2014.

12.24 Lucy was found to have many old injuries on her body as well as those arising from being strangled.

13. Timeline

13.1 The timeline below picks up where Lucy first came to the attention of services and then others from that point onwards. The timeline seeks to capture the main events to note for this review.

Date	Event/Circumstance
10.10.11 **Key event 1**	Lucy, aged 13 made an allegation to the police that her grandfather, John, had hit her which her grandfather denied. Although he was arrested, Lucy's account later changed and no formal complaint or charges were ever brought. However, a referral was made to Children's Social Care. The police described Lucy as an "out of control" child. Lucy went to stay with her father, Paul, having previously been living with her grandparents.
18.10.11	Lucy was seen by the Children and Young People's Service (CYPS), the Child and Adolescent Mental Health Service, for assessment. (She had been referred in September 2011 because of her behaviour and concerns around self-harm). CYPS concluded there was no role for them at that time and referred the family to a local charity, County Community Projects, for family mediation. This was not progressed as Lucy had moved in to live with Paul.
21.10.11	Children's Social Care completed an Initial Assessment for Lucy but conclude there was no role for them at that time.
5.11.11	Paul reported Lucy as missing. Lucy was located at a friend's home.
18.11.11	Paul reported Lucy as missing. Lucy was located at a friend's home.
11.4.12	At age 14, Lucy was prescribed the contraceptive pill for period pain control. She told the GP she was not sexually active.
7.10.12- 30.10.12	Lucy had recurrent urinary infections and visited the GP regularly mostly accompanied by Heather. Lucy denied any sexual activity.
7.01.13 **Key event 2**	Lucy saw her GP alone for the first time and she was very open and expressed insomnia; anxieties around various aspects of her life and family relationships. The GP referred Lucy to CYPS for a second time. It was around this time that Lucy started a relationship with Daniel.
24.01.13	Lucy's attended her appointment at CYPS. She was noted to have had low mood, anxiety, alcohol consumption and insomnia. Planned liaison with Children's Social Care was agreed and support to her family, with a parenting programme.
17.04.13	Lucy was refusing to go to school and was saying to Heather that no one wanted her. Lucy was now age 15 and her behaviours were proving more difficult to manage.
20.5.13	The parenting support referral was received by the CYPS Parenting Programme office.
29.4.13- 15.7.13	On-going appointments with CYPS.

22.7.13 **Key event 3**	Lucy was at a party where she believed she had been "injected by boys because they want to have sex with me". It is believed that Daniel was at the same party. Lucy was intoxicated and possibly sexually assaulted. In the early hours of the next day, Lucy was taken to Cheltenham General Hospital by Heather before being transferred to Gloucestershire Royal Hospital by ambulance. The incident at the party was reported to the police. The hospital found evidence of alcohol misuse. Tests were done. A referral to Children's Social Care was made but not accepted. Lucy's family were offered support through the Targeted Support Team, which offers support at a lower level, and an assessment under the Common Assessment Framework (CAF) was to be completed.
20.8.13	Lucy was reviewed by CYPS (the mental health service.) A referral was made for Cognitive Behavioural Therapy. Lucy was placed on the waiting list.
6.9.13 **Key event 4**	Heather and Hilary were offered but declined the Parenting Programme.
14.10.13	Heather reported to a nurse at the GP Practice that Lucy missed her contraceptive pill that month. Advice was given.
22.10.13	Lucy did a pregnancy test and this was negative. This was checked at school as Lucy presented herself to the school nurse and asked to be tested. She gave the impression to the nurse she wanted to be pregnant.
25.10.13 **Key event 5**	Lucy's care was reviewed by CYPS. Lucy remained on the waiting list for cognitive behavioural therapy. Other counselling was being offered as an alternative, to be provided by Teens in Crisis, a local charity, due to the waiting time for cognitive behavioural therapy.
26.10.13	Lucy believed she was having a threatened miscarriage- she was bleeding and this was reported to the Out-of-Hours GP service.
27.10.13	There was a 999 call to police from a female saying 'help me". The call cut off abruptly. The police call handler called the female back and she said things were fine and that she had called 999 by mistake and was going home. The incident was closed. It was only after Lucy's death that it was ascertained it was Lucy who had made this call.
31.10.13 1.11.13 **Key event 6**	A doctor neighbour of Paul's saw Lucy distressed in the street and with a visible injury to her face and signs of self-harm. This was at approximately 11.30pm. Lucy was taken in by the neighbour and the police called. Lucy told the neighbour that she had been assaulted by Daniel and that she thought she was pregnant. Lucy said that he had also knocked her to the ground and had kicked her in the stomach the weekend before when she had told him she thought she was pregnant. She said she had been in a relationship with him for nine months and there had been previous aggression. Lucy was 15, and Daniel 17. The police attended but after a short time and with Lucy in constant contact with Daniel by telephone, Lucy refused to make a formal complaint. No Domestic Abuse, Stalking and Honour Based Violence (DASH) form was completed that night by police but there was a handover to the police officer for the next shift. It was agreed that there would be full statements taken the next morning. The police were unable to locate Daniel that night. The attending police officer therefore handed the incident over to the day staff to progress.

1.11.13	Lucy was seen by a police officer for some time at her grandparent's house and encouraged to take matters further and make a formal complaint. Lucy declined. However, Lucy called the police that evening to say she would now like to make a formal complaint but this message was not picked up. A referral to Children's Social Care had been made by the police and an Initial Assessment by Children's Social Care would commence.
2.11.13	Daniel was arrested and stated that he and Lucy had split up and that was the reason Lucy was making the complaint. Daniel was released without charge. The police officer did not follow the Youth Process in accordance with police policy so the decision to release was not quality assured or approved at a senior level as per policy nor was the requisite follow up achieved. Hilary was informed that Daniel would be released. There was no further direct communication between Lucy and the police. The DASH form was categorised as standard.
11.11.13	A social worker (SW1) tried to see Lucy at her grandparents' home but she had moved back to Heather's so was not seen. This meeting was to progress an assessment.
13.11.13	Lucy had her first counselling session at school This was the first session since the GP referral in January 2013.
14.11.13	Lucy's pregnancy was confirmed by a nurse at the GP Practice. Lucy was 15. Her boyfriend was noted to be two years older. Lucy was referred to the GP.
16.11.13	Daniel had an altercation with someone and head-butted their car windscreen causing it to crack.
19.11.13 **Key event 7**	A further pregnancy test was conducted at school. This was positive. Heather was supportive. The school nurse referred Lucy to the Teenage Pregnancy Midwife. Shortly afterwards the pregnancy was announced on Facebook on Heather's page. Lucy had closed down her social media at Daniel's request. Lucy's family suspected that Daniel was taking money from Lucy.
26.11.13	Heather's mental health worker records that Heather had told her that Lucy was now living with her due to extreme difficulties with Lucy's relationship with her grand-parents.
28.11.13 **Key event 8**	A 999 call was received to the police by an anonymous caller. This was to report an on-going domestic at the "Rec", a park in Cheltenham. The caller heard Lucy saying that she could not breathe. The caller's neighbour then joined the caller and the police were told that it sounded as if the "lady may be in labour and her partner is not allowing her to call her mother." The police attended. Lucy denied domestic abuse. An ambulance was not needed but when Heather arrived to collect Lucy, police advised Heather to take Lucy to the Emergency Department.
10.12.13	Lucy attended an initial pregnancy booking appointment with the midwife and the midwife made a referral to the Teenage Pregnancy Midwife. This was the second referral to the Teenage Pregnancy Midwife. Intermittent bleeding was noted and urinary symptoms. Lucy was having on-going counselling at school. The Initial Assessment was not yet completed by Children's Social Care.

11.1.14 **Key event 9**	Lucy attended the Emergency Department. She was brought in by two members of the public. She had been hit to the ground by a male she would not name. She had been punched in the face and had a bleeding nose. After treatment Lucy was discharged to Heather's home. The doctor and Heather believed Daniel to have been the male who assaulted Lucy. Heather reported to the doctor that Lucy and Daniel argued a lot. The duty social worker in Children's Social Care was informed of the assault. The police were not involved. The GP was informed of Lucy's attendance at the hospital by letter.
14.1.14	A meeting was arranged by the school because Lucy's attendance was dropping off. The purpose of the meeting was to look at how professionals could support Lucy in attending school during her pregnancy. Lucy and Heather attended. The midwife, counsellor and pastoral head attended this meeting. Concerns were expressed about housing for Lucy. Sickness in pregnancy was also a problem. The Teens in Crisis counsellor was asked to follow up with Children's Social Care. On doing so the counsellor was advised of concerns around domestic abuse toward Lucy from Daniel by Children's Social Care. This was the first time school was informed of the incident in October 2013. Lucy's family noted that her mobile phones were being smashed by Daniel and they could not always get hold of her.
21.01.14	Lucy did not attend an appointment at the Sexual Health Clinic.
22.01.14	A call was made to the school nurse from the GP about Lucy. The GP had concerns whether enough support was in place for Lucy and that Lucy was considering a termination of the pregnancy. This was discussed at school and a Child Sexual Exploitation (CSE) tool was completed which came out with a high score. This form was sent to the police and risk discussed with Children's Social Care. Lucy was seen by the Teenage Pregnancy Midwife.
28.1.14 **Key event 10**	A multi-agency meeting was held by the school. After the meeting the Teenage Pregnancy Midwife made a referral to CYPS, which was accepted because of concerns about Lucy's mental health. Lucy had self-harmed at the beginning of the pregnancy. After the meeting the Pastoral Support Worker stated she told SW1 she had seen some bruising around Lucy's eye. The Initial Assessment by Children's Social Care was not yet complete.
February 2014	The Diversion and Placement Team started working with the family to get Lucy accommodated within her family. However, the family subsequently stated that they were still asking for Lucy to go into care away from Daniel to keep her safe.
3.2.14 **Key event 11**	A multi- agency management meeting was held in February 2014. Heather reported Lucy as missing to the police. She was believed to be with Daniel. Heather explained that Lucy did not have a mobile phone. Heather claimed that Daniel kept smashing Lucy's phones and had forced Lucy to close down her social media communications and that Daniel was repeatedly abusing Lucy. Lucy was not seeing her usual friends and her appearance changed. Lucy was not wearing make-up and was dressing down. Lucy was returned home by Daniel's grandmother.

4.2.14	Children's Social Care completed the Initial Assessment well outside the usual timescales. This was because of the absence of SW1 and it was not reallocated as SW1 kept indicating he would be back to work soon. The Initial Assessment took three months to complete rather than 10 days as was the practice standard at the time. Lucy's case was transferred from the Referral and Assessment Team to the Children and Families Team, within Children's Social Care for longer-term work.
5.2.14	Heather advised her mental health worker that Lucy had punched her in the face and she wanted Lucy to leave her home.
6.2.14	A home visit was made by Heather's mental health worker. Lucy was noted to be hostile, aggressive and abusive towards Heather.
8.2.14	Heather told her mental health worker that Lucy had abused her the previous day. Lucy accused Heather of informing Children's Social Care about the abuse. Lucy went to stay with Paul.
10.2.14	A student social worker (SSW) made a visit to Paul's home to see Lucy. The SSW who had day to day contact with Lucy recorded that throughout the contact with Lucy, Daniel was constantly calling and texting Lucy. There were six calls to Lucy from Daniel during a short period of time. Daniel seemed to be very controlling and dominating. Children's Social Care decide to arrange a strategy discussion in respect of Lucy and her unborn baby, Sarah.
11.2.14	Heather's mental health worker contacted SSW on behalf of Heather expressing concerns about Lucy. Heather had shared information with her about Lucy. Heather had said that Lucy was experiencing on-going assaults from her partner and Heather would describe it as being the "tip of the iceberg". Heather also said Lucy was self-harming and had lots of scars on her arms. Heather said Lucy had threatened her and had assaulted her. The SSW advised Heather to contact the police, if she was concerned. No further action was taken by the SSW or supervising social worker. Lucy became homeless. She was pregnant; a child herself and a victim of domestic abuse. Lucy could not be reached when with Daniel as he would not allow her a mobile phone. Children's Social Care Diversion and Placement Support Team became involved but were unable to secure a place for Lucy with any of her family members. Lucy went to stay with Daniel and his parents.
12.2.14	Lucy's 16th birthday. There were immediate issues of where Lucy could stay overnight and this was being managed by the SSW. Lucy declined foster care. Lucy expressed wanting a house with Daniel. Lucy was considered to be naïve and unrealistic around accommodation.

13.2.14	The SSW discusses a safety plan with Lucy while she was staying at Daniel's home. This was to ring 999 or other emergency services and Paul's house was identified as the place of safety for Lucy to go to in an emergency. SSW notes reported and unreported incidents of abuse. Daniel's parents permits Lucy to stay at their home as she has nowhere else to go and is pregnant.
17.2.14	Lucy declines Night-stop as she was scared of meeting strangers. The safety plan was reiterated.
18.2 14	The Teenage Pregnancy Midwife contacted CYPS as Lucy was identified as needing mental health support.
19.2.14	Heather informed her mental health worker and the SSW that Lucy had a bruised eye but she did not want to lose her relationship with Lucy by reporting it the police. Heather also said she was reluctant to inform the police because of their lack of response previously. Heather was encouraged to report it herself to the police. The SSW advised Heather that there was to be a strategy discussion by Children's Social Care to consider all the concerns.
25.2.14	A strategy discussion was held with regard to Sarah, Lucy's unborn child, as decided by social care on 11.02.14. A decision was to undertake a child protection investigation for the unborn child. Lucy was now living with Daniel and his parents and sleeping on the sofa. There were no vacancies at the Mother and Baby Unit until June.
5.3.14 **Key event 12**	Lucy was stating that she had no money. Paul advised Children's Social Care that Lucy was receiving money from the family but that Daniel was taking it from Lucy and that he had a gambling problem.
11.3.14	Children's Social Care drew up a Child in Need plan in respect of Lucy. She is referred to as a Child in Need. There was a clear plan of action and reference to the plan to be reviewed on 15th April.
17.3.14	An initial child protection conference was held in respect Sarah. The unborn child was made subject to Child Protection Plan category of "at risk of physical and emotional abuse." Children's Social Care advised Lucy that, given the relationship abuse, she would not be able to keep the baby if she remained with Daniel.
21.3.14 **Key event 13**	After an episode where Lucy was locked in Daniel's house, Lucy moved back with Heather in an attempt to separate from Daniel. She met the SSW and said that she wanted to make changes to reduce the risk to the baby.
25.3.14	A decision was made to close Lucy's social care case as it was decided that her needs could be met through Sarah's (the unborn baby) social care case. It is unclear to professionals if Lucy has definitely separated from Daniel.
26.3.14	A core group meeting was held. Separation from Daniel was not discussed nor the risk.
27 3.14	The school refused a request from Daniel to meet Lucy at the school. Lucy was still in agreement to the placement in the mother and baby unit.
2.4.14 **Fatal assault**	Fatal assault upon Lucy by Daniel after she was intercepted on her way to school and she and baby subsequently died on 5th April 2014. The post-mortem showed bruising in numerous parts of her body including her torso and thigh.

14. Analysis

14.1 Agencies were asked to provide chronologies of their involvement with both Lucy and Daniel as part of their IMR's.

14.2 Nine agencies and 29 professionals had direct contact with Lucy and three agencies with Daniel (the police following an allegation of assault; Children's Social Care where Daniel attended a child protection case conference in reference to the unborn child and Maternity Services when he attended an ante-natal appointment with Lucy). Daniel's family had contact with one agency the day before she died (Children's Social Care). This was with a student social worker and was in reference to a child protection plan for the unborn child.

14.3 The focus for this section of the report will be an analysis of the response of the agencies involved with Lucy and Daniel; why decisions were made and actions taken or not taken as indicated by the IMR's.

14.4 The Review Panel has made every effort to avoid hindsight bias and has viewed the case and its circumstances as it would have been seen by the individuals at the time. Where relevant learning points were identified by services and agencies - these are highlighted in bold.

14.5 It is important for this DHR to appreciate the life context for Lucy in which she met Daniel, and there to be an understanding of her vulnerability as a child entering a key time in her social and emotional development in her family setting. This context helps us understand the challenges of the adolescent years and how services can best support young people to distinguish between healthy and unhealthy relationships and how to keep them safe.

14.6 What the research tells us is that the teenage adolescent years can be a challenge even for the most resilient and secure individuals. Professionals face many dilemmas when working with an older child who lacks maturity and life experience but is actively seeking to assert their autonomy. Risk assessing and supporting a young person in a violent relationship brings a whole level of additional complexities for even the most skilled professionals. This is no better reflected than in The Research in Practice publication and research **"That Difficult Age - Developing a more effective response to risks in adolescence"** (Hanson and Holmes-2014). Extracts are used in this report but the review panel endorsed the whole paper as core reading for all professionals working with young people.

KEY EVENT 1 (10/10/11) - ESCALATING CONCERNS AT 13

14.7 Lucy aged 13 accused John, her grandfather of assault. However, she later retracted this and no charges were ever brought. The Police described her as "out of control". During this period, Lucy's family were increasingly struggling to manage her.

14.8 Lucy was seen by the Children and Young People's Service (CYPS), the Child and Adolescent Mental Health Service, for assessment. She had been referred in September 2011 because of her behaviour and concerns around self-harm. Lucy was assessed within the specified timeframe of 28 days. She did not meet the criteria for entry into the service so CYPS concluded there was no role for them at that time and referred the family to a local charity, County Community Projects, for family mediation. This was not taken up by the family though the reasons for this are unclear.

14.9 Lucy then went to stay with her father, Paul. He called the police for emergency assistance on 14/10/11. The incident was initially graded as attendance within an hour. During the call Paul said that Lucy was going to harm herself and this caused the incident to be upgraded to immediate attendance.

14.10 Paul had also called the police asking for help with Lucy some days earlier when he was re-directed by the police to social care. This incident is not fully recorded by the police and more information would be required to make a full assessment about the nature of the incident. There was no referral made by the police through to the Child Referral Unit for this incident and this was not picked up. The officers involved say there was no indication that there was anything of concern that would mean that it would warrant a referral/welfare concern to Children's Social Care.

14.11 On 24/10/11 Paul again called 999 concerned that Lucy was missing. There was also reference to sexual comments and self-harming on Facebook. This should have been a cause for concern as at this time Lucy was only 13 and by nature of her age was vulnerable. Lucy was identified as a missing person and the efforts to find her were correctly recorded. Risks were correctly identified and this dictated the level of intervention to try and find her, including visits to the home of her friends, checks were made on her social media and efforts to locate her. A record was made on the Child Protection Database, but not that she had said that she was going to harm herself. This was the second time in two weeks that she had come to the police's attention for making these claims. This information was not shared with Children's Social Care at this time. This may have made a difference to the way that Lucy was supported at this stage. Lucy was found at a friend's address; she stayed there for the night and did not return to Paul.

14.12 On 5/11/11 Paul had concerns again as to Lucy's location and contacted the police. She had sent a text to her father to say that she was going to kill herself, but she then called the police and said that she was not missing, but she did not want to come home. She was located at a friend's house by police soon afterward.

14.13 This incident did not result in a referral to Children's Social Care. Paul was recorded as being "very upset and he was concerned about her killing herself". It was not explored why Lucy did not want to go home. Paul and Lucy were eventually reunited which is a positive result to the intervention. There was no intervention with other agencies as it did not appear to warrant this by the police. However, these three incidents of Lucy going missing and previous police contact were treated in isolation. This was viewed as a family experiencing the testing of boundaries by a young teenager and the police would not have been the appropriate agency to deal with this.

14.14 Mediation signposting by CYPS was not taken up by the family. Mediation can be a useful process for families and may well have uncovered the full scale of the problems being encountered from all perspectives and provided the family with some whole family strategies to help manage Lucy's behaviours. This could have also identified who was going to lead the parenting of Lucy to provide her with consistency of boundaries and security of parenting. A feature of Lucy's upbringing was that this was not clear. Heather and Paul both had parental responsibility for Lucy but other family members also parented her and she moved around them all. Lucy was described by her family as sometimes playing one family member off against another and different boundaries were applied by different members of the family.

14.16 The lack of whole family working and mediation at this stage represents a missed opportunity for both the family and professionals to work together to better understand and manage the negative dynamics at play. Self-harming was also in itself an indicator that Lucy's resilience and emotional wellbeing were compromised.

KEY EVENT TWO (7/1/13-7/13) – THE BEGINNING OF THE RELATIONSHIP WITH DANIEL

14.17 Lucy did not come to the attention of services or agencies again to any real extent until the beginning of 2013.

14.18 Lucy saw her GP alone for the first time on 7/1/13. She was aged 14. Usually she was accompanied by Heather. Lucy had started contraceptives in 2012 for period pains and attended fairly regularly for associated problems.

14.19 On this occasion, Lucy expressed that she had suffered with insomnia for the previous 6 months, and she had difficulty making friends at school. She was worried about her mother's mental illness and that her father was having panic attacks. She was living back with Hilary and John. The GP referred Lucy to CYPS. Lucy herself chased this referral with the GP.

14.20 Heather informed the Recovery Team (the team supporting her for her mental health) that Lucy was back with Hilary and John and that she had concerns about Lucy's lifestyle – she was drinking alcohol, was swearing and 'mixing with the wrong crowd'. She reported the situation to be getting worse in April 2013 with Lucy now refusing to go to school. At this time Lucy had already started the relationship with Daniel.

14.21 There were numerous other contacts with the GP around urinary problems and abdominal pain throughout January to April 2013, but Lucy denied being sexually active. The GP was not aware of Heather's concerns about Lucy's lifestyle.

14.22 In the GP practice's IMR, they identified some learning points from these interactions:-

- **Relationships and the nature of these were not explored with Lucy and the GP practice has identified this as a learning point.**
- **The GP considers it would have been best practice to see Lucy alone more as most contacts were through or with her family. It is notable that when the GP did see Lucy alone she was much more open as to how she was feeling and that was happening in her life.**
- **In the DHR the GP explained that the nature of primary care then and now is that Lucy will have been seen by different GP's at different times and regular attendance by a young person is not easily picked up.**
- **Further, GP consultations are short to enable GP's to get through the volume of patients needing to be seen. Exploring social circumstances or wider issues such as risks to a young person even if they attend alone and are open is extremely time pressured. This was a learning point and something to which the practice has raised awareness.**

14.23 In early May 2013, Heather, Lucy, the Recovery Team worker and the Nurse Therapist for CYPS met. The Therapist and the Recovery Team Worker felt Lucy's behaviours were more characteristic of adolescent troublesome behaviour rather than mental illness. However, Lucy's problems were more deep-seated. Heather reflected that she continued to have emotional problems. Lucy was also moving around between Heather, Paul and Hilary and John as she came into disagreement with each one, as they became increasingly frustrated about her behaviours and felt less equipped or supported to manage these.

14.24 A counsellor continued to meet with Lucy for four more sessions. However, no risks to Lucy or to others were identified or recorded. There were no indicators that Lucy was in a violent or controlling relationship at this time and Lucy's family advised the review that they were pleased that Lucy was engaging in these sessions.

14.25 Moving further into 2013, Lucy continued to present with emotional wellbeing issues and behaviours that were causing her family immense stress and concern. At the same time Lucy was also expressing to health professionals that the family issues and her mother's mental illness were causing her to feel stressed and anxious.

14.26 Lucy had been in a relationship with Daniel for some months by now and Hannah recalls that the relationship became serious very quickly and that Daniel was nice to Lucy at first.

KEY EVENT 3 (22/7/13) - HOSPITAL ATTENDANCE

14.27 Lucy was 15 when she attended a house party where she believed she had been "injected by boys because they want to have sex with me". Lucy was intoxicated, allegedly injected or had her drink spiked and possibly been sexually assaulted. She was taken to the Emergency Department. The incident at the party was reported to the police. The hospital staff were of the opinion that Lucy was purely under the influence of alcohol. Drug tests were done.

14.28 It was Heather who called the police about this incident. Lucy's memory of the events was confused. The incident was not recorded as a crime and there was no further investigation. However, a CID officer did attend and had taken a full account. Lucy believed that she had been stabbed with a needle which at the least would have been an assault; however it appears the officer had cause to doubt the account with the lack of any further detail. If there had been an intelligence report then this would have captured the incident, which in conjunction with the other incidents around self-harm and sexual comments may have increased concern.

14.29 However, this incident came 20 months after the last intervention by the police and so would not necessarily have been seen as a continuation.

14.30 It was noted by health professionals that Lucy's school attendance had dropped and that she had low esteem and mood. She was subsequently discharged into Hilary's care for follow up from the GP. The GP received a discharge letter around this attendance and also a call from the hospital which is good practice.

14.31 Heather advised the review that there was another young person from the party in the Emergency Department making very similar allegations. Safeguarding processes were initiated for Lucy. A child protection referral to Children's Social Care was not however accepted as it was considered that family support could be provided by a Targeted Support Team, which offers support at a lower level.

14.32 CYPS were also notified of this incident by Cheltenham Targeted Support Team, and informed Lucy was to be subject to a 'Common Assessment Framework' (CAF). There is no evidence the CAF was undertaken for reasons that are unclear. The panel's view was that a CAF would have been helpful as a way to bring the family and professionals together.

14.33 A CAF is a process for gathering and recording information about a child for whom a practitioner has concerns in a standardised format, identifying the needs of the child and how the needs can be met. It is a shared assessment and planning framework for use across all children's services and all local areas in the UK. It helps to identify in the early stages the child's additional needs and promote coordinated service provision to meet them.

14.34 The CAF's purpose is to play a key part in delivering front line services that are integrated and focused around the needs of children and young people. Its aim is to support early intervention and improve joint working and communication between practitioners.

14.35 **The lack of a CAF was therefore a missed opportunity to bring everyone together, share information and best plan how best to support Lucy and her family with early intervention. This would have supported a collective responsibility for Lucy.**

KEY EVENT 4 (06/09/13) - PARENTING PROGRAMME

14.36 Heather and Hilary declined the Adolescent Parenting Programme as things had moved on. Lucy was waiting for CBT and during this time Heather reports that Lucy's behaviour continued to be challenging. Hilary and John were providing a great deal of practical help to Lucy. Hilary was clear that she was not Lucy's parent and that role and responsibility lay with Heather. The offer of parenting support was wholly appropriate though it took some months for a place to become available.

14.37 **At the time no professional or agency explored with Lucy's family why they were unable to take this support or what other support may have been helpful around the challenges with Lucy.**

14.38 There were periods of time when Heather was unable to effectively care for Lucy. The relationship with Daniel was very established by now.

14.39 Heather reflects that she formed the view that Lucy was seeking in the relationship with Daniel (Lucy's first serious relationship) a stable family to call her own. Heather's ill-health was also a source of stress for Lucy and she expressed this but it is difficult to say how this affected her mental health as this was not assessed at the time.

KEY EVENT 5 - Lucy unable to access Cognitive Behavioural Therapy (CBT)

14.40 We know that mental health problems in a carer or parent can be a risk factor for the development and emotional wellbeing or mental health problems in children.[4] This does not mean that those with poor mental health are poor parents, but poor parental health may intermittently undermine critical carer sensitivity and energy to adopt authoritative and positive parenting, with affected parents cycling between states of wellness and poor mental health (Hosman et al, 2009).

14.41 CBT could have arguably given Lucy strategies and a framework to manage her choices and stressors as well as any other underlying issues impacting upon her. Lucy had experienced unstable parenting for reasons explained. Hannah describes Lucy during this time as being in conflict with her family but very much "in love" with Daniel and saw a long-term future with him. Daniel did visit Hilary and John's house once, but he entered through the annexe (with a separate entrance to the house). Lucy was not keen to bring him back to her grandparent's house and so they spent time in parks and outside in the main at this point. Lucy's family did not get to know Daniel or have any real contact with him. His family were however known by Lucy's father as they had grown up in the same area.

[4] Leinonen et al, 2003

14.42 On 25/10/13 a review under the Care Programme Approach (CPA) was held, with a view to discharging Lucy from CYPS. CBT was still awaited and it was unclear when it would become available for Lucy. The lengthy wait for access to CBT for young people was not unusual and reflected the national picture of young people's ability to access this therapy. Lucy was discharged to a service called Teens in Crisis following the CPA review. This was the end of Lucy's second contact with CYPS. Teens in Crisis were to offer Lucy a different level of intervention to manage the "here and now" issues such as anxiety within school and she was therefore offered counselling instead of CBT.

14.43 The lack of early intervention via the mental health service from 2011 and latterly the unavailability of CBT to work with Lucy in 2013 has been a matter of great debate for the Review Panel. While generally the support offered was considered to be adequate at the time there is learning around early intervention. **This relates to how services can best intervene early with young people who are exhibiting anxiety, stress, risky behaviours and self-harming. The opportunity for early psychological intervention was lost.**

14.44 The IMR author for CYPS believes that Lucy would not have been emotionally stable enough to undertake CBT because of her chaotic lifestyle. CBT involves focused intervention. However, the referral for CBT was considered appropriate and this was not tested out. Also Lucy was requesting this which would seem to indicate she would have engaged. Therefore this is not seen as a learning point for CYPS but the Review Panel did consider that early intervention and the right level of support for a young person is important.

14.45 Lucy had moved schools numerous times and her last move for school had been in September 2011. There had been low level behavioural issues around her mobile phone and some concerns around truancy. She was particularly close to one of the Pastoral Support Workers at her school and this professional went above and beyond to support Lucy through her trials and tribulations. Heather describes Lucy as adoring this Pastoral Support Worker. However, Lucy did not share with her Pastoral Support Worker what was happening within her relationship with Daniel.

14.46 In September 2013, Lucy spoke to her Pastoral Support Worker and advised that she thought she might be pregnant. The school nurse organised a pregnancy test and the result was negative. However, the Designated Safeguarding Lead (DSL) remembers being surprised by Lucy's reaction and feeling that Lucy had really wanted to be pregnant. School also spoke to Lucy's mum at this stage to ensure that she was aware of the situation.

14.47 Lucy received care from both the School Nursing and Sexual Health service staff working within the Gloucestershire Care services NHS Trust (GCS). The main contact was with the school nurse. On 05/10/13 Lucy attended and disclosed that 'life was stressful' and that she was returning to live with her dad following arguments with her Nan, who she lived with. On that occasion the pregnancy test was again negative.

14.48 Lucy did not disclose to the school nurse her difficulties with her relationship with Daniel.

14.49 Lucy was 15 and so below the age from which the cross-government national definition of domestic abuse applies. We know that victims of abuse can go to some lengths to not disclose what is happening to them within an intimate relationship. This was compounded by Lucy's emotional investment in Daniel at a key developmental time and at a time when she was increasingly in conflict with her family. Hannah, one of Lucy's best friends noted the relationship changing and that Daniel was "off and on" with Lucy and that his mood and demeanour changed a lot. She describes Lucy changing too and needing to watch what she said around Daniel. Lucy started to dress down and not see her friends as much. Lucy told Hannah that Daniel was jealous and had accused her of trying to attract other boys when they were out and on social media. Lucy started to close down socially. Daniel's behaviour is what we know now as controlling. It was around this time that she thought she had been pregnant and had a threatened miscarriage.

14.50 During this period there was a lack of an inclusive whole family approach. This would mean working with and empowering individuals and families, and their support networks, to problem solve for themselves wherever possible. **The consensus of the Review Panel is that this may have gone some way to preserve family relationships, collectively and individually. This would have also afforded the opportunity to work with Lucy to address her self-esteem issues, stress, anxiety and reinforce what constitutes a healthy relationship. This would have provided an optimal opportunity to work with Lucy while she was still open to that.**

KEY EVENT 6 (31/10/13) - PHYSICAL ASSAULT

14.51 Lucy approached a member of the public out in the street at night distressed and physically injured. She said she had been punched in the mouth and she also had injuries to her arms. Lucy said she had been assaulted by Daniel and that she thought she was pregnant. Lucy said that he had also knocked her to the ground and kicked her in the stomach the weekend before when she had told him she thought she was pregnant.

14.52 The member of the public called the police and this was responded to straight away by officers. The officers noted an injury to Lucy's face. The officers immediately identified Daniel as the suspect from what Lucy told them and with the supporting evidence of the injury they arranged for other officers to affect an arrest. This is despite the fact that at this time they did not have a "formal" complaint i.e. not in writing. The officers spent a lot of time with Lucy asking where Daniel might be and asking for the police intelligence systems to be interrogated to try and locate him.

14.53 The officers spent a lot of time speaking with Lucy and explaining the process, and reassuring her about what would happen. Both officers tried different "tactics" to try and get her to make a complaint. There was a discussion around the DASH (Domestic Abuse, Stalking and Honour-Based Violence) form and its completion. However, the incident did not meet the national definition of domestic abuse as she was 15. A DASH form is risk assessment tool for domestic abuse. This states:

Domestic Abuse is:
"*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.*"

14.54 At the time of this incident Lucy was15 years old, and as such this should have been identified as a child protection incident and a referral should have been completed and made as soon as possible. During this incident Daniel was ringing and texting Lucy on her mobile while the police were present. The attending officer did consider speaking with Daniel on the phone, however there were already officers tasked to try and locate him. It was felt that it was more likely that Daniel would go home and they would locate him there. At this time Daniel was the suspect for an offence and was being actively sought. Had the officers spoken to him on the phone this may have developed into an interview and this would have potentially breached the law around interviewing suspects. Also, Lucy would not give her mobile phone to the officers and they had no right to take it from her by force unless it was believed to be evidence of an offence, which they had no grounds to suspect from this incident. Lucy was a victim of assault and a child and this would not have been appropriate. It is of course likely that Daniel was influencing Lucy into not making a complaint at that time. However, there were three adults at the address all speaking with her and none of them were able to take the phone from her to prevent the contact with Daniel.

14.55 The police officer did not take a statement from Lucy at the time due to her age; plus the facts that she was a little intoxicated, upset, it was late and that they were in someone else's house. That person had already said that they had to be up early for work. This was the rationale for not completing a DASH at the time. However as established, this did not fall into the remit of domestic abuse and a child protection referral form should have been completed instead rather than a DASH form.

14.56 For the review the police stated they would not as a matter of course take a statement from a person who was intoxicated if it could be avoided. This was good practice as the nature of the evidence obtained can be cast into doubt due to intoxication. Lucy was also a child who had been through a traumatic event that evening. The officer did not believe that anything would be lost by leaving it until the next day. During the attendance by the officers, Lucy's attitude changed and at this time was not willing to make a statement. She calmed down and said that she did not want to make a complaint and get Daniel into trouble. Notwithstanding that she had not made a complaint, positive action was taken in that Daniel was going to be arrested.

14.57 The officers emphasised to Lucy the ways that they could help her. They advised her that the best way forward was to provide a statement. She was also told that if Daniel was a violent person he would most likely assault her again at some point. However, the more this was discussed, the more Lucy withdrew from the process. She kept saying that she loved Daniel and that he was "not as bad as you think". She said that she knew what had happened was wrong. As the night continued Lucy became less upset and started to become more flippant about the incident. Hilary and John arrived to collect Lucy. The officer completed the handover for the early shift which included both officers' statements, copies of their pocket note-books and report outlining what they had done so far. The PC also gave the handover to the early shift sergeant in person.

14.58 The day-shift officer visited Lucy at her grandparent's home and spent several hours speaking with them, with Lucy and with Heather and explained the process that could be followed. He completed a DASH form with Lucy. Despite this not falling under the national domestic abuse definition, Lucy was offered the Gloucestershire Domestic Abuse Support Service (GDASS) option and the officer said that he explained this to her. She did not feel able to accept this support. GDASS had been developing a worker specifically for young people and this may have helped Lucy. The officer spent three hours or so with Lucy and her family trying to get her to make a complaint. The DASH form was processed and considered as a standard risk. The form was passed onto the Central Referral Unit given Lucy's age.

14.59 Lucy signed the officer's pocket note book in the presence of Heather to say that she would not make a complaint and that she did not want to get Daniel into trouble as he wanted to join the army. She would give no details about how the bruise to her face had been caused or about the incident on the 31st October and an alleged previous assault on 27th October. She also told the officer that she wanted the relationship to continue. Despite Lucy not wishing to make a complaint, the officer decided to take positive action and make an arrest. Daniel was arrested from home the next day on suspicion of both assaults.

14.60 During the course of this DHR it transpired that there had been a call to the police on 27th October, just a few days before this assault. It was a 999 call to police from a female saying 'help me" but the call was cut off abruptly. Police called the female back and she said things were fine and that she had called 999 by mistake and she was going home. The incident was closed. It was only after Lucy's death that it was ascertained it was Lucy who had made this call.

14.61 **The police IMR identified learning around this call and ways that the call handler could have elicited more information. Training has been provided around this.**

14.62 After interviewing Daniel, the police made the decision to take no further action. There should have been a submission of a Youth Process Form regarding Daniel while he was in custody due to the introduction on 8th April 2013 of the Legal Aid, Sentencing and Punishment of Offenders Act 2012 (LAPSO). It contained a number of significant changes with regard to out of court disposals for young people aged 10 to 17 years of age. One of the changes was the process by which inspectors are involved in all of the cases involving youths. The Youth Process form should have been completed while Daniel was in custody. The form should then have been emailed to the Duty Inspector. On receiving the form, the Inspector has access to an attachment which contains a gravity matrix for 'scoring' the offence. This should be done after a conversation with the officer in the case and an informed decision made as to how he should have been dealt with. The form would have contained more details about the incident and about Daniel himself. If the officer had completed this form and had a conversation with the Inspector, other information recorded may have been discussed in more detail particularly around risk.

14.63 The process involves the Inspector then endorsing the form with the decision he has made and then it is sent back to the officer in the case and onto the Youth Offending Team (YOT) for their consideration for intervention. This then forms part of the discussion with the Custody Sergeant as to what the disposal will be. The form was completed and submitted but retrospectively the next day.

14.64 The Police IMR stated that this process being completed is unlikely to have altered the outcome of how Daniel was dealt with. **However, the review panel is of the view that a senior officer supervisory oversight would have provided a check and balance that might have helped the Police understand the facts more clearly. The senior officer could have also considered seeking further evidence to be collated or initiated a warning to Daniel.**

14.65 The evening before Daniel's arrest Lucy phoned into force control room and said that she did want to make a complaint about the incident after all. The operator emailed the police officer who had seen her at home and put an update on the incident for his attention. The police officer said that he was not aware of this until this review but on checking he did reply with an acknowledgment to the operator. The email chain is no longer in the system due to the time that has passed.

14.66 The Incident Assessment Unit was questioned about this for the review and Police IMR. Sometimes the incident is not updated as often it is closed anyway by the time the call comes in. There is no specific direction about copying in a supervisor. If there is a crime recorded then there may be an instruction put on the crime record too. The officer is at loss as to why this was not actioned at the time.

14.67 **On discussing this with a Senior Officer at the Public Protection Bureau in Gloucestershire, he advised when victims of crime ring in on previously reported events it is not acceptable just to email the officer in the case. This provides no governance or oversight. The crime report must also be updated and raised for assessment or if no crime report the original incident opened and reassessed.**

14.68 Even if Daniel had not been arrested, Lucy's decision to make a complaint would have provided more evidence to submit to the Crown Prosecution Service for a charging decision. If Daniel did not come back into custody, it could have proceeded by way of summons. Daniel denied assaulting Lucy and stated she was making it up as he had tried to end the relationship. No statement was taken from the member of the public nor photographs taken of the injuries to Lucy's face, and arms. The fact that Daniel was constantly texting and speaking to Lucy even when she was in the presence of the police was not identified at the time as a mode of coercive control.

14.69 A DASH form was completed. This form was originally created for adult victims of domestic abuse. Since April 2013, the national definition of domestic abuse was extended to those aged 16 and 17. The DASH is therefore used for this age group as well as adults. At the time the DASH was completed for Lucy she was 15 years old and the review team considered that it was good practice that the DASH was completed, even though a 15 year old sits outside what is nationally defined as domestic abuse. At that time this was the only tool available to the police but since then other tools have been developed aimed more at the young person such as young person's DASH. The DASH used in this case was completed in Lucy's presence, as is good practice.

14.70 Essential information known to the police was not captured in the DASH, specifically that Lucy was alleging Daniel had punched her to the floor and kicked her in the stomach when she told him she thought she might be pregnant.

14.71 At the time of this incident the HMIC had assessed the local police forces response to domestic abuse incidents and this had been critical on numerous levels. However the DHR review panel has seen evidence that those criticisms have been actively addressed and continue to be so.

14.72 Children's Social Care was informed on 1st November 2013, of the incident. The social worker (SW1) made an appointment to see Paul, as the referral stated that Lucy was living with her father. He also sent an appointment to Hilary and John as Lucy was staying with them at the time of the incident. Due to the social worker's absence on sick leave there were no further arrangements to meet with the family until 9th January 2014. The case note says that Lucy's parents were both aware of abuse in the relationship and the pregnancy and would support Lucy. Lucy was not spoken to alone following the incident to see if Children's Social Care could establish her views.

14.73 **At the time this was not seen as a high risk case and so not prioritised for reallocation. The GSCB Gloucestershire's Children's Workforce Guidance for Levels of Intervention (v1 27 June 2011) did not explicitly describe teenagers in domestically abusive relationships and the level of intervention appropriate to respond to this. Domestic abuse is considered in the context of adult parents/carers and the risk posed to children who witness this. There was also a lack of knowledge around the identification and risk of any coercive control.**

14.74 In relation to the safeguarding response, at that time Working Together to Safeguard Children 2013 stipulated that an Initial Assessment should be completed within 10 working days of the referral. An Initial Assessment is a key stage of information gathering and communications which inform where the child should sit in the formal safeguarding system, if at all. Some young people will be seen as a child in need (with an associated plan) but others will be considered to be at risk of significant harm and require a formal child protection response. Some children and young people are so at risk that on consideration by a court, they can be taken into care. Being taken into care is not always the positive outcome it may seem and in all cases is not a step taken lightly. This involves removing the child from their family base because they are not safe from direct abuse or neglect. Due to the social worker's absence and the fact that the risks to Lucy had not fully emerged nor appreciated, the assessment relating to Lucy took too long. While the team manager stated that they had not anticipated the social worker being absent for very long, the initial assessment was not completed and signed off until 4th February 2014 some three months later.

14.75 **Maintaining momentum for assessment and prioritising accordingly is a learning point for Children's Social Care. Risk factors were building around Lucy and this was not assessed in a timely or effective manner. The longer-term work with Lucy could have commenced much earlier.**

KEY EVENT 7 – 19.11.13 - PREGNANCY

14.76 On 19/11/13, when Lucy's pregnancy was confirmed, Heather was noted to be supportive. The school nurse referred Lucy to the teenage pregnancy midwife. Shortly afterwards the pregnancy was announced on Facebook; Heather reports Lucy used her Facebook account to announce the pregnancy. She had closed down her own and other social media at Daniel's request. Lucy's family were also aware that Daniel was smashing her phones.

14.77 Lucy's best friend Hannah believed that Lucy stopped wearing make-up and dressing down in dowdy clothes so that other boys would not look at her. Hannah said she was pretty and could get a boyfriend easily but that she had fallen in love with Daniel and wanted to stay with him. In time this changed and Lucy was more worried about leaving him and of his jealousy.

14.78 **Had services been aware that the emerging pattern of Daniel's behaviour was coercive and controlling in nature then these risk factors and ways of mitigating these could have been identified**.

14.79 As our national understanding of domestic abuse has grown a feature of controlling behaviours has emerged which we now term nationally as “coercive control”. This can include 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 means needed for independence resistance and escape and regulating their everyday behaviour.

14.80 The core elements of ‘power and coercive control’ have long been recognised by those working in the domestic abuse field. However, it is only in more recent years that coercive control has taken prominence in the law. This feature of coercive control is considered to be so serious that this is now an offence in its own right. The law was enacted to make this a criminal offence in January 2016. This is under the Serious Crime Act 2015. It should be noted however that this was not an offence in 2013/14.

14.81 Warning signs and behavioural techniques of abuse considered to be components of coercive control include:

- Unpredictable mood swings- switching from charm to rage;
- Excessive jealousy and possessiveness;
- Isolation-preventing partner from seeing family or friends;
- Constant criticism including putting the partner down in public;
- Control of the partner’s money;
- Control over what the partner wears, who they see, where they go, what they think;
- Exerting pressure on the partner to have sex against their will;
- Use of threats of physical violence to punish partner if partner is considered to have disobeyed;
- Random and unexpected use of violence to frighten and subdue partner.

14.82 Most of these elements were emerging as features of Lucy’s relationship with Daniel.

14.83 Teenage intimate relationships are not immune to abuse or coercive control. The British crime survey 2009/10 found that 16-19 year olds were the group most likely to suffer abuse from a partner. 12.7 per cent of women and 6.2 per cent of men in this age group suffer abuse, compared to seven per cent of women and five per cent of men in older groups[5]. It was this increasing understanding that has led to the cross-government national definition of abuse being reduced to 16.

[5] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/116347/hosb1210.pdf

14.84 Where the victim is a child victim this brings with it additional complexities which are explored in this review but fundamentally the issues are ones of vulnerability and the management of risk. The inherent theme throughout this review is how risk to the young person was seen, interpreted and what agency responses this elicited both single and multi-agency and the effectiveness of those responses. The indicators of coercive control was a worrying development in Lucy and Daniel's relationship and was increasing at a time when no social worker was actively working with her; there was an additional risk factor of teenage pregnancy; her relationships with her some of her family further deteriorated after becoming pregnant, as she continued the relationship with Daniel. Lucy also had longstanding emotional wellbeing and self-esteem issues with intermittent self-harming with no substantive mental health services support.

14.85 Daniel's parents told the review that they saw a change in Daniel and the relationship when Lucy became pregnant and felt the relationship was far too intense. They spent all their time together and they worried about Daniel becoming a father as it is a big thing for a young man to take on and it was not planned. They say that Daniel seemed angry after that. Heather's partner also reported hearing Lucy and Daniel arguing and Daniel saying that he did not wish to become a father.

14.86 On 23rd November 2013 Lucy was seen at the local hospital with abdominal pain and bleeding post-coital. She was noted to be in the early stages of pregnancy. Lucy did not disclose any domestic abuse nor was she asked. The hospital were not aware of the incident which had occurred on 31st October 2013 when Lucy had been punched in the face but had also said that her boyfriend Daniel, had previously kicked in her in the stomach. **There was no mechanism to share that information with the local hospital and the author of the hospital IMR states that if they had known this information they would have been more probing.**

14.87 Lucy was seen at various points thereafter for ante-natal appointments. She was noted to be suffering from severe morning sickness with a low body mass weight. Lucy was either accompanied by her mother or Daniel.

14.87 In November 2013 the school nurse advised the school lead that Lucy was now pregnant. The school organised a Team Around the Child (TAC) meeting to support Lucy and at this point discovered that Lucy had a social worker who had not at that point contacted the school as the case had not been reallocated due to the absence of the social worker. The school were not invited to a meeting with Lucy's father where Children's Social Care tried hard to come to an agreement with him about accommodating Lucy at his home.

14.88 School reported that when pregnant, Lucy kept her core group of friends but did tend to isolate herself slightly. In early pregnancy she was hardly attending school. It is difficult to determine whether this was because of Daniel's influence, Lucy's ill-health or whether she felt less confident. During this time, Lucy would only attend lessons in Aspire, which is a small study unit within the school.

14.89 When seen on 10th December for her pregnancy booking appointment Lucy was accompanied by her mother. Lucy nor her mother mentioned any social problems and Lucy denied domestic abuse. Midwives as a matter of competent practice must ask expectant mothers of any relationship issues and domestic abuse. It is best practice to ask such questions privately and based on previous contacts with the GP, Lucy may have been unlikely to share information in front of her mother. It is best practice for any medical professional to afford a teenager the opportunity to speak privately.

14.90 The universal Midwife/Health Visitor/GP liaison form states that if vulnerability factors are identified, a "Maternity Social Concerns and Plan for Care Document" should be completed. This is used by the midwife to highlight a vulnerable mother and or unborn baby to other members of the maternity team and also to her midwifery manager. The document aims to improve communication, provide an opportunity for supervision and support the midwife in planning care. A "Maternity Social Concerns and Plan for Care Document" was completed by the Teenage Pregnancy Midwife on 18/02/14. It states "vulnerable 16 year-old with escalating domestic abuse in pregnancy. Made homeless and has no family support". It was filed in Lucy's hospital-held maternity records folder as per policy.

14.91 It is clear from research that domestic abuse is likely to commence or increase when a woman becomes pregnant[6]. The fact that Lucy was pregnant was therefore a major risk factor for an escalation of domestic abuse but one not recognised by Children's Social Care, as their response demonstrated. It is likely that it was the news of the possible pregnancy that was the trigger point for the physical abuse of Lucy by Daniel.

14.92 It is concerning that the social care workers involved in this case did not seem to recognise risk factors around the particular vulnerability of a child who is a victim of domestic abuse. The Review Panel would expect all social workers, particularly those in decision-making roles, to have an in depth understanding of domestic abuse, regardless of whether the victim is an adult or a child and the risk factors in both set of circumstances.

14.93 At this point, no steps were taken by any agency to engage with Daniel or his family as to how he felt about the prospect of becoming a father and the reality of that. Lucy and Daniel had an unrealistic expectation that Children's Social Care would find them nice accommodation in a good area with full financial support.

KEY EVENT 8 (28/11/13) - INCIDENT IN THE PARK

14.94 The police were contacted by a member of public who had concerns about a girl calling out in the park which backs onto their property. The police responded immediately to the anonymous call on the basis there was a domestic incident in progress. This is in line with force policy.

[6] http://www.refuge.org.uk/get-help-now/what-is-domestic-violence/domestic-violence-and-pregnancy

14.95 The police found the couple in the park. Lucy, without prompting had provided an explanation around a panic attack and that she had been shouting as the caller had indicated. The officer looked around for signs of a disturbance and at Lucy and her clothes for signs that she was either dishevelled or injured. The police found nothing.

14.96 The officers spoke to Lucy and Daniel away from each other so that they could get independent accounts. They could not remove either party from the scene as they had no grounds to at this time without the suspicion that an offence had taken place. They considered speaking with the caller, but they did not have details as it was an anonymous call. They both gave consideration to knocking on doors, but that did not seem proportionate as they could find no evidence of an offence taking place. Lucy had already called her mother and the officers considered that she was the best person that could look after Lucy, so they waited with her while she arrived. The female officer, on the way out of the park, reassured Lucy that the police would help her if she needed it. Lucy did not engage with the officer.

14.97 The officers stated that it was difficult to say what had actually occurred. The suspicion was that something had taken place, but there was nothing to corroborate this from within their accounts, physical evidence or what the officers witnessed. The fact that Daniel had walked off and left Lucy added to the suspicion. Daniel was moving away from Lucy as they arrived. The suspicion that something was occurring was tempered by Lucy's relaxed attitude to Daniel when he was there and how he spoke to the police. The officer said that if she had any suspicion that anything was happening that indicated domestic abuse, then she would have completed a DASH form. However, this would not have been the correct thing to do as Lucy was a child aged 15, and this was a child protection issue. In this instance nothing was shared with other agencies as it was considered there was no intelligence or similar to input into the system.

14.98 Around this time, Hannah said it was not always easy to contact Lucy and she had shut down her social media accounts as Daniel thought she would flirt with other boys. Paul did not want Daniel in his house as he had stolen items previously and this caused a tension between him and Lucy as she wanted to stay at Paul's house when he was on holiday.

14.99 **The period between October 2013 and January 2014 is significant as further risk factors were emerging for Lucy. Although Children's Social Care had initiated an Assessment under safeguarding processes in early November 2013 after the assault upon Lucy on 31st October 2013, this was not being progressed as social worker 1 (SW1) was absent and the case was not seen as a priority. In the review the Children's Social Care manager was of the opinion that the risks Lucy presented with were not novel or unusual and that there were many other "Lucys". Factually the lack of progress left Lucy for three months without a formal assessment outside statutory timescales.**

14.100 **Further and significantly her family reflect into the review that they felt left to manage a very difficult situation concerning Lucy who was pregnant and in an abusive relationship and they were desperate for help and support at this time. Lucy moved in with Heather as she fell out with her grandparents but Heather's mental health was worsening during this time. School were not aware of the magnitude of the problems facing Lucy and at this point her family did not have professional support to facilitate such processes as a CAF, even though any agency can trigger this process and there is a collective responsibility to consider this across agencies.**

KEY EVENT 9 (11/1/14) - ASSAULT BY UN-NAMED MALE

14.101 Lucy attended the Emergency Department. She was brought in by two members of the public. She had been hit to the ground by a male she would not name. She had been punched in the face and had a bleeding nose. After treatment Lucy was discharged to Heather's home. The doctor and Heather believed the assault to be by Daniel and Heather reported they argued a lot. The duty social worker was informed of the assault. The police were not involved. The GP was informed of the attendance by letter. Lucy had been brought in by two members of the public but it was not known what they may have seen. The duty social worker took no action and this is unexplained. The duty social worker told the doctor that Lucy was known and that a child protection conference was being held in a few days. This was not the case. It is now thought that the social worker may have become confused in that meetings were being held at school.

14.103 On this admission, Lucy was 15. Gloucestershire Hospitals Trust Emergency Assessment Record for Children and Young People was completed although the screening tool within was only partially completed. A key question within the screening tool asks "Is there anyone the child feels frightened by in and outside the home". This question does not appear to have been asked of Lucy. The name of SW1 is recorded at the bottom of the assessment; therefore it can be assumed that the nurse and consultant in ED were aware that a social worker was involved in her care.

14.104 **A reflection in the IMR by Gloucestershire Hospitals was whether Lucy should have been more closely examined for other injuries at this time. It was concluded that this may well have discovered other injuries but they would have needed Lucy's consent to further examine her and she and would not speak to the doctor about the incident at any length.**

14.105 **Staff at the hospital dealt with this incident as a child safeguarding matter but have since improved training and policy around domestic abuse responses for young people to ensure that the police are informed in all appropriate cases and to embed an understanding around 16 year olds and in line with the national definition.**

14.106 The school nurse was informed by the Paediatric Liaison Health Visitor. This is good practice for information sharing. The school nurse did not contact Lucy following this incident, but believed that others were involved in her care and leading a response. This was a reasonable assumption given that she had been told that Children's Social Care had been notified.

14.107 The hospital staff followed the Multi-Agency Policy and Procedures for the South West Region. This is included as part of the Think Family training. The DASH form is available for staff on the hospital website. None of the hospital staff involved in this case followed the Domestic Abuse Pathway nor completed the DASH form for Lucy. This would not be expected practice because in-line with the hospital's policy, the DASH form at that time was advertised for use with adults (over 18). Lucy was under 18.

14.108 Hospital staff did liaise with other agencies to information share under the multi-agency approach to safeguard children. There were no specific protocols in place for domestic violence and abuse for under 18's in the hospital (or the County) at this time. The issue was identifying that Lucy was experiencing domestic abuse and supporting her with this.

14.109 **Since that time, Gloucestershire Hospitals entire medical and nursing workforce have received safeguarding children and adults training in line with the Trust's mandatory safeguarding children training strategy.**

KEY EVENT 10 (22/01/14) - PROGRESSION THROUGH PREGNANCY

14.110 The school nurse was contacted by the GP on 22/01/2014 who raised serious concerns about Lucy's welfare. He felt that she was in an abusive relationship with her boyfriend, and wasn't well supported by her mother as she had mental health issues. The GP was aware that Heather's mental health workers were increasingly concerned about Heather's health and Lucy's safety. The school nurse contacted the school so that she could discuss Lucy's case. At that point the GP mentioned that Lucy was considering a termination. No advice was taken from the police as no specific events were mentioned and the response was to arrange a meeting to discuss matters more widely.

14.111 Following the phone call the school nurse completed a Child Sexual Exploitation (CSE) screening tool. In discussions with her, the school nurse wasn't sure that Lucy was at risk of CSE but was at a loss as to how to record or identify her concerns, and wasn't aware that there was a DASH form that was used particularly for teenagers in violent relationships. The form identified that Lucy was at 'high risk' of exploitation. This form was sent to the Children's Social Care helpdesk and the police Central Referral Unit. Neither have a record of receiving or responding to this risk assessment though the review panel do not doubt it was sent. This dilemma by the school nurse as how to objectively assess risk to Lucy reflects the confusion that pervades this review around teenage relationship abuse:

- How is this defined?
- How can professionals best support young people under-16 in abusive relationships?
- And how can the safeguarding children's system inform itself of the concepts of risk that are better understood in the field of domestic abuse in adults (including features of coercive control)?

14.112 The police were not contacted for advice by any agency and at that time the profile and understanding of relationship abuse amongst under-18's was less sophisticated. There had been national initiatives around this but not widely noted by agencies. However it is the responsibility of agencies and professionals to keep up to date with changes in legislation and legal definitions, especially those which directly affect their client groups. Resources and literature would have been available from national and local DASV organisations.

14.113 Lucy was aged 15 at the start of involvement with Gloucestershire Care Services, and it is apparent that although best practice was aspired to, her risk from the abusive relationship was not fully understood. This may have been due to the fact that Lucy was not always honest as to how the current situation was but it may also be, in part, due to the more recent changes in legislation that now considers a younger person aged 16-18 at risk of being in a relationship where domestic abuse may be a factor.

14.114 The national definition had changed to 16 year olds being able to be identified as victims of domestic abuse in their own right just one year prior. The Domestic and Sexual Violence Coordinator confirmed that this was not embedded within agencies at this time and that the localities were at differing development stages in their priorities and understanding. **This disparity will be resolved with a unifying approach to strengthen the professionals' response**.

14.115 As the pregnancy progressed Hannah saw Lucy less but Lucy showed her texts from her phone where Daniel was kind to her and then hateful. He would text her to say he would kill her and the baby. This really worried her best friend and she told her mother who advised that Lucy should share the communications with Heather so action could be taken. Her friends were surprised but she always wanted a family and place of her own to settle in. Lucy had a great sense of humour and was fun socially but also wanted to settle down. Lucy's best friend observed that Daniel was becoming Jekyll and Hyde, kind one minute but then jealous and paranoid at other times. Initially she thinks Lucy was quite flattered that Daniel was jealous. Lucy accepted the way he was but became scared of him and was careful what she said to him.

14.116 Hannah told the review that now she wishes she had told others about the texts and what Lucy was saying but that could have jeopardised this valued friendship. She said it would help if there was some way she could have told someone but stayed anonymous. **She asked the review to think about that and a good place for that would be at school in her view. This is something that the review panel has considered a great deal and is reflected in the recommendations**. The Review Panel are grateful to this young person in coming forward and assisting the review in such a positive and mature way.

14.117 The maternity records and the electronic records from the Emergency Department are held separately and not within the main health record**.** Therefore, when the Teenage Pregnancy Midwife saw Lucy for the first time in clinic on 22nd January 2014 she was not aware of the domestic abuse incident which had resulted in Lucy attending the Emergency Department on 11th January 2014 or the incident of 31/10/13.

14.118 During the consultation Lucy was noted to be already under the care of the Teens in Crisis Team and noted to have an allocated social worker. Therefore the day after the clinic the midwife rang Children's Social Care to find out more. The focus of multi-disciplinary working appears to be on the practical difficulties Lucy was experiencing currently with finance and housing and plans for Sarah the unborn child as opposed to the level of abuse she was experiencing and the risk of further assault. Lucy did disclose to her sexual health worker that the father of her baby had 'violent tendencies' but 'not recently' saying that he was "kind and helpful".

14.119 At that time her pregnancy was also discussed, including what support she would receive and whether she wanted to continue with the pregnancy or not. Lucy asked for an appointment with the Pregnancy Advisory Centre as she said that she felt frightened about the pregnancy.

14.120 In a follow up conversation, the sexual health advisor contacted the midwife that Lucy wished to 'carry on with the pregnancy'

14.121 Gloucestershire Care Services NHS Trust (responsible for sexual health and school nursing) have clear record keeping, domestic abuse and safeguarding policies and procedures, however the domestic abuse policy has only recently been updated to include reference to young people aged between 16 and 18 who are in abusive relationships with their partners.

14.122 The school nurse was notified by the school of a meeting to take place on the 28/01/2014. The school nurses called the social worker involved at that time, informed him of the CSE score and emailed the social worker a copy of the form, and also requested to be informed of any decisions made. At the same time Midwifery Services informed CYPS that Lucy was 14 weeks pregnant and there was evidence of self-harming behaviours. Lucy was re-referred back into CYPS. At the time of her death In April 2014, this had not been progressed.

14.123 Ongoing information sharing with the GP was sparse and he was left out of the safeguarding loop. It was acknowledged that there is a national issue of the availability of GPs to attend children's safeguarding meetings. The GP's concerned with Lucy acknowledge as a learning point that they must consider that patients may sometimes not be open about problems i.e. the need for healthy scepticism and respectful uncertainty. This can be particularly so if they are vulnerable to external influence.

14.124 **The GP practice has already made positive changes to improve processes and record keeping around children safeguarding and domestic abuse and to become more connected with children safeguarding processes.**

14.125 **All staff at the surgery undertake yearly safeguarding e-learning which includes domestic abuse. This is consistent with recommendation 16 from the 2014 guidance from the National Institute of Clinical Excellence (NICE). The surgery also used a quarterly development afternoon to learn more around domestic abuse. A speaker from the Gloucestershire Domestic Abuse Support Service attended. The whole surgery team attended this event. This process has highlighted the dilemma in disclosing domestic abuse including with young people.**

KEY EVENT 11 - MULTI- AGENCY MANAGEMENT – February 2014

14.126 Lucy did come to the attention of the police again on 4th February 2014. A missing person log was sent to the Children's Helpdesk from the police and a subsequent referral was sent to the Referral and Assessment Team. Heather was worried that Lucy was with Daniel, she told the police that Lucy was being abused by Daniel. He had broken her phones and forced her to close her social networking sites.

14.127 A child protection (CP) and a domestic abuse (DA) tag were added to the incident, this would have meant that the incident was sent to the Central Referral Unit (CRU), as per force policy with incidents marked with this tag. When Lucy returned home and there was a debrief, she said that she was not missing and that her mother knew where she was and that she would be back by 22.00 hours. In fact the record was closed at 21.38 so she was back by that time. The officer who completed the debrief identified that there were clear issues between mother and daughter. There was an update to the Central Referral Unit and this incident was recorded on the child protection database and was shared with Children's Social Care. There was no response about the claim that Heather made that Daniel was abusing Lucy and that he was smashing up her mobile phone. Instead this was seen as family conflict. This was a poor police response and Heather was not taken seriously nor further inquiries made. The police do not appear to have seen this incident in the context of all that had gone on before with Lucy and yet Heather had proactively reported her concerns.

14.128 Children's Social Care had taken a considerable time to complete their assessment and Heather stated she did not have an identifiable social worker to whom she could take her concerns at that point.

14.129 Following this incident Heather stated that Lucy could not live with her. The situation was impacting upon her health significantly and Heather's health workers started to communicate direct to Children's Social Care the seriousness of the situation and concerns about Lucy and her relationship with Daniel being abusive. Heather wanted Lucy to be taken into care and away from the area so safe from Daniel.

14.130 The Diversion Team within Children's Social Care was deployed. This team's remit is to ensure that admissions to care are limited to occasions where risks are perceived as too high to maintain children living with their own birth families and/or where becoming a 'Child in Care'. The Diversion team was successful in this role and liaised with the various family members. This did not include Daniel's family to address his behaviours but was focussed upon mediating to try and get agreement from one of the family to accommodate Lucy. Heather states that numerous value judgements were made about Lucy's situation in that her family had comfortable homes and she was not from a deprived family or area. Heather stated that a social worker had told her that "Social Care would not take a young person into care when they have all this". Heather was told that Lucy would have to be placed in another part of the country. Heather welcomed this as she wanted Lucy to have some place far away from Daniel. At the same time Lucy was minimising the abuse within her relationship and yet there were objective indicators that physical abuse was ongoing with coercive control. Heather's partner Mark told the Diversion Team that they were worried they would find Lucy hurt.

14.131 Heather said that her parents were at their 'wits ends' with Lucy. She couldn't think of anyone else who could accommodate her. Heather later agreed that Lucy could continue living with her until Lucy was 16 on the understanding that Lucy could access alternative supported accommodation once she was 16. Being 16 brings in additional provision to young people but there are considerations such as whether they have made themselves intentionally homeless. Even if there had been some refuge provision for Lucy it is unlikely she would have cooperated with going and she would not have been prepared not to see Daniel.

14.132 **However no active work was being done with Lucy by any agency to educate her as to the risks of her relationship. The professional response was driven by the very practical problem of her needing accommodation outside the family setting.**

14.133 The Children's Social Care Initial Assessment identified the concerns however it did not make a judgment about Lucy's risk particularly relating to the domestic abuse and coercive control she was experiencing. The assessment acknowledged that there had been two incidents and that Lucy was minimising the abuse and the impact it was having on her and her unborn baby. The decision at the end of the Initial Assessment was to pass the case to the long term social care team for further assessment and intervention as Lucy would need help with housing, finances and her baby. The last sentence stated that there were 'possible risks of Child Sexual Exploitation and domestic violence'.

14.134 **Given the information known at the time, the risks were not seen as 'high risk' through a lack of understanding of domestic abuse, coercive control and associated risks despite Children's Social Care stating that many social workers have experience of working with domestic abuse in relation to children; though this tended to be more around children witnessing abuse between parents rather than the focus of young people being direct victims or perpetrators in an intimate relationship.**

14.135 **GDASS at the time did not have specialist workers to work with young people but there are two now who are specifically tasked to work with young people who are victims of domestic abuse.**

14.136 **The Children's Social Care IMR highlights that it had been difficult to understand the risk to Lucy. The DASH form, which a social worker had tried to complete with Lucy, but she had refused, is designed for older victims. The DASH is a tool usually completed by the police when they attend a domestic incident and it doesn't reflect the issues that young people face well.**

14.137 Lucy's case was transferred to the Cheltenham Children and Families' Team and allocated to a senior practitioner social worker (SW3) and a student social worker (SSW). Paul informed the duty social worker that he was finding it hard to cope with Lucy. The duty social worker discussed the case with the manager of the Cheltenham Children and Families' Team, outlining the fact that Lucy was pregnant; there was domestic abuse and a risk of homelessness. A strategy discussion was convened. The SSW who was going to manage the case with his practice supervisor, agreed to do a joint visit as soon as possible.

14.138 Lucy was observed to be hostile towards her mother. Heather reported she was unhappy with the support she was receiving to manage Lucy's behaviours. The Mental Health Recovery Team liaised with the internal health safeguarding team, who advised to ensure a risk assessment was completed for Heather and to liaise with services involved with Lucy. They were aware of the assaults on Lucy at this point. Lucy left Heather's home to stay with Paul. Heather continued to express concerns about her daughter's behaviours – that she was 'jumping hotels' with Daniel (running out without paying). She had returned one evening to Heather's in a taxi having run out of a room in a local hotel with just a shirt, pants and with bare feet.

14.139 The SSW supporting Lucy was in his final year of training. The rationale was the SSW was additional capacity to focus upon specific tasks. The primary focus of his work was to get Lucy back with her family as it was a family breakdown to avoid homelessness. The discussion did note that Lucy was pregnant and that there was domestic abuse.

14.140 **The SSW said that he had little knowledge or experience in working with young people experiencing domestic abuse. Given he was unqualified and inexperienced, the review panel question whether it was appropriate in all the circumstances to allocate tasks on the case to a SSW even with senior social worker support. The SSW did a substantial element of the work with Lucy. Further, with the SSW being a young male, Daniel would not always permit Lucy to see him. Lucy's mother advised that given his age and inexperience Lucy did not take the SSW seriously and the family felt the SSW was out of his depth. While supervision did take place the reality was that the SSW was having all the face to face contact with Lucy and trying to progress matters on this complex case. Because all the risks to Lucy were not recognised nor the gravity of the situation understood by the SSW nor his supervisor, this inhibited the safeguarding response.**

14.141 When the SSW met Lucy and discussed matters with her, the SSW said it felt like Daniel was also with them because Daniel was persistently calling and texting Lucy. He could see how controlling Daniel was but did not link this as a risk factor as he had no knowledge of the dangers of coercive control. The SSW was directed to find somewhere for Lucy to live. Lucy was also offered a foster placement but she declined. The SSW looked for immediate accommodation through Youth Support Services and also a Mother and Baby placement through Home Group. The latter were happy to consider Lucy but there were no current vacancies and one would not be available until June. Also on application they wanted to assess further the domestic abuse issues as there were strict rules in relation to whom could access the facility.

14.142 Paul had explained that he could not have Lucy living with him as he didn't want Daniel in his house. Lucy was not taking advice from her family to separate from Daniel. During a meeting between the SSW, Lucy and Paul, Daniel was again constantly calling and texting Lucy. The SSW counted 6 calls over a very short period of time and observed Daniel to be very controlling during the calls based on the way that Lucy was responding. This was not challenged with Lucy or the nature of the relationship discussed with her and instead the focus stayed on her accommodation needs which was what he had been tasked to resolve.

14.143 The SSW saw Lucy regularly and mainly in his car. He would go and meet Lucy. He recalled when she got to the point that she was unable to stay with family he picked her up outside Tesco in the rain where she had some of her possessions packed up in carrier bags. The SSW also observed that Lucy would never have any money and yet he knew that her family were always generous with her and she also had her own account where her family would deposit money for her. He observed she would not have bus money to get to school or buy food. Where this money was going was not explored with Lucy but her family believed that Daniel was taking it and also some of her jewellery such as an expensive watch which they claimed he had sold to fund his gambling.

14.144 In mid-February on her 16th birthday Lucy told the SSW and her family that she would be staying at Daniel's house and living there. The SSW told Lucy that he was concerned about this decision as were her family. However Lucy was adamant and the SSW did not feel he had any powers he could use to prevent this. Heather was stressed at this development but was unable contact the senior social worker despite repeated attempts. The social worker was away on leave. The SSW though was able to discuss the case with other qualified SW's and did so.

14.145 The SSW suggested a safety plan with emergency numbers she could call.

14.146 **The safety plan was flawed as this was reliant on Lucy having access to a mobile phone. Heather had already reported to the police on 3rd February 2014 that Daniel had control over Lucy's phone; several of Lucy's phones had been damaged by Daniel. Both her family and SSW were having problems reaching Lucy at times.**

14.147 SW3 said that she and the SSW did discuss domestic abuse during their supervision but the SSW said that 'Daniel seemed okay'. This was despite the history of violence being known. SW3, the senior social worker and supervisor for SSW met Lucy on one occasion. There was evidence that the violence was continuing as stated by Heather. Heather contacted Children's Social Care on 19th February 2014 saying that Lucy had been to her house to pick some things up and she had a black eye. Heather was advised to call the police rather than this being used to trigger a multi-agency response. Heather was unwell at the time.

14.148 Other professionals and agencies thought that Children's Social Care should be doing more, particularly the school. SW3 saw the tensions and that school didn't believe that the fostering option had been fully explored. SW3 saw this as a dilemma of working with determined young people who might refuse to co-operate with plans that social care feel may best meet their needs.

14.149 The school did not use an escalation procedure to challenge Children's Social Care and this review has highlighted this as a major learning point. The awareness of how to initiate and escalate concerns where there are agency and professional differences of opinion around the risk to a young person was not readily known at the time. In this case there was deference to Children's Social Care as the lead agency when in fact the issues and challenges facing Lucy were everyone's business to act. The Children's Social Care manager's decision not to take Lucy to a child protection conference was not formally challenged as they were reassured that Lucy's needs could be provided for by the unborn baby's plan.

14.150 The Designated Safeguarding Lead and Pastoral Support Teacher felt that at the time, the SSW allocated to the case was placed in a situation where he was out of his depth. School felt that there was little rapport between Lucy and the student social worker and challenged the use of the term 'Unborn (surname)' throughout meetings which clearly upset Lucy. Neither member of school staff interviewed expressed any concern at the time about the SSW being male and working on a domestic abuse case with a young woman with a jealous and violent partner. This is because the level of abuse known about by the school at the time was considered to be very low.

14.151 Hannah, Heather and Paul advised the review that Lucy had no rapport with the SSW and did not take him seriously. Heather and Paul now consider that Lucy's situation was far too complex for the SSW. Heather considers that Children's Social Care simply did not grasp the gravity of the situation and find ways to effectively work with, and protect Lucy. They understand that teenagers may be a difficult group to work with but that this was even more reason to allocate the most experienced and skilled professional to work directly with Lucy to build a rapport with her and help educate her as to how unhealthy and dangerous the relationship had become.

14.152 **Equally they feel that work should have been done with Daniel and his family to educate him about his negative behaviours and that consequences should have followed his violent acts and abuse. Paul feels let down by Children's Social Care and is of the view that the service was not doing what it was required to regardless of the fact that the legal definition of domestic abuse excluded children and that she was at significant risk.**

14.153 **They consider that Daniel was permitted to abuse Lucy with no challenge by agencies whether the victim presses charges or not. They saw mixed messages being given to Daniel in that he was being praised for attending the child protection meetings when the family were excluded and they had key information that could have helped professionals see the wider picture. The family see his attendance as further evidence that Daniel was controlling what Lucy could say.**

14.154 The decision at the strategy meeting was made to focus on the unborn baby for the child protection conference rather than both Lucy and her unborn child. In discussion with the Children's Social Care team they felt any plan would need to meet both Lucy's and the unborn baby's need.

14.155 The unborn baby was allocated to SW3 to complete a Core Assessment and the SSW to complete a Core Assessment on Lucy. The rationale for this is flawed in the context of the multiple risks to Lucy in real time. Daniel's parents were not visited nor contacted by any agency when Lucy decided she would go there. She moved around the time of her 16th birthday.

14.156 Lucy said she had nowhere to go and Daniel's parents told the review that they agreed that Lucy could stay at their home on a temporary basis. They describe Daniel as being young for his age. They said a psychological report was done for the trial which confirmed that. At the trial, the Judge said he was "immature for his years" and "it was immaturity that contributed to the fatal events……and his inability to control his anger".

14.157 Daniel's parents were not happy with the situation and did not really have room for Lucy but they were fond of her plus she was having their grandchild. Lucy and Daniel's mother got on well and would chat and Lucy said she felt she was in a family as they would sit and all have a meal in the evening. Daniel's father stated that he contacted Paul on more than one occasion as he knew him and said that Lucy's family could be taking more responsibility for her. Daniel's family confirm they were not contacted at any time during this period by Children's Social Care. The SSW did visit them the day before Lucy was attacked to talk to them about the child protection plan for the unborn child.

14.158 On 28th February 2014, a meeting was held between SSW and a social worker from the Post-16 Assessment Team and concerns were shared that Lucy and her unborn child were at risk of domestic violence from her boyfriend. Given the concerns regarding domestic violence it was felt that it was not appropriate for Lucy to remain living at her boyfriend's home. Foster care and supported housing options were explored with the help of an officer from the housing team. However, Lucy stated that she was comfortable at Daniel's house and felt part of the family. They discussed foster care as an option but Lucy wanted to stay with Daniel and his family. Lucy said that there had not been any violent episodes since October 2013 and she did not feel at risk of violence from Daniel. She was seeing less of Daniel due to the fact she was now attending school regularly.

14.159 **Youth Support advised the review that a referral to the District Team should have been made when Lucy attended the Ante-Natal Drop in Clinic for checks with social care, school and other agencies involvement. There is a well-established process for assessing and supporting young people who present with housing needs.**

14.160 **Further that a decision should have been made to refer Lucy to the District Team when she attended the Ante-Natal Drop-In Clinic. Had a referral been made at this point, checks would have been made with Children's Social Care and concerns around domestic violence would have been identified.**

KEY EVENT 12 - ONGOING RISK TO LUCY AND SARAH

14.161 The family reported that Lucy had no money. Paul advised Children's Social Care that Lucy was getting money from the family but that Daniel was taking it from her to fund his gambling.

14.162 On 17th March 2014, both Daniel and Lucy were actively encouraged to be part of the child protection meeting. There was no consideration of a split conference, to ensure that Lucy had the opportunity to input openly without Daniel being present. Children's Social Care advise that split conferences are frequently held separately and exclusions are made whenever necessary depending on the circumstances. They advise that Chairs manage risk and repeat the conference information/process when needed and the minutes reflect this separation accordingly.

14.163 There is also a confidential slot and strategies are put in place by Chairs if they receive the information in advance and each is decided on a case by case basis.

14.164 The Gloucestershire Safeguarding Board Core Standards set out that the Chair has discretion to arrange for a split conference to allow attendance of all whose engagement is needed, eg in domestic abuse cases – Standard 1 e) and f). There is no detail on this because the decision needs to be driven by the child's specific circumstances and information known at the time to inform that decision. **However on closer analysis the national and local guidance around split conferences for situations such as Lucy as a child and direct victim of domestic abuse is sparse and there is an opportunity to improve this greatly.**

14.165 During the meeting the group became aware of another incident, where Daniel had head-butted a car windscreen causing it to crack. There were concerns raised by other professionals at this meeting that Lucy was not being seen as a Child in Need of a child protection plan as she was at risk from Daniel. There is no evidence that other professionals escalated their concerns that Lucy was not on a Child Protection Plan. Instead, Lucy was placed on a Child in Need plan. During the conference Daniel said he would be willing to attend anger management classes but the Chair advised that it was specialist domestic abuse services he would need to attend. He acknowledged the October assault and said he could get angry when drinking. He was however prepared to work on that with support. **This was not followed up**. The Chair of this case conference was impressed with Daniel and what she perceived as his openness. Heather was not at the case conference and therefore was not able to feed into that meeting the additional observations she had around their relationship, though she and her mental health workers had communicated that Lucy was actively being physically and emotionally abused by Daniel the previous month.

14.166 In terms of working with perpetrators at that time unless there was a contact point with the criminal justice system no specific behavioural programme was targeted toward those that perpetrate domestic abuse for someone of Daniel's age. There is a Turnaround programme but this is for older males. Daniel was still a teenager. His parents describe him as having a hard time at school as he was not academic at all but that they had not had any problems with him previously being violent.

14.167 It is recognised that working with perpetrators is vital to keep victims safe and to impact upon the lives of victims. Simply drawing the victim away from that relationship is not an over-arching prevention strategy. Further we know that victims of domestic violence will opt to stay as that can feel the safest way to manage the relationship and minimise the harm being done or not disclose at all.

14.168 Lucy's social worker and the social worker from the Post-16 Assessment Team carried out a joint visit to see Lucy on 18th March. They went through the 'Know Your Rights' booklet with regard to homelessness to ensure Lucy understood her rights in relation to her accommodation options. They discussed what options were available from Housing and offered accommodation under s.20 of the Children Act 1989 in accordance with the Southwark Ruling.

14.169 The Home Group application for the Mother and Baby Unit highlighted that Lucy required additional support with regard to the following issues:

- Aggression/Violence- Hit mother once during a row;
- Depression – period of 6 months;
- Domestic Violence – Lucy states that her boyfriend has slapped her twice. Statement from referring agency 'Her Boyfriend has hit her on a couple of occasions';
- Pregnancy – 19 weeks;
- Suicidal thoughts.

14.170 Due to the nature of the service, Home Group staff were aware that no vacancies would be available for a period of several months as none of the current clients were eligible/ready to move on nor were at risk of eviction. This influenced all decision making process in relation to the actions taken by staff. The next vacancy for the service did not become available until after her death. When interviewed both staff felt that the SSW did not understand what the unit could provide, making reference to the service not being a refuge nor emergency access housing.

14.171 The SSW informed staff Lucy and boyfriend both appeared compliant with Children's Social Care; that he didn't feel Lucy's boyfriend was high risk, but there had been some domestic violence. At this point the Unit had not had any direct contact with Lucy. It was agreed to proceed with an assessment.

14.172 Staff made two attempts to contact Lucy by telephone, but there was no answer so staff left a message asking Lucy to ring the service to arrange a date for the assessment interview. Staff called the SSW and left a message explaining that they were unable to contact Lucy. The SSW returned the call on the 24th March 2014 and informed staff that Lucy had a new number. The change in number is not explored by staff and no explanation is offered by the SSW. In hindsight this is a pivotal point as Daniel was smashing phones/not allowing access to phones and indicates coercive control and a level of risk that staff should have been aware of. However with the level of information known to the Unit staff at the time this would not have been evident.

14.173 Lucy attended at the Mother and Baby Unit with the SSW on 27th March 2014. The issues raised were:

- Domestic Abuse;
- Mental Wellbeing;
- Pregnancy;
- Violent aggressive behaviour; and
- Safeguarding

14.174 The Support Worker has been involved in the development of Home Groups revised Domestic Abuse training for staff and has lead a group of interns from the University of Gloucester to develop resources for an OCN accredited Healthy Relationships course along with facilitating the course. Lucy explained that her other housing options had been put to her; foster care; Nightstop etc but she wanted something with more long term support. It is not clear if all housing options had been fully explored from the assessment paperwork or if the reality of timescales for availability at the service were discussed.

14.175 Notes from the assessment show evidence of areas around Domestic Abuse that staff wanted to explore. These include discussing police involvement, Domestic Abuse services involvement (GDASS) more details of assaults and a note to cross reference to pregnancy/safeguarding sections. During the assessment notes are made that Lucy thinks some reports of domestic abuse are untrue; one incident she said was due to a fight with a girl; the other incident alcohol was involved; she agreed there would be verbal abuse by both and that Daniel had hit once and Lucy makes reference to her boyfriend not being charged. When interviewed both staff stated that they felt Lucy minimised the level of domestic abuse and highlighted this as a safety concern.

14.176 In the pregnancy section the Child Protection Plan was discussed. Staff asked Lucy how she would feel if the boyfriend was not able to visit the service due to domestic violence or Child Protection Plan. Lucy was unsure about this and staff highlighted this as a safety concern. Staff cross referenced this with the safeguarding section and discussing Home Group's out of contact policy during the assessment. Due to the level of potential risk around domestic abuse and Lucy's minimising of the abuse staff consulted with each other at the end of the assessment and agreed they needed more time to complete the safety planning and to consult with a manager. The assessment and decisions relating to the process appear to have been reached in an informed and professional way.

14.177 By the time accommodation in the Unit would have become available for Lucy, she would have been in the very late stages of pregnancy or have given birth. With so much pressure on finding Lucy a housing solution it is important that awareness is raised about the reality of housing options for young homeless people and that organisations should review how waiting lists are managed. The assessment was the only direct contact Home Group had with Lucy and this was in the presence of the SSW.

14.178 Lucy was attending her ante natal appointments and the Teenage Pregnancy Midwife supported Lucy to attend the child protection case conference on 17 March 2014 which was now being held for child protection of the unborn child. She told the midwife she was feeling overwhelmed.

14.179 Heather wanted to keep a link to Lucy and Lucy would pop into to see her intermittently through March 2014 and gradually their relationship improved and Heather started to get her health stabilised again. On one occasion she saw Lucy undressed and observed large bruises on her torso and thigh. Heather states she was reporting concerns to SSW but could never get through to SW3 who was the more senior practitioner. Lucy told Heather that she also believed that following her previous experience with the police that they would not be able to stop Daniel and she was actually enjoying being with his family. Objectively Lucy was observed as seeming to be more settled, her attendance at school improved and she put some weight on and on the surface seemed well. Lucy was telling Heather snippets of information and Heather was keen to rebuild the relationship and was looking forward to supporting Lucy with the baby.

KEY EVENT 13 (21/3/14) - SEPARATION FROM DANIEL

14.180 After a reported episode (at the trial) where Lucy was locked in Daniel's house, Lucy moved back with Heather in an attempt to separate from Daniel. She meets the SSW and says she wants to make changes to reduce the risk to the baby. Lucy is not entirely clear whether the relationship is coming to an end but she certainly physically separates from Daniel and is concerned that if she stays with him she will not be able to keep her baby for child protection reasons.

14.181 On 24th March 2014, Lucy told SSW that she had moved back to live with her mum. He asked if Lucy and Daniel had separated. She said they hadn't but he'd gone to some friends to 'clear his head' and she wanted to prioritise school and her baby.

14.182 On 25th March 2014, there is a supervision note in the case notes, which shows that this case was discussed in supervision between the senior social worker and the manager and there is a decision to close Lucy's case. The rationale was that she was now living with her mother and Lucy's needs could be met through the unborn baby's Child Protection Plan. The manager states now that the decision to close was changed later, although this is not recorded.

14.183 On 27th March 2014, Lucy's school contacted SSW to say that Daniel's sister had contacted the school to see if Daniel could meet with Lucy there. The school had said no, this couldn't happen on their premises.

14.184 On 1st April 2014, the SSW carried out a home visit to Daniel's parents to discuss the child protection plan for the unborn child. When they talked about the domestic abuse Daniel said "she is the only one" that made him feel like that.

14.185 Heather said that Lucy was feeling stronger in the pregnancy having had lots of morning sickness and she was making good progress in school. She talked to Heather the morning of her death about making appointments to have her hair done and other beauty treatments. She had started wearing make-up and looked smart for school. Heather said she would sort out some appointments for her. She went off to school happy and Heather does not think that it was a planned meeting with Daniel.

14.186 Later that day Heather discovered that Lucy had not made it into school and was in the hospital seriously ill having being intercepted by Daniel and harmed. Lucy and the baby died a few days later.

14.187 It transpired at the trial after analysis of Lucy's phone, and information from friends, that Lucy had received numerous death threats from Daniel during the relationship and when they had separated. Lucy had many other older injuries discovered on examination after her death.

15. Conclusions

15.1 In conclusion the Review Panel identified some **good practice points** as well as learning. The good practice points are set out below. These are set out as they relate to each agency:-

Youth Support Team

15.2 There are clear notes recorded on the management information system, IYSS, detailing the contact made at the Ante-Natal Drop-In Clinic. Lucy was provided with information about the Youth Support Team so when she did need something she knew where to go to get help.

CYPS

15.3 CYPS assessed Lucy according to Trust policy. The recording on RiO (the CYPS back-office management system) evidenced effective multi-agency working and communication with other agencies. Lucy's views were recorded and taken into account when planning intervention. Lucy was seen alone and with her mother obtaining both points of view.

15.4 The Recovery Team and CYPS worked well together. The teams shared appropriate information with each other e.g. the impact of her mother's mental health on her ability to parent. The meeting arranged between her mother, Lucy and both workers was evidence of this. The Recovery Team worker supported her mother to liaise with other agencies including Children's Social Care.

Gloucestershire Hospitals NHS Trust

15.5 The doctor acted positively and in a timely fashion to contact Children's Social Care when Lucy had been assaulted on January 2014 even though she was not identifying Daniel as the person who had assaulted her.

15.6 The booking visit for a pregnancy provides the midwife with an ideal opportunity to discuss and provide information on all aspects of pregnancy, health promotion and lifestyle affecting the women and her unborn baby (NICE, 2008). The midwife will risk assess the woman's pregnancy and health, based on her medical, previous obstetric, anaesthetic, social/life style and psychological history (Trust Antenatal care Policy and Action card). Lucy was questioned around domestic abuse.

School Nursing

15.7 In the care received by Lucy, the school nurse offered good advice when she first met Lucy and followed up on her care, making appropriate referrals to the teenage pregnancy midwife when Lucy found out she was pregnant.

Education

15.8 The school's practice of ensuring a robust relationship between Pastoral Support and the Designated Safeguarding Lead (DSL) ensured in this case that there were regular updates between the two and this in turn ensured discussion and timely sharing information with other agencies. This is effective practice within the school.

15.9 School appear to have continuously acted in Lucy's best interests. Throughout Lucy's attendance staff sought to work collaboratively with other agencies such as Children's Social Care, health services and Teens in Crisis. As well as not knowing about the first domestic abuse incident, the school were also not made aware that Lucy had been allocated a social worker. Once they were notified of this, the school made sure that they contacted the social worker and helped to lead multi-agency working.

15.10 The Teenage Relationship Abuse Curriculum Resource was launched to secondary schools just before Lucy's death. Lucy's school attended a DSL forum where this was discussed and were keen to timetable the resource into their PSHE curriculum.

15.11 Following Lucy's death, several other young people raised concerns about their own relationships which highlighted the requirement for a resource such as this. All schools should understand the importance of providing young people with tools to recognise when they might be in a difficult situation and what options are available. The launch and continued investment into this with the PiNK (People in the Know) Curriculum produced by Gloucestershire Healthy Living and Learning is good practice.

GP Practice

15.12 Lucy and her mother were allowed good access to the surgery both face-to-face and advice over the phone. The GP made positive contact with the school nurse and shared concerns around Lucy and her mother.

Police

15.13 Officers did invest time and effort into trying to reassure Lucy and her family and where necessary, positive action was taken in the form of an arrest.

15.14 Police officers acted with urgency when Lucy was reported missing and locating her quickly reuniting her with the family.

Home Group

15.15 It is felt that staff from Home group were sensitive to the needs of Lucy during their limited contact with her. Home group had no contact with the perpetrator and were not aware of him in any other context.

15.16 However the review also identified **rich learning which highlighted where improvements can be made**. Lucy's story reflects a number of challenges faced by professionals working with this age group. The research base recognises these challenges.

"The growing sense is that the current system of protection and risk reduction is not effective enough for many young people is accompanied by an increase in our knowledge and understanding about adolescent development and the specific risks they face. Research offers insights on physiological development, with adolescence now recognised as the fastest changing period of development aside from infancy (Coleman, 2011).

Research also provides clear evidence of the powerful and central role that relationships play in adolescent well-being (WHO, 2014). This evidence converges with key policy drivers, such as foregrounding the young person's perspective and experience of service intervention (for example, Munro 2011), and working preventatively with young people in order to support well-being.

If this understanding about adolescent development and the distinctive risks that young people face is not applied consistently across policy and practice, a range of consequences is likely:

- *missed opportunities to work as a team with the adolescent and often their family in combatting risk*
- *harmful assumptions made about adolescent choice (on the one hand choices are minimised, and on the other they are perceived as adult 'lifestyle choices'")*

15.17 There are numerous opportunities for additional support to have been offered and it is clear throughout that the main agency involved, the student social worker was out of his depth in working with Lucy.

15.18 Social care and police had identified that the relationship was abusive, and were aware of injuries previously sustained, albeit not to the full extent which have been revealed since Lucy's death.

15.19 Tools and advice were available to agencies working with Lucy, if they had been sought, to support agencies to identify risk, and the national definition of domestic abuse reflected that 16 year olds were at risk of serious harm through domestic abuse.

15.20 **All the above were features in this review and manifested themselves through our six learning points:-**

1: Ensure that young people have access to preventative work on healthy relationships

2: The need for early intervention adopting an inclusive family-based approach

3: Young people should get the right support at the right time.

4: Professionals need to recognise and respond to the indicators of relationship harm among young people including coercive control.

5: Professionals need to be able to navigate the challenges between young people's autonomy and the duty of professionals to keep them safe.

6: How do professionals and the wider community recognise and respond to abusive and controlling behaviours and engage with the abuser

16. Learning Points

16.1 The detail of the lessons learnt are set out below.

16.2 <u>Learning point 1</u>: Ensure that young people have access to preventative work on healthy relationships

16.3 This case demonstrated the value of school-based professionals including teachers, school nurses and Pastoral Support Workers in providing wider support and advocacy. Lucy attended both independent and state school.

16.4 Gloucestershire has developed the PiNK Curriculum which has been well received locally by schools. This should be given high priority by all state schools and academies as well as independent schools. Independent schools have pastoral leads but have more freedom on curriculum and may be less multi-agency focused. Independent schools, being reliant on private funding are highly sensitive to reputational risk.

16.5 All schools should continue to develop their practice on supporting young people who may be vulnerable to domestic abuse though the PiNK Curriculum and other work on healthy relationships.

"*The preventative model produces better outcomes for children, is financially sustainable and builds staff morale and capacity*."[7]

16.6 The Review Panel was disappointed to note that PHSE remains a non-statutory subject in education. PHSE plays an important part of preparing young people around relationships and life skills. It also works best with an approach bringing schools, children families and communities together.

16.7 PHSE in schools has a priority focus on educating children and young people about healthy relationships and what constitutes abuse including coercive control. This report therefore makes a national as well as local recommendation around the part that PHSE has to play in supporting healthy relationships.

16.8 The 2011/2012 British Crime Survey found that young people are more likely to suffer partner abuse than any other age group, with 12.7% of women and 6.2% of men aged 16-19 having experienced some kind of domestic abuse in the previous year.

16.9 A recent report by the charity Against Violence and Abuse indicates that "research has shown that some teenagers have worryingly high levels of acceptance of abuse within relationships and often justify the abuse with the actions of the victim, e.g. because they were unfaithful.

[7] "Breaking the Lock" a new preventative model to improve the lives of vulnerable children and make families stronger – Amanda Kelly 2014 Impower.

16.10 A study by the NSPCC and the University of Bristol found that 33% of girls and 16% of boys reported some form of sexual abuse and that 25% of girls (the same proportion as adult women) and 18% of boys reported some form of physical relationship abuse. In addition, around 75% of girls and 50% of boys reported some form of emotional relationship abuse.

16.11 Locally, the Gloucestershire Online Pupil Survey 2014 found that 2.5% of respondents suffered from domestic abuse from a boyfriend / girlfriend.

16.12 The Home Office recognise relationship abuse amongst teenagers has become more prevalent and that there is also a wider national context of the challenges faced in protecting children around Child Sexual Exploitation. The Home Office have launched a targeted campaign from December 2013 to April 2014 (www.thisisabuse.co.uk).

16.13 In this review, Lucy's friend suggested it would have been very helpful if she could have shared her concerns and what she knew about Lucy at school. She emphasised this would need to be done anonymously so as not to damage the relationship with her friend. She would like schools to have some way to do this eg worry box for student concerns around peers. This could then be picked up by the pastoral team for consideration and early action where necessary and appropriate.

Recommendations - Learning Point 1

- **1A - For the Gloucestershire Multi Agency Quality Assurance Sub-Group (MAQuA), on behalf of the GSCB to carry out a review to test the effectiveness of existing arrangements for young people having access to preventative work on healthy relationships.**
- **1B - For the Gloucestershire Children's Partnership to ensure that the DHR recommendations are fully reflected in the new Children and Young People's Plan that is being developed and for the SLG to support the GCP in this piece of work.**
- **1C – For Gloucestershire County Council to work with localities to review the Early Help 'offer' to ensure it includes sufficient advice, guidance and information for professionals, carers and community groups in respect of relationship issues/abuse**
- **1D - In circumstances of relationship harm (criminal abuse or assault) among young people the Police should take a robust enforcement approach. That would normally mean seeking the arrest of the perpetrator**
- **1E - For Gloucestershire Healthy Living and Learning (GHLL) to continue to update their work on PSHE including the on-line PinK Curriculum and to support school staff with training.**
- **1F - GHLL/Schools safeguarding network to reflect on how young people can be encouraged to alert staff to concerns they have about their peers**
- **1G – Cheltenham Partnerships to work with GDASS and other partners to facilitate a conference for practitioners to reiterate the importance of preventative work on healthy relationships for young people**

<u>Learning Point 2</u>: The need for early intervention adopting an inclusive family-based approach

16.14 There were numerous opportunities to use whole family approach with Lucy:-

1. Mediation (this was declined in 2011 and not challenged)
2. Parenting Programme (this was declined in 2011 and not challenged or other collaborative options posed)
3. Common Assessment Framework (CAF) – was not followed through
4. CYPS- could have used family systems therapy underpinned by Lucy also receiving CBT
5. Informal meeting with the whole family facilitated by the Diversion Team – the social worker here saw family members separately rather than bring them all in a room together to problem solve the challenges posed by Lucy and her relationship and behaviours.
6. Family Group Conference – Lucy declined and this was not challenged or an alternative way found to bring the family all together to share all knowledge and a workable plan. There was a perception by some professionals that Lucy was resistant to a family group conference. This is stated as the rationale for the process not taking place because at that time in Gloucestershire it was considered preferable if the young person was consenting to the conference. Essentially the family group conference is stated to be a restorative process and if all parties do not consent the process is considered as futile. Gloucestershire's Family Group Conference Policy, which is currently in draft states that the young person has to be in agreement for the conference to take place, if they are considered to have the maturity to make the decision for themselves, independent of those with parental responsibility.

Recommendations - Learning Point 2

- **2A – Further embed restorative practice across the wider partnership in order to work more inclusively with families - even when families don't engage**
- **2B – Cheltenham Partnerships to support the development of a local partnership model that provides oversight over the early help graduated pathway.**

<u>Learning point 3</u>: Young people should get the right support at the right time.

16.15 This review demonstrates why early intervention by all agencies at all levels is vital to a young person's wellbeing and mental health when they lose self-esteem and resilience or have underlying psychological problems.

"Approaches are likely to be most effective if services provide support when adolescents need and want it; and when they are responsive....."

Resilience is the process by which an individual avoids or overcomes the negative effects of risk exposure (Fergus and Zimmerman, 2005).

16.16 It became apparent as Lucy entered her teenage years that she was becoming less emotionally stable and resilient. It cannot be known if there was a familial element to that or psychological factors around her attachments. Lucy had several indicators that she was in need of formal professional support from mental health services from 2011 onwards and probably before that point. She articulated to her GP and her friend her stress triggers such as maternal mental health, family instability, self-harming, insomnia, low self-esteem, anxiety and was open and motivated to receive help. This was assessed and a programme of CBT was considered to be a positive step forward. However this did not come to fruition due to availability and considerable waiting times. The big picture of what was going on in Lucy's life was not understood by professionals.

16.17 There were other several points where Lucy was prepared to engage in mental health care and had needs but was referred to Teens in Crisis. Before and during her relationship with Daniel she would have benefited from more intense mental health support. While it was proactive to seek to fill the gap of cognitive behavioural therapy with some counselling at school more intense work was required as previously identified. That is not to detract from the excellent work school counsellors do of course but Lucy presented with complex problems. Heather's mental health professionals raised concerns but it was obviously not in their remit to have any therapeutic relationship with Lucy.

"*When young people get stuck in patterns of challenging behaviour it is important to take early effective action to improve their mental health and reduce the chances of them accumulating other risks because of their behaviour*.[8]"

Recommendation to Learning Point 3

- **3A - Carry out a review of the local Futures in Mind plan* in the light of this DHR and consider how well young people access emotional health and wellbeing support and services in a timely manner.**

<u>Learning Point 4</u> – Professionals need to recognise and respond to the indicators of relationship harm among young people including coercive control.

16.18 In 2014 Research in Practice published "That Difficult Age: Developing a more effective response to risks in adolescence" on behalf of The Association of Directors of Children's Services and the Families, Children and Young People Committee. The paper concludes:-

[8] Missed Opportunities – A review of recent evidence into children and young people's mental health. Lorraine Khan, 2016

"*A paradigm shift is now needed in how we understand and respond to risk in adolescence" because "A child protection system that is conceptualised primarily around preventing harm and maltreatment among younger children, who may be most at risk within their own family, is not well placed to serve the needs of adolescents". Two of the greatest challenges in working with teenagers are that a teenager may be exposing themselves to risk through their behaviours, relationships and decisions they make and as professionals we cannot impose on teenagers as we can with younger children. Compliance with young children is not an issue but with teenagers one has to secure engagement and compliance. This calls for a sophisticated and collaborative way of working*"

16.19 The risk tool used was the DASH form for the first known assault on Lucy. The DASH form is an inadequate risk tool to be used for young people and it was not designed for children other than as witnesses to adult domestic abuse. The Domestic Abuse, Stalking, Harassment and Honour Based Violence (DASH) form makes it highly likely that critical information will be missed if used for people under 18.

16.20 In this case, Lucy presented with multiple risks, but in the later stages of her life, professionals saw her homelessness as the key risk to her and Sarah's wellbeing. This was not the case, and therefore systems need to be implemented to support professionals working in multi-agency settings to identify, assess and manage multiple risks in adolescents

16.21 Safe Lives (previously known as CAADA) developed a young person's DASH form in 2013. Each local authority was asked to nominate an individual/practitioner to attend some free training provided by CAADA to become an accredited young person's violence advisor. Gloucestershire nominated a practitioner from Prospects who works part time. Another practitioner has also undertaken this training and is part of the GDASS team. Both of these individuals are trained to use the Young Person's DASH and to utilise the tool.

16.22 The most striking element of the DHR was the lack of orientation to the possible components of domestic abuse. This pervaded across all professionals and agencies and in particular around coercive control. **The behaviours of coercive control were blatant and those behaviours recorded, but did not elicit a professional response from anyone.** The confusion around below 16's experiencing abusive acts against them pertaining to domestic abuse causes great confusion.

16.23 There is now an offence of Controlling or Coercive Behaviour: **s76 Serious Crime Act 2015. ...** It creates the specific offence of "*controlling or coercive behaviour in an intimate or family relationship*" where the victim and the abuser are, as the Act puts it, "*personally connected*". This was not an offence at time of Lucy's relationship with Daniel. Coercive control however was a feature of their relationship and one in which society as a whole needs educating. This review can usefully highlight the elements of coercive control that can occur.

16.24 It should be noted that the challenges faced by professionals in response to working effectively with child victims of domestic abuse is also a national issue.

16.25 Risk assessment was inhibited by a lack of information sharing. This is an issue across all agencies but it is not just about information it is also about understanding each other's language, systems and processes. It is a common theme of other reviews nationally that information has not been shared between agencies.

Recommendations to Learning Point 4

- **4A - GSCB to ensure that risks in adolescents are appropriately identified and managed by considering training for professionals in respect of management of risk in adolescence and monitoring the effectiveness of work being undertaken by CSC/YST to review the safeguarding system for adolescents**
- **4B - Undertake dedicated public campaigns aimed toward all ages supported by all agencies around the elements of coercive control and that it is an offence in its own right.**
- **4C – The GCSB to ensure that the Young Person's DASH has been adopted across relevant agencies.**
- **4D - Specific policy guidance should be developed around the use of split conferences. This should include clear direction for CP Conference Chairs in relation to conferences for child victims where the perpetrator may be present. This needs to take into account that while a child may agree for a perpetrator to attend this may be coercion and/or control to stop the victim being honest and open during the conference**
- **4E - Raise awareness that social care cases are not allocated to student social workers and all professionals need to engage with the allocated social worker. The allocated social worker must ensure that they have proper oversight over the case i.e. engaging with the family.**

<u>Learning point 5</u>- Professionals need to be able to navigate the challenges between young people's autonomy and the duty of professionals to keep them safe.

16.26 This issue is explored in "This Difficult Age". Some professionals appear to view many of the harms that young people experience as having been freely 'chosen' in a way that is comparable to an adult choosing to engage in an activity – hence the use of terms such as 'lifestyle choice' applied to risks such as sexual exploitation. Others appear to take the opposite view, perceiving those same adolescents as straightforward victims of their circumstances, similar perhaps to younger children; from this perspective, the role of the adolescent's emerging agency in risks and resilience is minimised.

16.27 Engagement can also be difficult when a young person's ability to trust others, in particular adults, has been significantly compromised by, for example, maltreatment within the family, and/or fleeting relationships with multiple professionals, the latter often driven by organisational constraints and practices (The Care Inquiry, 2013). Because of these past experiences, adolescents may struggle to believe that others will keep their commitments, have the right intentions, and/or, most fundamentally, be able to help them in any meaningful way (see Coffey, 2014,)

16.28 When a young person feels this way, they may adopt a (protective) disengaged and resistant stance, which further hinders the formation of such relationships – even though they often want to be proved wrong and to have a reason to shift their beliefs. What is often effective in this situation is to develop, through persistence and outreach, a relationship with that young person in which the adult consistently delivers on their commitments. Advocacy and practical help may be useful, both in and of themselves and via the impact they have on developing a young person's belief in their own worth and the efficacy of others.

16.29 The Review Panel identified just one professional who Lucy trusted and with whom she had rapport. That was her pastoral support worker. No consideration was given to supporting this professional to work with Lucy around the risks she faced. The school was only informed of the October 2013 assault in late January and there was no consideration of who Lucy trusted the most and could perhaps work with. The issue of differing professional opinions around Lucy was explored earlier in this report.

16.30 When a teenager is involved in an intimate abusive relationship, professionals do not always seek to test out whether the young person does truly have rights of self-determination. Such rights of self-determination can be impaired by elements of the abusive relationship, such as coercive control. This increases the likelihood that the teenager will be left at risk. Duress and control can impair free will to communicate with others; free association and even extend to what is permitted in terms of clothing and appearance.

16.31 The concept of "they should just leave" is not a valid judgement. Some victims conclude, particularly if there is nowhere to go, there is a lack of family/professional support that it is safer to stay put. It is a choice of sorts but one where the rationale is based on fear, dependency or duress. We know that coercive control strips the victim of all confidence and there were many, many features of control evident in the relationship between Lucy and Daniel. This was verified throughout.

16.32 In this review the person with whom Lucy had the strongest rapport was her pastoral support at school whom her family said she adored and highly respected. CSC were rather late in informing school of the October assault due to delays in assessment but nevertheless there was ample opportunity to use the rapport and skills of the pastoral lead to work more closely with Lucy around some of her perspectives of the relationship with Daniel. This was never initiated. Lucy's main contact was a student social worker with whom she told family and friends she did not like or respect.

Recommendations to Learning Point 5

- **5A - Children's Social Care and the Youth Support Service will implement the BASE practice model* (developed through DfE Innovations Programme) and evaluate its effectiveness in managing adolescent risk.**
- **5B - Agencies working with young people are able to identify who the child has the strongest rapport/relationship with and that person work with the young person to coordinate support, alongside the multi-agency team**

<u>Learning point 6</u> - How do professionals and the wider community recognise and respond to abusive and controlling behaviours and engage with the abuser

16.33 There is no national or local guidance on involving any young person who is a perpetrator of domestic abuse in maternal and child services. In Gloucestershire there are no policies or procedures in place for staff working across the statutory agencies to guide them in their practice. There are particular vulnerabilities when the perpetrator is below 18 given they are still children and this will bring further complexities (Sharpen, J 2012).

16.34 Because of this Review Panel tell us there is inconsistency in practice. Perpetrators may be praised for attending ante-natal and subsequent services without questioning whether the motivation for engagement or attendance maybe controlling in its nature.

16.35 If a perpetrator comes into the criminal justice system they may or may not have to attend a perpetrator programme. If a perpetrator is not prosecuted there is no specific service provision to work with that perpetrator, even though it may be apparent that they are a perpetrator of domestic abuse.

16.36 In Gloucestershire there has been a voluntary perpetrator programme in place since 2013 but this is for perpetrators over the age of 21. In Gloucestershire decisions about whether to involve fathers who are perpetrators of domestic abuse are made on a case-by-case basis. There is no clear national guidance as to the most effective way to involve perpetrators in the child protection process. Consideration of how to involve the perpetrator in the process must be balanced with consideration of the risk to the victim and the unborn child.

16.37 The Review Panel advise of inconsistencies of how we work with young males who are perpetrators of domestic abuse; unless they are under the criminal justice system, when there will then be clearer pathways.

16.38 Not all perpetrators of domestic abuse are prosecuted and there is inconsistency nationally around pursuing prosecution in the absence of the victim agreeing to press charges. The Review Panel found that one of the inhibitors of prosecuting is the possible implications and repercussions on the victim, from the perpetrator while others have a zero tolerance approach. In all cases it must be recognised that there are real evidential challenges when the victim is not prepared or able to give evidence and take complaints forward assertively.

16.39 The issues as described here are not unique to Gloucestershire. How to work effectively and safely with perpetrators is a national dilemma. The Review Panel have informed the review that there is inconsistency of practice when it comes to involving parents or carers who are perpetrators of domestic abuse in child and family services because of a lack of guidance.

Recommendations to Learning Point 6

- **6A – Work with Safer Gloucestershire to explore options for increasing perpetrators programmes for under 21's in the county.**
- **6B - Review current resources for professionals and ensure development of guidance documents to support professionals in identifying and responding to domestic abuse.**
- **6C - Continued development of www.glostakeastand.com to ensure section specifically for professionals so they can access relevant information on domestic abuse.**
- **6D - To ensure that the analysis of need overseen by Safer Glos and the GDASV Commissioning Group includes research into the prevalence of domestic abuse affecting young people to shape future commissioning arrangements of support for young people and their families**
- **6E - To scope options to develop an advice guide for parents on abuse in teenage relationships.**
- **6F - Explore engagement opportunities with community groups and sports clubs to increase awareness of domestic abuse and encourage a zero tolerance stance.**

16.40 National recommendations

1 Further national guidance on risk management is given to professionals when the victim is under 16 and advice on expectations as to professional response in the context of statutory safeguarding systems.

2. The Home Office work with the national data agencies to capture national information on the incident and trend relating to domestic abuse in under 18's. It is recommended that this is be facilitated by National Oversight Group

3. The Home Office to review the national definition of domestic abuse to reflect on younger victims and provide clarity for professionals.

4 PSHE should be a statutory requirement in education and can play an important part in keeping young people safe. This should be an inspection standard for scrutiny by Ofsted.

5. There should be a national campaign by the Home Office in partnership with others, to educate the public, including young people around coercive control.

Summary of recommendations:

Learning point 1: Ensure that young people have access to preventative work on healthy relationships	1A - For the Gloucestershire Multi Agency Quality Assurance Sub-Group (MAQuA), on behalf of the GSCB to carry out a review to test the effectiveness of existing arrangements for young people having access to preventative work on healthy relationships.
	1B - For the Gloucestershire Children's Partnership to ensure that the DHR recommendations are fully reflected in the new Children and Young People's Plan that is being developed and for the SLG to support the GCP in this piece of work.
	1C – For Gloucestershire County Council to work with localities to review the Early Help 'offer' to ensure it includes sufficient advice, guidance and information for professionals, carers and community groups in respect of relationship issues/abuse
	1D - In circumstances of relationship harm (criminal abuse or assault) among young people the Police should take a robust enforcement approach. That would normally mean seeking the arrest of the perpetrator
	1E - For Gloucestershire Healthy Living and Learning (GHLL) to continue to update their work on PSHE including the on-line PinK Curriculum and to support school staff with training.
	1F - GHLL/Schools safeguarding network to reflect on how young people can be encouraged to alert staff to concerns they have about their peers
	1G – Cheltenham Partnerships to work with GDASS and other partners to facilitate a conference for practitioners to reiterate the importance of preventative work on healthy relationships for young people
Learning Point 2: The need for early intervention adopting an inclusive family-based approach	2A – Further embed restorative practice across the wider partnership in order to work more inclusively with families - even when families don't engage
	2B – Cheltenham Partnerships to support the development of a local partnership model that provides oversight over the early help graduated pathway.
Learning point 3: Young people should get the right support at the right time.	3A - Carry out a review of the local Futures in Mind plan* in the light of this DHR and consider how well young people access emotional health and wellbeing support and services in a timely manner.
Learning Point 4: Professionals need to recognise and respond to the indicators of relationship harm among young people including coercive control.	4A - GSCB to ensure that risks in adolescents are appropriately identified and managed by considering training for professionals in respect of management of risk in adolescence and monitoring the effectiveness of work being undertaken by CSC/YST to review the safeguarding system for adolescents

	4B - Undertake dedicated public campaigns aimed toward all ages supported by all agencies around the elements of coercive control and that it is an offence in its own right.
	4C – The GCSB to ensure that the Young Person's DASH has been adopted across relevant agencies.
	4D - Specific policy guidance should be developed around the use of split conferences. This should include clear direction for CP Conference Chairs in relation to conferences for child victims where the perpetrator may be present. This needs to take into account that while a child may agree for a perpetrator to attend this may be coercion and/or control to stop the victim being honest and open during the conference
	4E - Raise awareness that social care cases are not allocated to student social workers and all professionals need to engage with the allocated social worker. The allocated social worker must ensure that they have proper oversight over the case i.e. engaging with the family.
Learning point 5: Professionals need to be able to navigate the challenges between young people's autonomy and the duty of professionals to keep them safe.	5A - Children's Social Care and the Youth Support Service will implement the BASE practice model* (developed through DfE Innovations Programme) and evaluate its effectiveness in managing adolescent risk.
	5B - When working with young people, agencies are able to identify who the child has the strongest rapport with and use that professional to work with the young person and to support them though the system supported by the multi-agency team and legal advice if necessary
Learning point 6: How do professionals and the wider community recognise and respond to abusive and controlling behaviours and engage with the abuser	6A – Work with Safer Gloucestershire to explore options for increasing perpetrators programmes for under 21's in the county.
	6B - Review current resources for professionals and ensure development of guidance documents to support professionals in identifying and responding to domestic abuse.
	6C - Continued development of www.glostakeastand.com to ensure section specifically for professionals so they can access relevant information on domestic abuse.
	6D - To ensure that the analysis of need overseen by Safer Glos and the GDASV Commissioning Group includes research into the prevalence of domestic abuse affecting young people to shape future commissioning arrangements of support for young people and their families
	6E - To scope options to develop an advice guide for parents on abuse in teenage relationships.
	6F - Explore engagement opportunities with community groups and sports clubs to increase awareness of domestic abuse and encourage a zero tolerance stance.

17. Postscript

17.1 This DHR reflects one of the greatest challenges to our children safeguarding and domestic abuse systems in requiring a cultural shift in how all agencies work with young people who are teenagers who may become victims or perpetrators of domestic abuse as a result of unhealthy relationships. It has also highlighted the rights of autonomy professionals afford to an older child even when they are vulnerable. The need for a sophisticated, highly informed and skilled approach to these young people to optimise engagement and personal safety has never been greater**.**

APPENDIX ONE

Acronyms and Glossary

CAF- Core Assessment Framework

CAADA – Co-ordinated Action Against Domestic Abuse. A national domestic abuse charity that has now been renamed Safe Lives.

Child in need - Under Section 17 (10) of the Children Act 1989, a child is a Child in Need if:

- He/she is unlikely to achieve or maintain, or have the opportunity of achieving or maintaining, a reasonable standard of health or development without the provision for him/her of services by a local authority;
- His/her health or development is likely to be significantly impaired, or further impaired, without the provision for him/her of such services; or
- He/she is a Disabled Child.

Child protection – Section 47(1) of the Children Act 1989 states that: Where a local authority have reasonable cause to suspect that a child who lives, or is found, in the area and is suffering, or is likely to suffer, significant harm, the authority shall make such enquiries as they consider necessary to enable them to decide whether they should take any action to safeguard or promote the child's welfare.

Child protection procedures - the system in place to protect children, which include policies, procedures, training and resources.

Coercive control - "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 means needed for independence resistance and escape and regulating their everyday behaviour"

DASH - Domestic Abuse, Stalking and Honour Based Violence

Domestic abuse - 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
- Emotional

Family Group Conference - A family group conference is a process led by family members to plan and make decisions for a child who is at risk. It is a voluntary process and families cannot be forced to have a family group conference.

Fraser Guidelines - When deciding whether a child is mature enough to make decisions, people often talk about whether a child is 'Gillick competent' or whether they meet the 'Fraser guidelines'. Gillick competency and Fraser guidelines refer to a legal case which looked specifically at whether doctors should be able to give contraceptive advice or treatment to under 16-year olds without parental consent. But since then, they have been more widely used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions.

In 1982 Mrs Victoria Gillick took her local health authority (West Norfolk and Wisbech Area Health Authority) and the Department of Health and Social Security to court in an attempt to stop doctors from giving contraceptive advice or treatment to under 16-year-olds without parental consent.

The case went to the High Court where Mr Justice Woolf dismissed Mrs Gillick's claims. The Court of Appeal reversed this decision, but in 1985 it went to the House of Lords and the Law Lords (Lord Scarman, Lord Fraser and Lord Bridge) ruled in favour of the original judgment delivered by Mr Justice Woolf: "...whether or not a child is capable of giving the necessary consent will depend on the child's maturity and understanding and the nature of the consent required. The child must be capable of making a reasonable assessment of the advantages and disadvantages of the treatment proposed, so the consent, if given, can be properly and fairly described as true consent."

GDASS- Gloucestershire Domestic Abuse Support Service : County wide service to reduce the level of domestic abuse and improve safety of victims 16 and over and their families.

GSCB – Gloucestershire Safeguarding Children Board

LSCB – Local Safeguarding Children Board

MARAC – Multi-agency risk assessment conference. A MARAC is a regular local meeting to discuss how to help victims at high risk of murder or serious harm. A domestic abuse specialist (IDVA), police, children's social care, health and other relevant agencies all sit around the same table. They talk about the victim, the family and perpetrator, and share information. The meeting is confidential[9]

Nightstop - a charity that works directly with single young homeless people aged 16-25 across the county of Gloucestershire.

Safe Lives - A national domestic abuse charity

SCIE – Social Care Institute for Excellence

SCR – serious case review

[9] http://www.safelives.org.uk/practice-support/resources-marac-meetings

Section 11 audit - s.11 of the Children Act 2004 places duties on a range of organisations and individuals to ensure their functions and any services that they contract out to others are discharged having regard to the need to safeguard and promote the welfare of children.

Teenage relationship abuse - Teenage relationship abuse is domestic abuse that affects teenagers. It is being increasingly recognised however there is not as yet a formal legal definition as to what constitutes teenage relationship abuse, other than a teenager is aged between 13-19. For young people age 16 and over the formal definition of domestic abuse can be used. The law therefore formally recognises domestic abuse for those 16 and above but has no legal definition for under 16's who may be experiencing abuse in intimate relationships. This is a lacuna in the law.

Working Together to Safeguard Children, 2013. The statutory guidance for inter-agency working to safeguard and promote the welfare of children.

APPENDIX TWO
Terms of Reference

The general terms of the reference are:-

1. Decide whether in all the circumstances at the time, any agency or individual intervention could have potentially prevented Lucy's death.
2. Review current responsibilities, policies and practices in relation to victims of domestic abuse – to build up a picture of what should have happened and review national best practice in respect of protecting young adults from domestic abuse.
3. Examine the roles of the organisations involved in her case; the extent to which she had involvement with those agencies, and the appropriateness of single agency and partnership responses to her case to draw out the strengths and weaknesses.
4. Establish whether there are lessons to be learnt from this case about the way in which organisations and partnerships carried out their responsibilities to safeguard her wellbeing.
5. Identify clearly what those lessons are.
6. Identify whether, as a result, there is a need for changes in organisational and/or partnership policy, procedures or practice in Gloucestershire in order to improve our work to better safeguard victims of domestic abuse.

The specific terms of reference are set out below:-

1. Consider how best agencies should and individuals understand the dynamics of relationships between teenagers that feature domestic abuse, including the issue of supreme control of the abuser upon the victim.
2. Appraise if is there a gap in services around working with young people who are considered to be involved in perpetrating domestic violence.
3. Explore how professionals and services can optimise support to young people who have left abusive partners and ensure they are able to sustain that separation and independence.
4. Consider when a woman who is subject to domestic violence is pregnant, what additional safeguards should be in place to protect the young woman and unborn child.
5. Consider any incidence of, and impact of any possible collusion by others such as peers.
6. Consider how young people who may be aware that peers are being subjected to domestic abuse, can be supported to share information to safeguard the victim, including sharing information on social media.

APPENDIX THREE

ACTION PLANS

1. DHR Learning Points and Recommendations

SEE SEPARATE DOCUMENT

2. Action plan – National recommendations

Recommendation	Scope of recommendation	Action to take	Lead Agency	Key milestones	Target Date	Date of completion and Outcome
1 Further national guidance on risk management is given to professionals when the victim is under 16 and advice on expectations as to professional response in the context of statutory safeguarding systems.	National	Formal request to the Home Office	SLG with Chair of Gloucestershire Safeguarding Children's Board		When submitting DHR	
2. The Home Office work with the national data agencies to capture national information on the incident and trend relating to domestic abuse in under 18's. It is recommended that this is be facilitated by National Oversight Group	National	Formal written request to National Oversight Group	SLG with Chair of Gloucestershire Safeguarding Children's Board		When submitting DHR	
3. The Home Office to review the national definition of domestic abuse to reflect on younger victims and provide clarity for professionals.	National	Communicate this via DHR report	SLG			
4 PSHE should be a statutory requirement in education and can play an important part in keeping young people safe. This should be an inspection standard for scrutiny by Ofsted.	National	SLG and LSCB Chair to write to Department of Education sharing reports.	LSCB			
6. There should be a national campaign by the Home Office in partnership with others, to educate the public, including young people around coercive control.	National	SLG and LSCB Chair to write to Home Office	LSCB			

3. Serious Case Review response plan to align with DHR

Finding One: In Gloucestershire safeguarding teenagers at risk can lead to challenges between the young person's autonomy and the duty of professionals to keep them safe			
How Will We Know We Are Making a Difference?	**What are We Going to Do?**	**Who will Lead?**	**By When**
The BASE model, which is being designed for working with young people, will have been directly informed by the findings from this SCR – so that more young people have been and have felt fully engaged in the plan for their safety and wellbeing.	• Share the findings from the Serious Case Review with the Innovations Project Group • Pilot of Base model is going and use this case as a scenario in risk management tool training	Rob England Karen Goulding	June 2016 September 2016
Professionals will be able to work collaboratively with young people, whilst effectively identifying and managing risk	• Request a presentation and discussion at a GSCB Board meeting in relation to the Innovations work • Share findings from the review with educational settings • Explore through the WfD Sub-Group whether bespoke training in relation to the challenges of safeguarding teenagers at risk should be commissioned	Rob England Jane Bee Carol Oram/Izzy Dougan	September 2016 June 2016 July 2016
The Board will be assured that when a child becomes pregnant the focus remains equally on the child and the unborn baby rather than shifting from the child to the unborn baby	• Review the safeguarding process when a child at risk becomes pregnant, alongside the CP Conference Team, Youth Support Service and Ambassadors for Vulnerable Children and Young People	Karen Goulding/Cathy Griffiths/Rob England	July 2016
Finding Two: The design of the Domestic Abuse, Stalking, Harrassment and Honour Based Violence (DASH) form makes it highly likely that critical information will be missed if used for people under 18 and/or victims of teenage domestic abuse			
How Will We Know We Are Making a Difference?	**What are We Going to Do?**	**Who will Lead?**	**By When**
The risks to children and young people will be appropriately assessed and managed through a coordinated multi-agency response	The Task and Finish Group consider that the DASH remains a good tool to use with victims of domestic abuse. However, to ensure robust tools that can be used for either children or adults depending on individual needs and circumstance, we will be: • Considering the national response to young people who are suffering from domestic abuse within a relationship • Holding a 'managing risk' multi-agency workshop to	Sophie Jarrett/Alison Croft Sophie Jarrett/Alison	July 2016 August 2016

	confirm the range of risk assessment tools available to practitioners and young people at risk of domestic abuse. • GSCB sign off of the revised pathway and launch	Croft Sophie Jarrett/Alison Croft	 September 2016
Finding Three: This review indicates a general lack of understanding of how to recognise key features of domestic abuse between young people, leaving child victims and perpetrators without the necessary support and protection			
How Will We Know We Are Making a Difference?	**What are We Going to Do?**	**Who will Lead?**	**By When**
Professionals will have a clear understanding of the features of domestic abuse in children under the age of 18 years and will be confident in identifying and responding to their needs	• Research what existing or new training and awareness raising is available for professionals and whether this should be commissioned in Gloucestershire • Clarify local and national expectations, including how we define teenagers who are suffering domestic abuse within a relationship • Establish a Task and Finish group to develop and communicate a Gloucestershire pathway to clarify how professionals respond to children under 18 who are experiencing domestic abuse within a relationship • Work with the Ambassadors for Vulnerable Children and Young People on creative and innovative ways to share the learning from the review across the workforce	Carol Oram/Izzy Dougan Sophie Jarrett/Alison Croft Sophie Jarrett/Alison Croft Alison Croft/Izzy Dougan	July 2016 August 2016 September 2016 September 2016
Commissioning arrangements in Gloucestershire will have been shaped by the findings from the review, as well as the availability of more robust data and intelligence so that children and young people are appropriately supported and protected	• Share the findings from the review with the Gloucestershire Domestic Abuse and Sexual Violence Steering Group • Consider how the Board can use its role of holding to account to ensure that agencies are appropriately implementing the revised pathway	Alison Croft MAQuA	June 2016 March 2017
Finding Four: A healthy culture of challenge and response is not fully embedded in Gloucestershire. This may leave children more vulnerable			
How Will We Know We Are Making A Difference?	**What are We Going to Do?**	**Who will Lead?**	**By When**
Healthy challenge will be evidenced as an integral part of our professional culture	• Continue the work that we are already doing to raise awareness of the importance of healthy challenge across the children's workforce in Gloucestershire • The GSCB Business Unit will gather examples of where healthy challenge has been effective in order to inform and increase confidence and competence	GSCB Business Unit GSCB Business Unit	Ongoing Throughout 2016/17

	• Review and update the Escalation Policy to include healthy challenge principles and standards	P&P Sub-Group	September 2016
Finding Five: In Gloucestershire there is a lack of established practice and process to support a full multi-agency understanding of the child's experience and this inhibits a comprehensive assessment of risk			
How Will We Know We Are Making A Difference?	**What Are We Going To Do?**	**Who will Lead?**	**By When**
Professionals in Gloucestershire will have a complete multi-agency understanding of the child's views and experiences and this will inform a full assessment of risk to ensure that the most appropriate support can be put in place	• Request an analysis of how often multi-agency chronologies are produced before an Initial Child Protection Conference takes place • Continue work to produce a GSCB multi-agency chronology guidance document, to include reference to the child's voice • Review the MARF to consider whether a chronology prompt could be added to the form. • Request that a piece of work is undertaken through the South West Child Protection Procedures to produce shared guidance in relation to the use of multi-agency chronologies	P&P Sub-Group P&P Sub-Group Alison Croft/Julie Miles P&P Sub-Group	July 2016 August 2016 July 2016 September 2016
Finding Six: In Gloucestershire understanding how to work effectively and safely with young males who are perpetrators of domestic abuse requires further development			
How Will We Know We Are Making A Difference?	**What are We Going to Do?**	**Who will Lead?**	**By When**
Young people, especially young males at risk of developing abusive or unhealthy behaviours will be identified as early as possible and there will be appropriate support services in place to stop their behaviours from escalating.	• Request a report on the work that is currently taking place with young males who are the perpetrators of domestic abuse, specifically in relation to the interventions that are in place • Work with the Innovations Project to explore the national picture and the types of services that are available to support young males who are perpetrators of domestic abuse • Explore whether professionals have the skills and experience to work and engage with young male perpetrators	Tina Hemingway/Sophie Jarrett Rob England/Karen Goulding Rob England/Karen Goulding	July 2016

APPENDIX FOUR - REFERENCES

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