DOMESTIC HOMICIDE REVIEW

East Sussex Safer Communities Partnership

Overview Report into the murder of Henrietta (Adult E) August 2015

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DHR East Sussex Safer Communities Partnership

Overview Report

1. Introduction

1.1 Outline of the circumstances that led to a DHR

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

1.1.2 The evening before, the father of the children and Henrietta's ex-partner, Peter, had the children overnight at his mother's address and he returned the children to Henrietta the following morning having met her in Town 1 Town Centre. They then travelled to Town 2 by train, went shopping and returned to Henrietta's flat at approximately 1:25 pm. This is known by accounts from CCTV and investigation by Sussex Police.

1.1.3 At 1:36 pm, a 999 call was made to police by a male caller reporting shouting and screaming; this was followed by a call from Henrietta herself to South East Coast Ambulance Service (SECAMB) at 1:42 pm reporting she had been stabbed multiple times by her ex -boyfriend, she was bleeding, unable to breathe and that *"she was going to die".*

1.1.4 Emergency services attended the address, including the Air Ambulance, and Henrietta suffered a cardiac arrest and she tragically died at 2:20 pm. The initial investigation was carried out by divisional police staff and then handed over to the Major Crime Team. Peter was subsequently arrested having been located at a relative's address. He was interviewed and remanded in custody. Peter stood trial in July 2016 after pleading not guilty to the murder. The jury found him guilty and he was sentenced to life with a minimum tariff of 24 years.

1.2 Domestic Homicide Reviews

1.2.1 This Domestic Homicide Review (DHR) was commissioned by the East Sussex Safer Communities Partnership.

1.2.2 DHRs were established under Section 9(3), Domestic Violence, Crime and Victims Act 2004 and are conducted in accordance with Home Office guidance.

1.2.3 The purpose of these reviews is to:

a) Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims.

b) Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result.

c) Apply those lessons to service responses including changes to policies and procedures as appropriate.

d) Prevent domestic homicide and improve service responses for all domestic violence and abuse victims and their children through improved intra and inter-agency working.

1.2.4 This review process does not take the place of the criminal or coroner's courts, nor does it take the form of a disciplinary process.

1.3 Timescales

1.3.1 Sussex Police notified the East Sussex Safer Communities Partnership on the 8th September 2015 that the case should be considered as a DHR. An initial meeting was held on the 8th October 2015 between representatives from the East Sussex Safer Communities Partnership and Sussex Police to establish the scope of the DHR, as well as to identify how it would dovetail with the then ongoing criminal investigation. It was agreed that the review would not to be fully commenced until the conclusion of criminal proceedings. Subsequently, the East Sussex Safer Communities Partnership made a decision to conduct a DHR, and having agreed to undertake a review, the Home Office was notified of the decision on the 8th October 2015.

1.3.2 In parallel with the decision making process about whether to conduct of a DHR, a process was completed to identify an independent chair. Following the conclusion of this process Standing Together Against Domestic Violence (STADV) was commissioned to provide an independent chair for this DHR on 5th of October 2015. The first meeting of the Review Panel was held on 17th December 2015, with further meetings on the 28th April 2016, 8th July 2016 and the 14th October 2016. Subsequently the Review Panel provided electronic feedback on drafts of the report in January and March 2017.

1.3.3 Home Office guidance states that a review should be completed within six months of the initial decision. The review was delayed due to the criminal trial which took place in July 2016, the need for the chair to have a further one to one meeting with Affinity Housing and for time to reach out to friends and family to be involved in this review. The panel felt that the family and friends of both Henrietta and Peter should be contacted post-trial for a further opportunity for involvement in the DHR. This contact was concluded in February and March 2017.

1.3.4 The Executive Summary and Overview Report, as well as recommendations in response to the findings, were presented to the Resources & Performances Group of the Safer Communities Board in February 2017, before sign off by the Chair of the Board in May 2017 (as the Chair is the Lead Member for Communities and Safety for East Sussex County Council, this was delayed due to Local Government Elections on the 4th May 2017) . They were submitted to the Home Office in May 2017 and were considered at the November 22nd 2017 meeting of the Home Office Quality Assurance Panel. The Home Office provided notification and approval for publication on the 15th December 2017. The Home Office letter is included in this report as Appendix 1.

1.3.5 Initially this case was known as that of 'Adult E' in East Sussex. Subsequently, the sister of the victim was interviewed as part of the DHR and chose the pseudonym 'Henrietta' and agreed to the other names being chosen by the report author.

1.3.6 The following people have seen copies of the draft Overview Report prior to publishing:

Nicole Jacobs (*Independent Chair)*	Standing Together Against Domestic Violence.
Carol Redford	East Sussex County Council (Adult Social Care).
Carol Studley	Rother District Council.
Chris Simmons	Affinity Sutton.
DCI Ali Eaton	Sussex Police.
Debbie Barnes	Eastbourne Hailsham and Seaford (EHS) and Hastings and Rother (HR) and High Weald Lewes Havens (HWLH) Clinical Commissioning Groups.
Gillian Dennehy	Standing Together Against Domestic Violence.
Gillian Field	Eastbourne Hailsham and Seaford (EHS) and Hastings and Rother (HR) and High Weald Lewes Havens (HWLH) Clinical Commissioning Groups.
James Rowlands	Joint Domestic, Sexual Violence & Abuse and Violence against Women & Girls (VAWG) Unit – Brighton & Hove and East Sussex.
Jude Davies	East Sussex County Council (Supporting People Commissioning Project).
Micky Richards	Change, Grow, Live (CGL).
Nicky Spiers	Joint Unit – Brighton & Hove and East Sussex.
Sara Jones	Office of the Sussex Police & Crime Commissioner (OSPCC).
Sister of Henrietta	n/a.
Tosca Tizzano	Standing Together Against Domestic Violence.

1.3.7 Once published, the final report will be shared with the governance boards and committees of participating statutory agencies. This includes:

- Members of the East Sussex Safer Communities Partnership Board, the Local Safeguarding Children Board and the Safeguarding Adults Board, for consideration and dissemination within their own organisations
- The Pan Sussex Domestic Abuse Management Group.

1.3.8 A number of learning events have been planned to ensure that the lessons are disseminated as widely as possible; the first of these will be a confidential briefing to key local partners which will share critical learning from this and another local DHR which is taking place in April 2017. Once permission is granted by the Home Office to publish, this report will be more widely disseminated to the local professional network including:

- The Domestic Violence and Abuse, Sexual Violence and Violence Against Women and Girls Champions Network and Multi-Agency Risk Assessment Conference
- Targeted briefings including to specialist domestic and sexual abuse services.

1.4 Terms of Reference

1.4.1 The full Terms of Reference (ToR) are included at Appendix 1. The essence of this review is to establish how well the agencies worked together both independently and together from 2009 up to the homicide and to examine what lessons can be learnt for the future. The panel explored aspects of this case which related to perceptions of 'medium' risk and low thresholds of need, the ability to engage young adults and in particular young fathers.

1.4.2 This review aims to identify the learning from Henrietta and Peter's experiences, and for action to be taken in response to that learning: with a view to preventing homicide and ensuring that individuals and families are better supported.

1.4.3 The Review Panel comprised agencies from East Sussex, as the victim and perpetrator were living in that area at the time of the homicide. Agencies were contacted as soon as possible after the DHR was established to inform them of the review, their participation and the need to secure their records.

1.4.4 During the East Sussex Safer Communities Partnership scoping exercise prior to the first panel meeting the following agencies provided information:

- Affinity Sutton (registered social housing provider[1]).
- East Sussex County Council (ESCC) Children's Social Care - Early Help, Targeted Youth Support and SWIFT Specialist Family Support.
- East Sussex Health Care Trust (ESHT) Acute and Community Services (Health Visiting/Family Nurse Partnership and Maternity Services).
- Home Works (a housing and homelessness service Home provided by Southdown and commissioned by East Sussex County Council[2]).
- Primary care services.
- Rother District Council Housing (the housing authority in the local authority area where Henrietta died).
- Sussex Partnership NHS Foundation Trust (SPFT) (the local mental health service).
- Sussex Police.
- Victim Support.

[1] For more information go to https://www.affinitysutton.com/
[2] For more information go to http://www.southdownhousing.org/housing-support/home-works-east-sussex

1.4.5 As information was provided during the review, it was established that Henrietta and Peter had contact with agencies in other parts of the country and therefore agencies were contacted for information and involved remotely in the review.

1.4.6 At the first meeting, the Review Panel shared brief information about agency contact with the individuals involved, and, as a result, established that the time period to be reviewed would be from 2009 to the date of the homicide in late August 2015. The ToR date was set for early 2009 when the relationship between Henrietta and Peter began.

1.4.7 Agencies were asked to summarise any relevant contact they had had with Henrietta or Peter outside of these dates.

1.4.8 At the first panel meeting the chair and panel discussed those issues particularly pertinent to this review, which were identified as the age of both Henrietta and Peter as they were young parents often experiencing services for the first time as young adults.

1.5 Parallel Reviews

1.5.1 The criminal trial concluded in July 2016. Sussex Police had input on the scope of the review and it was agreed that no witness's/family members/friends of either victim or perpetrator would be interviewed until the trial was completed. However, the review was initiated to avoid any significant delays and began gathering information and reports from agencies involved in the review.

1.5.2 A Coroner's Inquest is not pending – reflecting local practice, there was regular communication between the East Sussex Safer Communities Partnership and H.M. Senior Coroner for East Sussex about the progress of the DHR. The Coroner confirmed their intention not to resume the inquest in October 2016.

1.5.3 A Serious Incident Investigation was initiated but it was downgraded and closed by Sussex Partnership NHS Foundation Trust. The analysis from this review was shared with the panel, a senior officer from the Trust was consulted in the process of the drafting of the report and the findings are noted further in 4.1 below.

1.6 Equality and Diversity

1.6.1 The Chair of the Review and the Review Panel bore in mind all the protected characteristics of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation during the DHR process.

1.6.2 Henrietta was a heterosexual white female who was 20 at the time of her death. Peter was a 21-year-old heterosexual white male. They were not married. The protected characteristics of disability, gender reassignment, religion/belief and sexual orientation do not pertain to this case in that neither party was disabled or was at any stage of transitioning from one gender to the other. They did not hold particular religious or other beliefs as far as we can tell from the records or from speaking to the family or to Peter directly.

1.6.3 The Review Panel gave consideration to age of the victim and the perpetrator, as well as pregnancy and maternity throughout this review. Henrietta was a young mother. Her first pregnancy was at 16 and her second at 18. The panel discussed in

some depth how this may have impacted on her perceptions of services as well as her perceived options for help. This was explored in the Chair's interview with Henrietta's sister. The same considerations were made for Peter with regard to his age and his perceptions of services. This was explored in depth during the Chair's interview with him. This has been included in the analysis section.

1.6.4 Sex should always require special consideration. Being female is a risk factor for being targeted by a perpetrator of domestic abuse; domestic abuse is a gendered crime with the overwhelming majority of victims being female and the perpetrators being overwhelmingly male.[3] Therefore, making this characteristic relevant for this case, Henrietta having been female and a victim of domestic abuse from Peter a male.

1.6.5 No additional equalities issues were identified during the course of the review.

1.7 Methodology and Contributors to the Review

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

1.7.2 Of these, 16 agencies reviewed their files and notified the review that they had no involvement with Henrietta or Peter. Therefore, these agencies were <u>not</u> asked to complete an Individual Management Review (IMR). These included:

- East Sussex County Council Adult Social Care.
- East Sussex Fire and Rescue Service (ESFRS).
- Eastbourne Borough Council Housing.
- Hastings Borough Council Housing.
- Kent, Surrey and Sussex Community Rehabilitation Company (KSS CRC).
- Lewes District Council Housing.
- Surrey and Sussex Multi-Agency Public Protection Arrangements (MAPPA).
- National Probation Service (NPS).
- The local specialist domestic abuse service (provided in East Sussex by Change, grow, live (CGL), which is a delivery partner in 'The Portal[4]).

[3] Walby & Allen 2004 (from British Crime Survey);

[4] The Portal is a partnership of leading Sussex Domestic and Sexual Abuse Charities – including RISE,

- The local domestic violence refuge service (provided in East Sussex by Refuge[5]).

- The East Sussex Drug and Alcohol Recovery Service, STAR (provided in East Sussex by Change, grow, live (CGL).

- Wealden District Council Housing.

1.7.3 11 agencies notified the review that they had been involved with Henrietta and/or Peter, and IMRs were requested from these organisations (of these two organisations completed combined IMRs across service areas, including East Sussex County Council (ESCC) Children's Social Care and East Sussex Health Care Trust (ESHT) Acute and Community Services).

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

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

1.7.6 *Independence:* Members of staff not directly involved with Henrietta, Peter or any family members undertook the IMRs.

1.7.7 IMRs were received from:

- Affinity Sutton (registered social housing provider).

- East Sussex County Council (ESCC) Children's Social Care - Early Help, Targeted Youth Support and SWIFT Specialist Family Support.

- East Sussex Health Care Trust (ESHT) Acute and Community Services (Health Visiting/Family Nurse Partnership and Maternity Services).

- Home Works (a housing and homelessness service Home provided by Southdown and commissioned by East Sussex County Council[6]).

- Primary care services.

- Sussex Partnership NHS Foundation Trust (SPFT) (the local mental health service).

- Sussex Police.

Survivors' Network and CGL – and provides a single point of access and helps victim/survivors of domestic and sexual violence and abuse to find advice and support in Brighton & Hove and East Sussex. For more information go to http://www.theportal.org.uk

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

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

- Victim Support.

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

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

1.7.10 An IMR was also requested from the General Practice. As there was a significant amount of contact by staff within the General Practice, the IMR was completed by a member of staff acting on behalf of the Eastbourne, Hailsham and Seaford (EHS) and Hastings and Rother (HR) and High Weald Lewes Havens (HWLH) Clinical Commissioning Groups.

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

1.8 The Review Panel Members

1.8.1 The Review Panel members and Chair were:

Name	Job Title	Organisation
Carol Redford	Operations Manager, Safeguarding Development Team	East Sussex County Council.
Carol Studley	Partnerships and Community Safety Coordinator	Rother District Council.
DCI Ali Eaton	Safeguarding Investigation Unit, East Sussex Division	Sussex Police.
Debbie Barnes	Designated Nurse Child Safeguarding	Eastbourne Hailsham and Seaford (EHS) and Hastings and Rother (HR) and High Weald Lewes Havens (HWLH) Clinical Commissioning Groups.
Gillian Field	Designated Nurse Adult Safeguarding James Rowlands	Eastbourne Hailsham and Seaford (EHS) and Hastings and Rother (HR) and High Weald Lewes Havens

		(HWLH) Clinical Commissioning Groups.
James Rowlands	Strategic Commissioner (*Partnership Lead*)	Joint Domestic, Sexual Violence & Abuse and Violence against Women & Girls (VAWG) Unit – Brighton & Hove and East Sussex.
Micky Richards	Director	Change, Grow, Live (CGL).
Nicky Spiers	MARAC Development Officer	Joint Unit – Brighton & Hove and East Sussex.
Nicole Jacobs (*Independent Chair*)	CEO	Standing Together Against Domestic Violence (STADV)
Sara Jones	Business Manager Victim and Witness Service	Office of the Sussex Police & Crime Commissioner (OSPCC).

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

1.9 Contact with the family

1.9.1 The family was notified that a DHR was being commissioned and a letter was sent to Henrietta's mother from the East Sussex Safer Communities Partnership via the Family Liaison Officer in September 2015. This letter outlined the purpose of the review, identified the points at which family members could participate in the review if they wished and introduced the Independent Chair.

1.9.2 The Independent Chair subsequently attempted to make contact with Henrietta's mother on several occasions by direct mail and via the Family Liaison Officer. When sending a letter, the Independent Chair included both the Home Office leaflet and the leaflet for AAFDA (Advocacy After Fatal Domestic Abuse)[7]. The Independent Chair confirmed with Victim Support Homicide Service that they were not supporting the family in this case. Ultimately Henrietta's mother declined to participate in this review and communicated that through the Family Liaison Officer.

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

1.9.4 The Independent Chair sent her first initial letter to Peter via the prison post-trial on the 11th October 2016. No response or confirmation of receiving this letter was received from the prison or Peter. In the meantime, the probation representative on

[7] AAFDA specialise in guiding families through Inquiries including Domestic Homicide Reviews and Mental Health Reviews, and we assist with and represent on Inquests, Independent Police Complaints Commission (IPCC) inquiries and other reviews. For more information go to http://aafda.org.uk

the panel informed the Independent Chair that Peter was interested in being involved in the review. The Independent Chair then sent another letter via the prison governor to Peter on the 15th December 2016. The Independent Chair met with Peter on the 14th February 2017 and his views are incorporated in this review.

1.10 Chair of the DHR and Author of the Overview Report

1.10.1 The Independent Chair of this DHR is Nicole Jacobs, CEO of Standing Together Against Domestic Violence, an organisation dedicated to developing and delivering a coordinated response to domestic abuse through multi-agency partnerships. She has conducted domestic abuse partnership reviews for the Home Office as part of the Standing Together team that created the Home Office guidance on DV partnerships, 'In Search of Excellence'. She has worked in the field of domestic abuse intervention for over 20 years.

1.10.2 Standing Together Against Domestic Violence (STADV) is a UK charity bringing communities together to end domestic abuse. We aim to see every area in the UK adopt the Coordinated Community Response (CCR). The CCR is based on the principle that no single agency or professional has a complete picture of the life of a domestic abuse survivor, but many will have insights that are crucial to their safety. It is paramount that agencies work together effectively and systematically to increase survivors' safety, hold perpetrators to account and ultimately prevent domestic homicides.

1.10.3 STADV has been involved in the Domestic Homicide Review process from its inception, chairing over 50 reviews, including 41% of all London DHRs from 1st January 2013 to 17th May 2016.

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

2. The Facts

2.1 Outline on relationship between Henrietta and Peter and their family makeup

2.1.1 Similar to agency description of Henrietta, her family describes her as a happy, outgoing young woman. Her sister said that, "she was always laughing and got along with anyone. She never had a bad word to say about anyone". She is also described as a competent person and very intelligent. Her sister is four years older and they were close and spoke most days.

2.1.2 Peter lived with his mother and was very close and actively involved with his older sister. He described his family relationships as very close and his household as active, with many friends and relatives dropping in and out of the house often. Peter's sister's relationship and circumstances had an effect on his views of social workers and intervention from various services. His sister tragically died two years prior to the homicide and Peter was deeply affected by the loss of his sister. He formed negative views of social workers and services of various professionals over the period of years.

2.1.3 Henrietta met Peter in 2009, when she was 15/16 years old and still at school. Although they had attended the same school, they met online. They started going out and Peter was her first serious boyfriend. Henrietta became pregnant with Child 1 who was born in May 2012. Henrietta gave birth to her second child, Child 2, in June 2014. Henrietta and Peter had just broken up in the weeks prior to the homicide.

2.1.4 Peter described himself as having some trouble in school which is why he was attending an alternative school at the time he met Henrietta. He described himself as having grown up "in and around drugs" and, for a period of years through to the time he was with Henrietta, he smoked cannabis every day in the morning and the evening. He did not perceive this as a point of contention between him and Henrietta although her use of drugs was much less.

2.1.5 After Child 1's birth, Henrietta remained living with her mother. Peter remained living with his mother. When Child 1 was 18 months old, Henrietta got a two-bedroom flat in Town 1 and Peter stayed there a most of the time but Peter was not listed as a tenant at Henrietta's flat.

2.1.6 Her family state that the abuse escalated when Henrietta moved into her own flat. Henrietta became frustrated that Peter would not take responsibility for being a parent. "Once in a blue moon" he would look after the children so Henrietta could go out but during that time he would call her non-stop whilst she was out asking what to do with the children.

2.1.7 Peter describes their life in Town 1 as "normal" whereby he went to work (at first at a taxi rank and then at a hotel) and Henrietta looked after the children. He described that their life centred around this routine and the children. Peter described that, as Henrietta was a young mother, many of her friends lost active contact with her as they did not have children and the same responsibilities as Henrietta.

2.1.8 Henrietta saw her family often. She comes from a large and close family and Peter would often accompany her to wider family outings. He would remain largely quiet and in the background during these events.

2.1.9 Henrietta was active online, particularly in groups which related to children. Peter describes not looking or knowing much about that but understood that she was actively engaged in these fora and that this was a way that Henrietta sought help, advice and also social contact.

2.1.10 Peter lost his job at the taxi rank because he was making phone calls to Henrietta. All calls were strictly forbidden while on duty. He would call Henrietta, keep her on the line while he would do his work and then pick the phone back up to continue speaking to her.

2.1.11 Henrietta's family learned from attendance at the criminal trial that Peter's calling and texting was excessive. On some days, he was contacting or texting Henrietta hundreds of times in a day. When Henrietta was with her sister, she was often checking her phone which now, in retrospect, makes sense to her sister.

2.1.12 Peter described that in the year before the homicide, Henrietta began socialising with a friend and they would often go to parties together. Peter describes not liking the situation as he felt that she was "forgetting her responsibilities." Henrietta was likely asserting her independence and her true personality, which was that of a fun loving, happy and extraverted person.

2.1.13 In the months prior to the homicide, Peter lost his job for leaving early without permission and the relationship between Peter and Henrietta began to break down further. Peter was asked to sleep on the couch and in his own words, he felt his was in the "dog house" during this time, but his perception was that things were improving.

2.1.14 Henrietta was striving for more independence. She was a dedicated and loving mother and she was attempting to distance herself from Peter while trying to cause the least amount of aggravation. This was her first significant relationship and this was likely her first attempt to end the relationship. Henrietta's sister made an important point that, for Henrietta, the break up would have presented the possibly frightening prospect of being on her own for the first time and that this should not be underestimated. Henrietta spoke to her sister about feeling she would be "better off single" and she was clearly summoning up the courage to take that step. She also spoke to both her Facebook mother's group and her sister about physical abuse by Peter. She posted to her Facebook group a photo of a bruise inflicted by Peter and she spoke of him always coming home angry. When asked online if she needed help she replied that she felt Peter was stressed due to his grieving for his sister's death. She spoke to her sister about being pinned down by Peter and strangled. But, again, her overriding concern was that the wider family not get involved. Henrietta comes from a very close knit family and Henrietta may well have felt that if the family knew the details of Peter's abuse, they may intervene and that could have been a concern for Henrietta.

2.1.15 Henrietta's sister recalled a text message conversation with Henrietta in July 2015 – Henrietta "Of course I love him, but not enough I don't think, especially when he treats me the way he does sometimes, but other times everything are fine, Oh I don't know", "Yes… I wish he was not so grumpy and pissed off all the time he is literally the hardest person to please… I haven't got time to faff around making him

happy when I've got the boys to deal with. He's pissed off with work doesn't want to work there and just came in taken it out on me Cheers Mate xxx".

2.1.16 In late July, Henrietta texted her sister to say that: "Peter lost his job and we have split up btw". Henrietta later texted her sister to ask: "Were you friends with Peter on FB has he deleted you? He's written loads of stuff about me on it and I can't see it and no one will tell me or can't see it either because he's deleted everyone close to me". Her sister replied that she and Peter had not been friends on Facebook for a very long time.

2.1.17 In early August 2015, they split up and Henrietta told her family this was due to his being controlling and used the example of Peter not permitting her to see her friends. They said that Peter texted Henrietta all the time she was out and also texted and called her family members to find out Henrietta's whereabouts.

2.1.18 One night Henrietta went to party while Peter was looking after the children at home. He received a call from a friend to say that Henrietta had left the party with a male friend of Peter's. This was a friend he has known since nursery school. So, Peter called his mother to look after the children and he went to his friend's house and found Henrietta there. This culminated in a police incident which is outlined in 2.4.

2.1.19 This incident triggered a referral from the Police to Victim Support who contacted Henrietta and offered support. Henrietta spoke to Victim Support but did not indicate that she felt she needed further support. Henrietta's sister felt a service described as addressing domestic abuse would have likely put off Henrietta as she may not have identified with that term. Her sister felt that a proactive contact in the weeks following may well have helped her sister to engage with services and/or further advice.

2.1.20 After this incident, Peter turned off his phone for a week and stayed at his mother's house. When he turned the phone back on, he was surprised to see that no contact had been attempted by either Henrietta or his friend. He describes feeling he could not "get away" from news of Henrietta or his friend. His friend lived near to his mother's house. There were many friends and cousins who reported seeing or hearing about Henrietta and/or his friend and this led him to the feeling that he had to get away.

2.1.21 In the weeks before the homicide, Peter called the Army recruitment centre. He had signed up for the Army before and was accepted and was going to be sent for training before he decided not to go. Based on his previous experience he knew this may be an option to leave the area. He was told he would have to travel to the centre which he was unable to afford and he tried to arrange a ride with family members but he was not able to progress with this plan. When asked if he considered seeking housing to get away from his environment, he recollected that due to prior experience he knew that his mother would have to say that she would not have him at home and he did not think his mother would make such a statement.

2.1.22 In this state, he reports that he began to think and speculate about Henrietta and his friend and he started to question if they had been together and for how long.

2.1.23 During this period of separation Henrietta felt that Peter should live up to his responsibilities as a parent. She spoke to a solicitor about child contact

arrangements. She was proactive in wanting to set up visitation between Peter and the children.

2.2 Overview of agencies involvement

2.3 Sussex Police

2.3.1 There are three occasions where Sussex Police have had contact with the Henrietta and Peter. In all cases Henrietta was the victim with Peter as the alleged perpetrator.

1. A Non Crime Domestic on 27th November 2013.
2. A Violent Domestic of 2nd August 2015.
3. The Murder of Henrietta at the end of August 2015.

2.3.2 *Incident 1*: At 8:15 pm on 27th November 2013 the police received a 999 call from Henrietta's neighbour, who reported screaming and banging from Henrietta's flat. Police attended and there were four adults smoking and a strong smell of cannabis. Henrietta stated that an argument had taken place whilst celebrating her birthday but there were no longer any problems. There was no sign of any disturbance or injuries, although there were concerns about suspected drug abuse. Whilst there was a child in the flat (Child 1), the child looked well fed and looked after. This was recorded as a non-crime domestic.

2.3.3 A DASH Risk Indicator Checklist (RIC) form was completed and the circumstances and the officers' comments are exactly the same as on the completed MOGP1 (Memorandum of Good Practice). The risk was assessed as 'standard' by the officer attending and endorsed as such by their supervisor with the comment that the domestic abuse aspect was minor and there were no reports of physical violence. The main cause for concern recorded on the MOGP1 was drug use. This form was not endorsed by APT and the option to email the form to the domestic abuse service in East Sussex was not selected because it was a case that was deemed to be standard risk and Peter was not charged with a crime.

2.3.4 Henrietta responded "No" to nearly all the risk indicator questions on the DASH RIC form. She answered yes to the following:

1. Having had a child in past 12 months.
2. That Peter had past criminal behaviour (noted for "silly things"). Research showed no history of any previous reports of abuse on police records at that time.

2.3.5 Smoking around the young child and drug use was noted as a risk factor.

2.3.6 The MOGP1 was emailed to CSC at 09:42 hours on 28th November 2015. At 1:10pm the NICHE[8] log entry states that the family was not previously known to CSC and the report was forwarded to for their assessment (this is the MOGP1 that was accidentally deleted by Children's Service).

[8] NICHE is a data management system used by the police in Sussex as well as in 20 different police force areas across the country.

2.3.7 *Incident 2:* On 2nd August 2015 Sussex Police received a call at 6:26 am. Henrietta made a 999 call stating Peter was kicking her front door and then spat in her face when she opened it. Her friend, who was staying over, had gone outside and had an argument with him. Henrietta told him to get back inside. NICHE research showed Peter was known but no warnings shown. The incident was recorded as a Violent Domestic. Peter was arrested for Assault Occasioning Actual Bodily Harm (ABH) to his friend MALE 1 and Common assault on Henrietta. A history marker was created.

2.3.8 The same incident was recorded by the Police via a call from Henrietta's neighbour. On 2nd August 2015, Sussex Police received a call at 6:27 am from a neighbour of Henrietta. The neighbour made a 999 call to police to report a very loud argument in the flats' block corridor and a female shouting for male to leave, other people also involved and that children were crying. The caller states that 45 minutes earlier a male had turned up, went away and then came back, and that the argument at that time was much louder. The neighbour could hear fighting and very loud banging.

2.3.9 Police recorded the circumstances of the incident were that the suspect, Peter, had been in a relationship with his ex-partner Henrietta for the last 4-5 years, this was until they split up 2 weeks prior. Despite the breakup, he was still often at her flat to care for the children. On Saturday 1st August 2015, the suspect Peter was at Henrietta's address with his young children for the evening, Henrietta was out at a party in Sidley, also present at this party was MALE 1, who Peter had been friends with for the past 19 years. Afterwards, Henrietta stayed with MALE 1 at his address in Town 1 where they slept in the same bed. Peter arrived at the address at around 4:00 hours. He climbed in the bedroom through the window and shouted *"*what the fuck are you doing" and "how the fuck could you do this to me*?".* MALE 1 grabbed Peter and pushed him out of the house. (It has subsequently been ascertained that Peter had arranged for his mother to look after the children). MALE 1 then went with Henrietta to her flat where Henrietta asked Peter's mother to leave. Peter arrived a short time later and shouted for MALE 1 to come outside the flat and speak to him. Henrietta crouched down and told Peter, through the letter box, to go away at which point he spat at her in the face. MALE 1 opened the door and Peter threw a punch and, in swinging his arms, caught MALE 1 on the right arm and scratched his bicep. A fight then took place in the hallway to the block of flats with MALE 1 claiming that he was restraining Peter by pinning him to the floor.

2.3.10 Police then attended and spoke to all parties and Peter was arrested for Common Assault against Henrietta and Assault Occasioning Actual Bodily Harm against MALE 1. The police completed the evidence gathering process and Henrietta provided a positive statement supporting a police prosecution and Peter was subsequently cautioned for Common Assault. MALE 1 did not wish to support a prosecution for the assault to himself by Peter.

2.3.11 In her statement made on 2nd August 2015, Henrietta stated that she had known Peter for five years and that her relationship with Peter had naturally come to an end two weeks earlier, and they had separated. Peter still visited to see the children and on occasion looked after them when she went out. She had a couple of text messages from him whilst she was at the party to let her know the boys were alright. She described Peter climbing through the window and called her a slut or similar. She mentions returning to her flat with MALE 1 and then the incident that followed where Peter spat at her and the fight in the corridor where Peter assaulted MALE 1. Her children started crying and at this time she was on the phone to the police and she returned to the flat. MALE 1 was restraining Peter and said *"*I'm not

letting go until you promise to leave*"*. Henrietta went on to say that she was shocked that he had spat in her face and never expected he would behave that way. She was upset and confused by his behaviour and felt it was excessive. Henrietta stated that this was the first violent incident between herself and Peter. The children Child 1 and Child 2 were present.

2.3.12 In summary the risk assessment indicated the following risk factors as contained on the DASH RIC form: There was recent separation. Henrietta was receiving constant and frequent texts. There were young children in the family. Peter displayed jealous behaviour and that he had been in the trouble with the police when he was younger and that he may have a criminal history.

2.3.13 The risk on the Single Combined Assessment of Risk Form (SCARF) was assessed as 'standard' by the Officer in Charge's supervisor and "On the information above I do not fear that in this incident those involved are at risk of sustaining significant/serious injury, nor do I suggest that lasting mental anguish is a concern" and the SCARF was passed to Child Protection Team (CPT).

2.3.14 The Child to Notice Specialist Officer comments were as follows – "This family is previously known on the CPT database; however, this has been reviewed as a standard risk only. The parents have separated but have been living together this has led to father taking drastic measures by climbing through another person's window to locate them. It is unknown who was caring for the children whilst he did this. This family appears in need of some agency support therefore forwarded to Children's Social Care for their attention". At 2.01 pm on 3rd August 2015, the relevant sections of the SCARF were e-mailed to CSC.

2.3.15 With regard to this SCARF submission and NICHE record, a number of officers were involved in the investigation at various stages, of which two were supervisors who reviewed the SCARF and the investigation recorded on NICHE.

2.3.16 Upon release from custody the day after the incident, Peter recollected that there was a female police officer who gave him a number to call. She said to him that times like these were hard and that "we've all been through it." He understood this to mean relationship breakdown. He was given a paper with a number to call for support. He reported that he threw the number away saying that it would not be like him to try to seek help in that way. Although Peter remembers this to be the Police, this may have been the Court Liaison and Diversion Practitioner from the Sussex Partnership NHS Foundation Trust (see 2.5) who record providing him a number for mental health services.

2.3.17 *Incident 3*: Sussex Police were called on 28th August 2015 at 1:36 pm by a male caller. The caller stated that there was 'lots of screaming and shouting'" coming from Henrietta's address. History markers were checked and it was noted on the serial that there were three history markers relating to the address. Two related to two different previous occupants in 2014 and one related to Henrietta – 2nd August 2015 which showed *"*On-going domestic incidents between Henrietta and Peter. Young children living at the address".

2.3.18 At 1:42 pm, a female who gave her name as Henrietta called Police to say that she had been stabbed multiple times by her ex-boyfriend. She said that was bleeding, was unable to breathe and was "going to die". Children could be heard in the background.

2.3.19 The first police officers to attend the scene arrived at 1:44 pm. The door to the flat was opened by a three-year-old boy (Child 1) who showed the officers to the kitchen where the victim was on the floor. At this stage she was still conscious and had a pulse. Paramedics and a doctor from the Helicopter Emergency Medical Service attended the scene and attempted to resuscitate the victim who subsequently suffered cardiac arrest. She died at 2:20 pm.

2.4 Sussex Partnership NHS Foundation Trust (SPFT)

2.4.1 SPFT offer Specialist Mental Health services across Sussex, Kent, Hampshire and parts of London.

2.4.2 The Police and Court Liaison and Diversion Service ensures that people who come into contact with the criminal justice system who may have mental health conditions are recognised and are promptly referred into health and allied services to get the treatment or support they require. Research demonstrates that identification of people with mental health issues as they enter the criminal justice system through Liaison and Diversion schemes can ensure that individuals receive support, whilst the police are able to benefit from up to date information on a person's state of mind at that particular time.

2.4.3 Peter was assessed on two occasions by staff from Sussex Partnership Foundation Trust.

2.4.4 The first contact in January 2012 with Peter was triggered by an incident of self-harm which appears to have occurred as an impulsive reaction in response to an argument with his girlfriend (presumed to be Henrietta) whilst at a party. The conclusion of the assessment was that there was no further support and treatment required by mental health services at the time. This decision was made following a discussion between 2 members of staff providing liaison within the Accident and Emergency (A&E) setting at the time and which took into account Peter's presentation, the fact that he had no previous history of mental illness and that there was no evidence/indication of mental illness. The actions taken at this time were in accordance with Trust policy and procedure and included communication with Peter's General Practitioner.

2.4.5 When interviewed Peter recollected this treatment and assessment. He did not recollect the disclosure of an argument with his girlfriend (who he confirmed would have been Henrietta at the time) but said there were many things happening in his family at the time which "piled up." He said that during the assessment his overriding concern was to go home and get a shower. He recollected that he tried to answer questions in the way that "they wanted to hear" so that he could go home quickly.

2.4.6 The second contact with Peter was triggered by his acknowledgement on arrival in police custody in August 2015 that he had previously taken an overdose in 2012. In August of 2015, the police requested that a Court Liaison and Diversion Practitioner assess Peter in relation to his risk towards himself.

2.4.7 A Police and Court Liaison and Diversion Practitioners would not be asked to assess potential risk towards others in isolation although this is assessed as part of the Trust's Screening Risk Assessment and the Level 1 Risk Assessment tool used by Sussex Partnership Foundation Trust.

2.4.8 In this instance, the Screening Risk Assessment tool was completed but did not trigger a full Level 1 assessment due to a lack of significant active risk being identified. One of the questions to be considered during the Screening Risk Assessment (which is completed for any adult person accessing services for whom a Level 1 comprehensive risk assessment is not automatically required) is, "is there is any evidence to suggest that the person could cause harm to others?" On this occasion the response is documented as "unknown."

2.4.9 The Police and Court Liaison and Diversion Practitioner would not have been made aware of the type of incident leading to his arrest and is not permitted to discuss the details of the incident during assessment.

2.4.10 If the answer to the question had been recorded as "yes", it may not have necessarily triggered a full Level 1 assessment in view of there being no identified mental health concerns during the assessment.

2.4.11 On the two occasions that Peter came into contact with staff from SFPT, there was sufficient level of staffing available to provide the appropriate level of assessment and advice required at the time.

2.5 Acute Services, East Sussex Healthcare NHS Trust (ESHT)

2.5.1 The Conquest Hospital form part of the ESHT Acute Services and is a modern district general hospital, located in St Leonard's-on-Sea, on the outskirts of Hastings.

2.5.2 *Contact with Henrietta*
Henrietta initially presented at the Conquest Hospital Accident & Emergency (A&E) on 7th January 2012 where she was assessed briefly due to a head injury after stating she had fallen down the stairs. She was transferred immediately to the obstetric team as she was 18 weeks pregnant (see 3.5.1).

2.5.3 *Contact with Peter*
On 23rd January 2012 Peter attended at the Conquest Hospital A&E. Peter was treated following an overdose of anti-depressants. He had a mental health review and was discharged home with advice.

2.6 Community Services, East Sussex Healthcare NHS Trust (ESHT)

2.6.1 As well as running acute service (2.5), ESHT provide community services for people living in East Sussex.

2.6.2 ESHT Community Midwifery Services initially became involved with Henrietta during her first pregnancy (with Child 1). ESHT Midwifery Service raised an Additional Support Form (ASF) because Henrietta was sixteen at the time of booking. The ASF contained details about Peter, recording him as having no psychological or drug problems, no difficulties with the midwifery interview and being resident with his mother. Henrietta met the criteria for Family Nurse Partnership (FNP) as she was sixteen at the time of the midwifery ante-natal booking on 15th January 2012. A referral into the FNP was made by the midwives.

2.6.3 One 'recruitment' visit was made by the FNP Nurse who visited Henrietta at home. Peter was not seen. At this visit the nurse asked Henrietta about relationships and

support. Henrietta reported that her boyfriend and family were supportive. At this time Henrietta lived with her mother. The FNP programme has a much more detailed investigation tool to look at relationships which is used on the fourth client visit but there was no opportunity to use this as Henrietta decided she did not need their service and declined FNP intervention. She was therefore referred back to the Health Visiting Service.

2.6.4 At that time the Health Visiting Team were piloting the Goodstart Programme in Town 1. This project focused on early engagement of clients, increased ante-natal visiting and effective multi-agency working between Midwives, Health Visitors and Children's Centre Family Outreach Service Workers. Liaison between the Midwives and Health Visitors was reported by the interviewed staff to be regular and effective.

2.6.5 Henrietta received two ante-natal visits when she was pregnant with Child 1 as a result of the Goodstart Pilot Programme. The normal, universal mandated service at that time would have provided one ante-natal visit. Interviewed staff by the IMR author report that they worked hard despite decreased staff levels to deliver the service to their clients.

2.6.6 Henrietta engaged well with the Health Visitor (HV) ante-natal service. The HV who visited her does not remember Henrietta specifically and her records detail no concerns. Peter was present for the second ante-natal visit and presented as more anxious than Henrietta but this was considered to be within the normal limits of paternal behaviour. The experienced HV who visited Henrietta has stated that, if there had been any concerns related to Henrietta, she is sure she would have remembered the family. The HV stated on interview that her records suggested that Henrietta presented as a young, well-supported, sensible mother who did not raise any concerns requiring additional help.

2.6.7 The Family Health Assessment completed at the first ante-natal visit includes questions about domestic abuse, mental health and substance misuse. These questions were asked by the HV and no concerns or disclosures were made by Henrietta at this time.

2.6.8 On the second ante-natal visit Peter was reported to be in employment, the couple were hoping to move to independent accommodation and the assessment was updated with this information accordingly. The families were assigned a core, universal service which indicated that they did not require any additional, targeted help.

2.6.9 From this point onwards the family/child received a universal service. Henrietta and her son, Child 1, were seen at the following contacts; a New Birth Visit at home by the HV, a six-week check at home by the HV Staff Nurse (a trained nurse but not a Health Visitor), two clinic visits where they were seen by a Community Nursery Nurse (CNN) and a four-month home visit by a CNN.

2.6.10 Henrietta also attended an eleven-week post-natal group with her son, Child 1. This group was run by the CNN with some input from a HV. The sessions included sessions on baby massage, safety and women's health, including emotional health /post-natal depression. Henrietta attended every session and made friendships within the group. The CNN remembers Henrietta well and reported that Henrietta presented as a happy, outgoing woman who was a good mother. She demonstrated warmth, caring and a firm attachment to her child. No safeguarding concerns were raised during this period of professional involvement.

2.6.11 Fathers can and sometimes do attend the post-natal group but Peter did not attend. The group is run during the day and may be less accessible for fathers in employment.

2.6.12 On 23rd November 2012, Child 1 was taken to the A&E by ambulance with vomiting and dehydration. Both parents attended with him. The Emergency Department card records that Henrietta was a "happy and well-supported mother". Child 1 was discharged home following treatment.

2.6.13 On 13th May 2013, a one-year questionnaire was sent to the family home with advice to contact the HV if they had any concerns. This visit was normally carried out at home but the CNN staff member interviewed reported that they did not have capacity to complete the home visit and were advised by Clinical Leads to send a letter instead. There was no reply to this letter.

2.6.14 On 10th December 2013, there was a contact by the ESCC Integrated Screening Hub (ISH) regarding an MOGP1 from police. Arguing and cannabis use had been reported at the flat where Henrietta lived. This referral was followed up appropriately by the HV. One attempted visit was made on 21st January 2013, where an unidentified male answered the intercom at the flat and suggested another appointment was made. A home visit to Henrietta was made 8 days later on 29th January 2013.

2.6.15 At the home visit, the HV discussed the referral and the impact of domestic abuse on children. Henrietta reported that it was a "one-off". The couple now lived apart and she did not make any disclosure of further concerns. She also reported that she was pregnant at this time.

2.6.16 An ante-natal visit took place on 3rd March 2014, and after the birth of her second son, Child 2, a new birth visit took place on 2nd July 2014, by the HV. Peter was not present at these visits. There is no record of a six-week check being completed by the HV. The staff that were interviewed as part of the IMR process do not remember why this did not take place.

2.6.17 On 18th June 2015, the CNN completed a one-year check on Child 2 at home. Henrietta and Child 1 were present. Child 2's gross motor skills were delayed and an appointment was made to review this in September 2015.

2.6.18 The HV Team was notified of the death of Henrietta by the Specialist HV for Duty and Assessment on the day of her death.

2.6.19 Peter confirmed that he had no contact with these services as appointment took place when he was at work but that Henrietta would tell him about them. Because of his experiences with his sister, Peter often perceived anyone coming to the home as a social worker and would not have been clear about the differences in roles of health visitors and social workers and their respective duties and responsibilities.

2.7 Maternity Services, East Sussex Healthcare NHS Trust (ESHT)

2.7.1 The ESHT maternity service serves the population of East Sussex and care for around 3,300 women and their babies each year, during pregnancy, labour, birth and up until one month after birth. Midwives provide midwifery-led care in a number of settings, including local General Practitioner (GP) surgeries, children's centres

and within hospitals at Conquest Hospital consultant-led maternity unit and Eastbourne midwifery-led unit.

2.7.2 In 2011, Henrietta was seen by maternity services on five occasions which were all routine appointments. An ASF was generated due to Henrietta's age. This documented that information had been given about the teen support group and requests Additional Support Midwife (ASM) input. Peter reported as father to unborn and that Peter was unemployed at the time.

2.7.3 In 2012, Henrietta was seen on 7th January 2012. This was during an A&E visit which related to injuries sustained when falling down stairs. There is limited documentation about this visit and no evidence of exploration of the incident or exploration about how it happened. The notes do not comment regarding persons present for this appointment.

2.7.4 Henrietta had seven subsequent visits related to routine checks for pregnancy and birth. She included her mum and Peter in her birth plan. Child 1 was delivered in May 2012 with Peter and family present. She had a subsequent four visits related to general health and wellbeing of Henrietta and Child 1. Most of the focus of these visits was related to Child 1's jaundice. Henrietta was described on 24th May 2012 as having "a supportive mum and good network."

2.7.5 In 2013, Henrietta attended maternity services for a second pregnancy on 5th November 2013. Henrietta attended alone and was asked about domestic abuse and Henrietta did not disclose any abuse.

2.7.6 As Henrietta was 18 years old, this should have triggered an ASF however, an ASF was not created throughout pregnancy. She attended five appointments related to routine checks for pregnancy. She was urged to stay overnight on 22nd March 2014 due to bleeding but self-discharged stating that she had to go home for childcare reasons. She attended the following day as agreed. She then had another 13 visits to maternity services (a couple of which were 'phone calls) related to routine checks conducted during pregnancy and following delivery. Child 2 was born in June 2014. Peter attended after he finished work at 2pm that day. Four subsequent entries relate to routine visits related to the general health and wellbeing of Henrietta and Child 2.

2.8 Primary Care Service

2.8.1 Henrietta, Peter and their children were registered at a local medical practice, Henrietta registered in February 1995 and Peter from August 1995. Their children were registered at the same medical practice from their birth.

2.8.2 Records were viewed from the timescales estimated that Henrietta and Peter's relationship began (2009). At that time Henrietta was approximately 16 years old and Peter approximately 17 years of age.

2.8.3 Henrietta visited the surgery for a variety of non-specific medical complaints.

2.8.4 In October 2011 Henrietta, attended and reported to be pregnant, antenatal examination conducted and GP referred her to Midwifery services. There is no documented discussion with Henrietta regarding relationship status or the father of the baby.

2.9 East Sussex County Council (ESCC) Children's Social Care

2.9.1 According to CSC records, there was contact between Connexions staff and Henrietta when Henrietta was younger, from October 2008 to March 2009. There were a total of eight contacts which were not significant to this review.

2.9.2 There were three contacts pertaining to Peter as a child between April 1996 and July 2003 which are not significant to this review.

2.9.3 The remainder of this section will be designated to periods of contact in reference to either Henrietta or Peter's contact with CSC.

2.9.4 *Period of contact 1 with Peter:* On 9th November 2009, the Youth Support Team East received a Sussex Police Report (MOGP1). The report advised that Peter (15), then a pupil at Town 1 High School, went into school and carried out an unprovoked attack on another pupil. The police advised that the matter was being dealt with as an Actual Bodily Harm (ABH) offence. The notification was screened by a social worker and the outcome was that there was no further role for CSC. The rationale for this decision was that there was no existing social care involvement, no significant historic information, and the matter would continue to be dealt with by the police and the Youth Offending Team would become involved were Peter to be charged.

2.9.5 *Period of contact 2 with Henrietta*: On 5th September 2012, on the advice of Rother District Council, Henrietta (then 17 years old) contacted the Youth Support Team East to request a Homeless Assessment for access to accommodation. She reported that she had been "kicked out" of her mother's home with her 4-month old baby (Child 1) and was staying at the baby's paternal grandmother's house for a short period of time. She reported that she had no other family in the area and her sister was at University. Her details were recorded by an administrative support officer and were passed along for screening.

2.9.6 A Youth Support Team Caseworker made several unsuccessful attempts to contact Henrietta by phone to gain further information to inform the screening process. As her calls were not answered and there was no answerphone facility to leave message the Caseworker sent a text asking her to make contact. The possibility of the telephone number having been recorded wrongly is noted. There was no further contact from Henrietta and, with the recorded oversight of the Youth Support Team, East Practice Manager, the case was closed on the 20th September 2012.

2.9.7 Whilst all referrals are now screened through the Multi Agency Screening Hub (MASH), at that time the Youth Support Team's incorporated the Intake and Referral screening function for all contacts pertaining to young people 11 years and over. The Practice Manager reports having fewer qualified Social Workers in her team during this period. In the absence of any information of concern relating to the care of Child 1, the focus of the referral screening process was on Henrietta's needs.

2.9.8 Henrietta's baby's details were not recorded at the point of contact but would have been elicited during the process of gathering further information. As there had been no other entries for Henrietta on the CareFirst electronic records database the assumption was that there had been no previous referrals in respect of Child 1.

2.9.9 In advising Henrietta to self-refer for a Homeless Assessment, as opposed to the agency referring her, this indicated that Rother District Council had not identified any concerns regarding Child 1.

2.9.10 If the Youth Support Team had managed to make contact with Henrietta, the likely advice she would have been given would have been to remain at Child 1's grandmother's home until she was 18, in two months' time. At 18, she would be entitled to a tenancy in her own right.

2.9.11 Whilst best practice might suggest greater professional curiosity in recording the baby's details, exploring the reasons behind them being "kicked out" and contacting Rother District Council to double check contact details, the expectation would have been that Henrietta would make contact again.

2.9.12 *Period of contact 3 with Henrietta*: On 28th November 2013, CSC received a Sussex Police Report (MOGP1) detailing attendance at Henrietta's home address following reports of an argument at the property when the police had been contacted by neighbours. This referral was processed by CSC on the same day. On attendance, lights were off and entry to the property was initially refused. Cannabis could be smelt through the letterbox. Entry was gained and four adults were in the address in a smoked-filled living room.

2.9.13 Henrietta confirmed her partner Peter lived with her and their child. No signs of any disturbance or injuries and the situation appeared calm. The police saw Child 1 and felt his care was satisfactory and they were not concerned about his presentation or care. Parents were considered capable of looking after the child who was not at risk of being neglected. They did however note concerns about cannabis use in the property. The MOGP1 did not identify 'Evidence of Substance Misuse by Parents' as a factor within the Risk Assessment nor did it include any details regarding the other two adults in the flat.

2.9.14 The details included on the MOGP1 form do not include a DASH RIC form which is the national risk assessment checklist for domestic abuse used nationally. It was not until the introduction of the SCARF in 2014 that CSC were also sent these DASH RIC forms in cases where domestic abuse had taken place or was suspected.

2.9.15 As in this case, MOGP1s are not routinely uploaded to the relevant adult's electronic case files but only to the child's case file.

2.9.16 The expectation is that once this report is sent to CSC, a Triage Decision is made and recorded within 24 hours. This is based on an assessment of the level of risk and need included in the initial contact and the framework used is the Continuum of Need.

2.9.17 On the 5th December 2013, the Duty and Assessment Team Practice Manager recorded that the needs were screened at Level 3 Continuum of Need. There was screening activity between 28th November 2013 and 5th December 2013. For a case at Level 3 there is an expectation that a previous history of CSC involvement would be ascertained from the records to inform this decision. It is noted in this case that there was no previous history for the children at this time. A check was made against the Children's Index to understand whether any other professionals are already working with the family.

2.9.18 The Practice Manager made the decision to refer directly to Early Help services through the local Team Around the Family meeting (TAF) without taking the matter to the Integrated Screening Hub (ISH). The Practice Manager had the option of asking for the case to be presented and discussed at the Integrated Screening Hub (ISH) attended by key Early Help professionals, to either gather further information or to inform decision making within 72 hours.

2.9.19 As was common practice at that time, the Tracer Card was used for the referral to TAF. The referral included details of the incident taken directly from the MOGP1 but focused the request for support on the substance misuse and smoking.

2.9.20 Errors in the recording of both parents' names on the MOGP1 were carried over to Tracer Card. Duplicate P (case file) numbers were created for Henrietta and Peter, possibly due to the incorrect surnames provided. There is a possibility that the historical information held on the parents pre-existing case files was not identified and cross referenced during the screening process because of this. It is however unlikely that the historic information held would have had much bearing on the assessment of risk or need and decision to refer to TAF.

2.9.21 *Period of contact 4: December 2013 – 28 January 2014*: The family was considered at the TAF meetings on 10th December 2013, 21st January 2014 and 28th January 2014. At each meeting it was agreed that the Health Visitor for the family should set up a home visit. The TAF meetings felt the cannabis smoking near a child should be addressed by the health visitor which seemed an appropriate response given the information that had been provided by the Drug Action Team.

2.9.22 At the meeting on 21st October 2014 the Health Visitor reported that she had written asking for a meeting on the 28th of January. There is no record of any further discussion of the family at a TAF meeting. At that time, it would have been expected that the case would be reviewed at a further meeting. A review did not take place on the 4th February 2014, as the TAF administrator did not add the case to agenda and although there was a regular administrator for the Town 1 meeting at times one of the other two administrators would cover. All TAF notes now have a record of who the chair and administrator are for each meeting which ensures clarity about responsibility. At the time there was an expectation that cases be reviewed, this practice has since been changed and cases are no longer reviewed unless they are open for more than nine months. There is an expectation that professionals undertake the tasks agreed at the meeting. Information about contact by the HV service is being submitted separately by the ESHT safeguarding team.

2.9.23 *Period of contact 5*: *September 2014 – 16 June 2015*: A number of contacts took place between Henrietta and the [REDACTED] Children's Centre nursery in Town 1, about the attendance of her son Child 1. The Centre had no safeguarding concerns for Child 1. Child 1 appeared well cared for and was dressed appropriately. Henrietta was always positive and she engaged very well with the setting. The practitioners remember her as happy and upbeat. She was never withdrawn and always came into the nursery to hold discussions with practitioners and was happy to answer any questions regarding Child 1, including why they had been absent from nursery. She was always keen to share with the Centre what she and Child 1 had been doing, and these examples never included Peter. Peter was not known to the Centre as he never dropped off or collected Child 1 from nursery.

2.9.24 Child 1's attendance was poor and the Centre had formal and informal conversations with Henrietta regarding this. After a formal meeting Henrietta started

to ring the Centre when Child 1 was going to be absent, and although this did not improve Child 1's attendance, they were able to have conversations with Henrietta and record the reasons for absence more accurately. Practice has recently been changed in line with the new Ofsted Common Inspection Framework Sept 2015 that asks early years' settings to monitor attendance in preparation for required attendance the following year. Services have formed a rigorous system of monitoring attendance and have considered when low attendance becomes a concern. However, a system of attendance monitoring was followed in this case which did not lead to any disclosure.

2.9.25 Child 1's key worker had informal discussions with Henrietta as Child 1 needed some support in managing their feelings and behaviours. Henrietta reported similar behaviours at home. These behaviours were age-appropriate and centred on difficulties in sharing and causing conflicts with other children. There was no delay in Child 1's personal, social and emotional skills. This was all supported through appropriate next steps and activities within the setting. Child 1's behaviour did not have any noticeable pattern e.g. particularly challenging after a weekend or period of absence etc.

2.9.26 A meeting was called in May 2015 to support attendance and Child 1's behaviour as the key person felt Child 1 needed consistent boundaries between home and nursery for Child 1 to continue to make progress in managing these concerns. During the meeting the key worker was also going to discuss the possibility of a speech and language referral. The setting used the speech and language therapy flowcharts for when to refer to support them in this decision making, although this took longer than would have been ideal because of the poor attendance over the summer break.

2.9.27 *Period of contact* 6: On 3rd August 2015, Sussex Police emailed a SCARF relating to an incident that took place on the 2nd August to the Duty and Assessment Team East inbox. The system was and is for the Duty Administrative Support Officer to check the DAT East Inbox 4 times a day for referrals.

- All referrals are printed.
- Details are cross referenced with the CareFirst data base and if the family are an 'open case' the referral is passed to the relevant team.
- If the family are not known, their details are added to the database, reference numbers are created and the referral passed to Screening.
- If the family are already known but not an open case the referral is passed to Screening.
- No emails should ever be deleted as they are filed in electronic folders.

2.9.28 This SCARF was not screened as it had been inadvertently deleted from the Duty In-Box by a member of the administrative staff before it had been screened by the Social Work staff. The mishandling of the SCARF was identified during a discussion between a Social Worker and the Police on the day of Henrietta' death, 28th August 2015. The document was uploaded to CareFirst that day.

2.9.29 Due to the inadvertent SCARF deletion, the following information was not known to CSC from 3rd August 2015 until the date of the murder on 28th August 2015. The Initial Contact related to a physical assault by Peter (thought to be separated at the time from Henrietta) on both her and a friend whom Peter had suspected of having a sexual relationship with Henrietta. Peter was arrested for Common Assault on Henrietta (spitting at her though the letterbox) and Assault Occasioning Actual

Bodily Harm on MALE 1, an adult male who was with Henrietta on that evening. The SCARF states that it was not clear who was caring for the children at the time of the assaults although it is noted that when Henrietta returned to her own flat the children were being cared for by the paternal grandmother.

2.9.30 Peter was arrested to prevent any further offences occurring and was later charged with Common Assault and Actual Bodily Harm. A history marker was added onto the address by the police. Henrietta stated that this was the first violent incident between them.

2.9.31 The accompanying DASH RIC form relating to this risk of domestic abuse is scored at 5 and assessed as 'standard' risk. The score for referral to the local Multi-Agency Risk Assessment Conference (MARAC) is 14 (although accepting cases with lesser scores can happen based on professional judgment). The 5 affirmative answers relate to Peter harassing her through sending text messages and that he can be jealous.

2.9.32 The police recorded that the SCARF had been forwarded to CSC as they considered the family to be in need of support.

2.9.33 If the SCARF referral had been screened by the East Duty & Assessment Service, it is likely that the following actions would have been undertaken:

1) Initial Triage decision by Senior Practitioner within 24 hours of receipt.
2) Children's Index checks to ascertain whether any Early Help professionals were working with the family.
3) If assessed at Level 2 on the Continuum of Need the details would be forwarded to Early Help professionals identified via the Children's Index check with no role for CSC.
4) If assessed at Level 3 on the Continuum of Need a decision would then be taken about whether to present the case at the Integrated Screening Hub or to pass for Early Help support directly.

2.9.34 The retrospective view of the Operations Manager responsible for Duty and Assessment Teams is that the triage decision would have been to locate the SCARF referral at Level 2 on the Continuum of Need. Early Help is provided with Level 3 and enhanced services are provided with Level 2. The rationale for this decision is based on the fact that Henrietta had engaged with a DASH risk assessment and was supporting a prosecution of Peter. A history marker was added to her address by the police. This was reportedly the first violent incident between them. There is no information in the initial contact that would suggest that a Social Worker contacting Henrietta to discuss the incident would elicit more information than gathered via the Police SCARF.

2.9.35 It is noted that the current MASH practice is that Initial Contacts from a police source that have a Triage decision of Level 2 Continuum of Need would not be accepted as an Initial Contact and only now formally recorded as such if they meet the threshold for at least Level 3 on the Continuum of Need. However, this practice was not as well embedded in August 2015 as it is now and the SCARF was sent to East Duty & Assessment Team but not processed due to administrative error.

2.10 Home Works

2.10.1 Home Works is a service in East Sussex for those aged 16 to 64 (a single person, a couple or a family) who are homeless or at risk of losing of their home, and need support to live independently. It is a free service which provides flexible and tailored support to prevent homelessness.

2.10.2 Henrietta made a self-referral via the telephone to Home Works on 18th July 2012. The referral form on the client database states:

- Henrietta was living with her mother in a 2-bedroom house and she would like to move out and find her own accommodation.
- Henrietta had a 2-month old child and wanted to be independent.
- Henrietta needed support to find her own accommodation and support to fill in forms.
- Henrietta was claiming Income Support and Child Benefit.
- Henrietta had been to Rother District Council for housing solutions, but nothing had progressed as of the date she made the self- referral.

2.10.3 According to the notes and referral form on the client database, Henrietta did not disclose any information regarding risk of harm to herself to the Gateway Officer during the self-referral telephone call.

2.10.4 The Home Works Gateway Officer booked a telephone assessment with Henrietta for 20th July 2012 to gather further information on Henrietta's support needs and eligibility for the Home Works service. The referral form states that Henrietta preferred to be contacted on her mobile. There is no indication on the client database of why a telephone assessment was a preferred method.

2.10.5 On the 20th July 2012, a Home Works Gateway Officer telephoned Henrietta's previously given contact telephone number to complete a telephone assessment as arranged previously on 18th July 2012. Henrietta did not answer the telephone. The notes on the client database do not state whether a voicemail message was left.

2.10.6 On the 23rd July 2012, a Home Works Gateway Officer called the telephone number as given by Henrietta to re-arrange an assessment. Henrietta did not answer the telephone. The Home Works Gateway Officer left a voicemail message asking Henrietta to make contact with Home Works; this message included the Home Works Gateway telephone contact number.

2.10.7 On the 31st July 2012, a Home Works Gateway Officer called the telephone number as given by Henrietta to re-arrange an assessment. Henrietta did not answer the telephone. The notes on the client database do not state whether a voicemail message or the Home Works Gateway contact telephone number was left during the attempt to call Henrietta on the 31st July 2012.

2.10.8 On the 1st August 2012, a Home Works Gateway Officer sent a text message to the telephone number as given by Henrietta, asking her to contact the Home Works Gateway if she would like to rebook the assessment. Henrietta did not reply to the text message.

2.10.9 On the 3rd August 2012, following no response from Henrietta, the referral was closed to Home Works.

2.11 Victim Support

2.11.1 Victim Support is a service for victims of crime in Sussex. They are an independent charity which members of the public can contact them regardless of whether they have had contact with the police or not. They advertise a phone line, with opening hours on Monday through Saturday, and advice via their website. The website states that their local Victim Support team will ensure callers get the information and support and cite examples such as arranging a meeting, emotional support and speaking in confidence, help to fill out a compensation form, or get advice on how to make one's home more secure. They will also refer callers to other specialist organisations.

2.11.2 Victim Support is commissioned by the Police and Crime Commissioner in Sussex to provide support to domestic abuse victims who come in to contact with the police who are deemed to be at 'standard' risk and where the perpetrator has been charged with a crime.

2.11.3 Victim Support received a referral related to Henrietta on the 4th August 2015 via automatic Data Transfer from Sussex Police. This was two days after the incident took place. The case was flagged as domestic abuse; with perpetrator named as an ex-partner. The information received included the charge, location (type, description and occupancy), and victim age, relationship to the offender, offending behaviour, injury, victim resistance and free text. The information given was correct and the injuries were described as "none".

2.11.4 As per arrangements at the time, Victim Support did not receive a copy of the DASH RIC from Sussex Police, nor did they receive any indications of the level of risk (standard, medium or high).

2.11.5 On 7th August 2015, five days after the police incident and four days after the referral to Victim Support from the police, the first attempt was made to contact Henrietta but there was no contact made and no reply from Henrietta.

2.11.6 On 8th August 2015, six days after the police incident and five days after the referral from Sussex Police, successful telephone contact was made.

2.11.7 The Victim Support contract specifies 3 calls within 48 hours of the receipt of a referral.

2.11.8 Henrietta was willing to engage but declined completion of DASH RIC and offer of support. She stated that "everything is settled down now." In this conversation Henrietta confirmed the following:

- She was not in contact with another domestic abuse support service.
- She was not aware of being referred to a MARAC in the past year (she had not - this is simply as standard question asked in a first contact).
- Her age.
- Peter was not living with her at the time.
- Peter had been arrested.
- She thought he may have bail conditions but was not sure.
- She confirmed that the situation has not escalated since her contact with police.

2.11.9 Henrietta was advised to call 101 to check bail conditions and she was given the National Centre for Domestic Violence (NCDV)[9] number which was texted to her. She was given the Victim Support phone number if anything changed or if she felt she needed further help. She was advised to call 999 if needed and was given basic safety planning advice regarding seeking help from friends and family and thinking through safe spaces in her home.

2.11.10 Victim Support policy is that if the client does not wish to answer their DASH RIC questions, Victim Support asks basic safety planning questions and will try to make a professional judgment about the risks that are being disclosed.

2.11.11 Victim Support indicated that they had been working with senior Sussex Police colleagues for two years to try to resolve issues related to the DASH RIC sharing of information and possible duplication of risk assessment with victims to domestic abuse. It is not Victim Support's policy to require receipt of the SCARF form as they carry out their own DASH RIC on first successful contact with the client.

2.12 Affinity Sutton

2.12.1 Affinity Sutton, part of Clarion Housing Group, is one of the largest providers of affordable housing in England with over 125,000 homes and a 100-year history. Affinity Sutton covers over 100 local authorities and has over 1,000 employees.

2.12.2 Affinity Sutton organises support for tenants by specialist operational teams. For example, there is a Lettings Team, a Customer Service Team, a Housing Management Team, a Maintenance Team, a Finance Team etc. This means that a tenant may interact with multiple employees of Affinity Sutton depending on the issue to be addressed or resolved.

2.12.3 Most queries from tenants or other professionals are taken via a Contact Centre. A case recording system logs calls, the issue(s) identified and the query is assigned to a workflow. This way calls are closely actioned to ensure efficient and effective communication.

2.12.4 Housing Officers at Affinity Sutton often cover a large geographical area. In the case of the Henrietta's Housing Officer, this could be as large as 700 properties. Housing Officers work to an action planning system of 'process reporting' whereby the call centre, colleague or the housing officer themselves will generate a 'process report' which indicates that something should be actioned related to the property or tenant at any given time. This means the work of Housing Officers is monitored and they are held to account for addressing their process reports at any given time. A Housing Officer may have between 30-100 active process reports at any given time to aid them in keeping track of work or attention required for the hundreds of properties and tenancies for which they are responsible.

2.12.5 Affinity Sutton had a domestic abuse policy and procedure at the time that Henrietta was a tenant. This policy was not used in this specific case because the process logs (report of incidents) related to Henrietta were deemed to be related to Anti-Social Behaviour (ASB) or more general "Tenancy Issues". For example, calls or

[9] The National Centre for Domestic Violence (NCDV) provides a free, fast emergency injunction service to survivors of domestic violence. For more information, go to http://www.ncdv.org.uk/

reports were logged under the category of 'noise nuisance' in line with the 'Anti-Social Behaviour' procedure, or more general 'tenancy issues'. Calls are only logged and categorised as 'domestic abuse' when the call is overtly labelled / reported as 'domestic abuse'. In those cases, the appropriate domestic abuse policy and procedure is followed, as well as when a victim contacts the Association seeking support, advice and or help.

2.12.6 Henrietta held a tenancy with Affinity Sutton from 15th July 2013 until her death. She held a sole tenancy and lived with her young children. Henrietta had a baby during the tenancy but did not officially notify Affinity Sutton of this. Their records only show that Henrietta had one child.

2.12.7 During the tenancy, the Housing Officer visited Henrietta on a number of occasions at her property. She stated that at no time did she have any cause for concern for Henrietta's safety or the safety of Henrietta's child/children. Henrietta came was described as happy in demeanour and a good mother.

2.12.8 Henrietta had a Housing Officer who was long standing in post and therefore well known to neighbours and to local services such as the police, through partnership working. In this case, the Housing Officer was able to pick up information about Henrietta during interactions with neighbours during regular visits to their area.

2.12.9 A couple of months into Henrietta's tenancy on 25th September 2013, a neighbour approached the Housing Officer while on a regular visit to the area, and requested that the Housing Officer contact Henrietta about noisy arguments that were disturbing her household. Quotes were recorded as that Henrietta was screaming at 3:30 am to "pack your bags and leave." The Housing Officer wrote to Henrietta about the noise and Henrietta did not respond. As no further complaints were made, the case was closed, in line with the 'Anti-Social Behaviour' policy and procedure.

2.12.10 Two months later, on 28th November 2013, Henrietta called Affinity Sutton to make a complaint about being disturbed by her neighbour. This happened to be the same neighbour who had complained about Henrietta. The relationship between this neighbour and Henrietta is unclear and it is not known if Henrietta knew or suspected that her neighbour had initiated the complaint two months prior. This would not have been communicated via Affinity Sutton in any way. The Housing Officer dealt with Henrietta's complaint and the case was closed.

2.12.11 Approximately four months later, on 10th March 2014, the same neighbour made a second complaint about being disturbed by Henrietta and her partner arguing at night, as well as being disturbed by the sound of Henrietta's child running around the flat. No safety concerns were raised. The Housing Officer wrote to Henrietta and Henrietta responded to explain that her partner visits to see their son but he did not stay overnight so the noise reported by the neighbour was probably her "screaming at her child" and she would change her behaviour.

2.12.12 One month later, on the same day, both Henrietta and her neighbour called Affinity Sutton to complain about each other. Their versions differed but were to do with the neighbour going to Henrietta's property to speak about "banging" that was disturbing her child. Peter was mentioned in the complaint stating that he was allegedly verbally abusive towards the neighbour. Henrietta stated that the neighbour started the argument. No other neighbours reported any disturbance that

evening. The Housing Officer acknowledged these complaints and they were deemed to be resolved.

2.12.13 Nearly 16 months later, on 3rd August 2015, a tenant friendly to Henrietta mentioned to the Housing Officer on routine visit to the area that police had attended Henrietta's flat. The Housing Officer contacted the police for information and they stated that Peter was trying to gain access to the property due to an earlier incident with another male. He was arrested for assault on the other male and Henrietta. The other male would not support police action, so no charges were made against him. The Housing Officer was told that Peter admitted spitting at Henrietta through the letterbox and was cautioned for this. The police did not advise of any risk to Henrietta or suggest any action to be taken by Affinity Sutton. No further action was taken by the Housing Officer since there were no further complaints and no obvious on-going risks identified.

2.12.14 Peter reported similar experiences in relation to the neighbour which indicates that the record keeping of events in relation to this were well recorded and accurate. He reported that he and Henrietta had discussed, and were concerned, that Henrietta was the sole tenant and that he often resided in the flat. Peter said they had agreed that if it were raised by the landlord, he would move to his mom's for a short time.

3. Analysis

3.1 Domestic Abuse/Violence Definition

3.1.1 The government definition of domestic violence and 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. This can encompass, but is not limited to, the following types of abuse: psychological; physical; sexual; financial; and emotional.
- Controlling behaviour is: a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.
- Coercive behaviour is: an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim

3.1.2 Evidence of coercive and controlling behaviour was present in Henrietta and Peter's relationship. This is most evident in her disclosures to her family which are evidenced in excessive phone calls and controlling behaviour when Henrietta was outside of the home. The extent of physical violence is unknown before the time of the murder but it is clear from Henrietta's admissions to friends and family that she was subject to physical violence.

3.1.3 The responsibility for the tragic death of Henrietta rests solely with Peter. The following sections outline the reflections of the Independent Chair of the Review and Review Panel with regard to possible missed opportunities to help and support Peter and Henrietta as well as areas of improvement needed in East Sussex.

3.2 Key Issues Arising from The Review

3.3 Sussex Partnership NHS Foundation Trust (SPFT)

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

3.3.1 The primary focus of the referral is in relation to determining if the person in custody is a risk to him/herself but PCLDS colleagues also state that an additional purpose is to determine if there are unmet needs of the offender. It seems that in Peter's case an unmet need would have been the stress he was demonstrating due to the

breakdown in his relationship with Henrietta. Peter was given helpline information for mental health but was not provided with specific information related to support for those who are experiencing relationship breakdown and / for whom there may be a concern that they are perpetrating domestic violence and abuse.

3.4 **The East Sussex Safer Communities Partnership**

Considering learning for the wider partnership, if Peter had disclosed relationship problems, it may have been appropriate for professionals to provide information on sources of help and support. There is a national helpline that Peter could have been signposted to for confidential support and advice (the Respect Phoneline)[10] and professionals should be aware of this information and it is not clear that is always the case.

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

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

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

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

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

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

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

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

The maternity care provided to Henrietta during two pregnancies is viewed as quality obstetric care, which provided the positive outcome of safe delivery of her two children. Henrietta support systems were recorded as good and she was described as a happy, well-adjusted mum. During the period of care for the pregnancy of Henrietta's first child, Child 1, an ASF was in place due to Henrietta's age. Safeguarding supervision within midwifery had not commenced at that point. Contact by Additional Support Midwife (ASM) was requested but no documentation is present to establish if contact was made.

3.6.1 There are two occasions when the professional curiosity of the midwives should have been adopted. On 7th January 2012, there is documentation relating to Henrietta having a "fall down the stairs" and sustaining a head injury. The entry fails to provide adequate information surrounding the incident. Henrietta initially presented at A&E where she was briefly assessed. It could be that the midwife assumed the details of the situation thorough background information that had been gained from A&E. It would have been appropriate to update the Additional Support Form in this instance. There is no further evidence of follow-up conversations about the incident.

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

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

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

3.7 **Primary Care Services**

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

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

3.7.2 In January 2012, a discharge summary is received from Accident and Emergency (A&E) detailing Henrietta attending with abdominal pain following a fall, there is no

documentation within the records of this being explored or discussed with Henrietta when she attended the surgery.

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

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

3.7.5 Consultation/attendances at the surgery from this date forward regarding Henrietta, Peter or their children (Child 1 and Child 2) are routine in nature and relate mainly to ante-natal care, post-natal care and routine immunisation of the children.

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

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

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

All contacts with the family were completed as per the health visiting service specification at that time, with the exception of the six-week visit following Child 2's birth. Henrietta received a more intensive service because of the Goodstart Programme for her first child, Child 1. This meant she had two ante-natal visits and eleven post-natal group sessions. She always presented as a capable, caring parent who engaged well with the service.

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

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

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

3.8.4 It is not documented if there was a missed opportunity after the incident on 10th December 2013 when there was a contact by the ESCC Integrated Screening Hub (ISH) regarding an MOGP1 from Police. This was the incident when the police had been called when there was arguing and cannabis use at the flat where Henrietta lived. Noted good practice is that the Health Visitor ensured that Henrietta was visited after this incident. Henrietta reported the incident as a "one-off." The detail of Henrietta's conversation with the Health Visitor was not noted and it may be that safety-netting advice was given. It is an important learning point for Health Visitors (as well as all frontline professionals) that these opportunities are critical so that patients know the range of services offered in Sussex should they ever need it. Often survivors of domestic abuse do not know there is independent support and advice beyond that of statutory services.

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

There is also a clear deficit of documented acknowledgement concerning the presence of Peter. It is recognised as a failure of services to identify and adopt professional curiosity regarding men around the family in previous serious case reviews. Henrietta's maternity records do not reflect the state of her relationship and her family dynamic.

3.9.1 This review reflects an ongoing pattern of findings related to the invisibility of fathers in both national and local findings. A Serious Case Review, a result of the deaths of two children (Child J and Child K)[11] was commissioned by the East Sussex Local Safeguarding Children Board in December 2011 and states, "opportunities were missed to develop a fuller picture of what was going on and what standards of parenting were available from both mother and father … and this would have been assisted by a fuller assessment process...". The actions are overseen, and progress monitored, by the Local Safeguarding Children Board's Case Review Group.

3.10 **Sussex Police**

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

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

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

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

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

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

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

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

3.10.5 However, of the five members of staff involved in the paper trail for the incident on2nd August 2015, only two of them had attended the mandatory training for first responders. Whilst every effort has been made to ensure that first responders attend the mandatory training a number of members of staff have not attended and attendance on the Domestic Abuse workshop training is voluntary.

3.11 East Sussex County Council (ESCC) Children Social Care(CSC)

There were three issues identified in relation to CSC during this review.

3.11.1 The first was an acknowledgement that Youth Support Team did not manage to contact Henrietta when she disclosed being "kicked out" of her home with a child when 17 years old. Whilst best practice might suggest greater professional curiosity; in recording the baby's details, exploring the reasons behind them being "kicked out" and contacting Rother District Council to double check contact details. The expectation would have been that Henrietta would make contact again but a learning opportunity with this review and with other related reviews is that reflection is required as to how to properly engage young people. The Single Point of Advice would now be responsible for this contact and would link efforts back to the continuum of need.

3.11.2 The issue identified related to the instance when Henrietta's referral from the police to CSC following police attendance at her home was lost due to an administrative error. Whilst no system is infallible, the service needs to ensure that the

administrative processes are as robust as possible to avoid omissions and errors. If the SCARF referral had been appropriately actioned the retrospective view of professionals at CSC is that it would have been at a low level of concern and Henrietta's reaction to a further assessment and/or contact with CSC cannot be known.

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

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

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

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

3.12 Victim Support

Henrietta was referred to Victim Support two days after the police incident. This referral came to Victim Support on a Tuesday and the attempt to reach her was not until Friday. The contract with Victim Support is to offer support within 48 hours which did not happen in this case.

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

3.12.2 It was also unclear if, given a more accurate picture of risk at the time of the referral, this would have allowed for Victim Support to use professional judgment in terms of risk. Henrietta was recently separated for the first time with very small children and other risk factors at play such as jealousy, recent violence, the mental health and

previous violence and substance misuse of Peter and escalation. Henrietta was stating she was surprised by the actions of Peter over past weeks. It would heavily depend on the conversation and concerns of Henrietta but it could be that Henrietta's risk assessment might have changed to a higher concern for her immediate safety and that of her children. It is clear that the referral arrangement did not allow for professionals at Victim Support to get off to the best start with the information they were given.

3.12.3 Records indicate that the National Centre for Domestic Violence (NCDV) number was provided to Henrietta and not the National Domestic Violence Helpline.[12] The NCDV provides a free, fast emergency injunction service to survivors of domestic violence. During Henrietta's contact with Victim Support Henrietta had indicated that "everything is settled down now." Providing information on injunctions would therefore be unlikely to be the most appropriate offer; in contrast providing more general information about the National Domestic Violence Helpline and local specialist services would have been more appropriate.

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

3.13 **East Sussex Safer Communities Partnership and the Office of the PCC**

The referral pathway at the time of Henrietta's referral in early August of 2015 left victims of domestic violence abuse exposed to potential pitfalls in their offer of support. If a victim was assessed by the police to be high or medium risk, they were referred to the local specialist domestic abuse service. For those deemed to be standard risk, they were referred to Victim Support. There is no referral pathway for victims who come to the attention of the Police where there is "non-crime." Henrietta's sister felt strongly that Henrietta would have benefitted from a proactive phone call in the week after the case had been closed by Victim Support or No Further Actioned by the Police. She felt that additional effort could be made to try to engage people in situations where the whole situation or risk level is unclear.

3.14 **Affinity Sutton**

They addressed the initial complaint related to arguments as per their antisocial behaviour policy and as such, the Housing Officer did what would be expected as per that policy. This did not recognise the context which could have indicated domestic abuse and neither did it trigger a child safeguarding referral. Henrietta was reported to have been screaming at 3:30 am to "pack your bags and leave." It may have indicated to the Housing Officers that the noise was related to a relationship breakdown. The letter to address the 'anti-social behaviour' could well have served to silence Henrietta by thinking that she was perceived to be a problem whereas by referring to the DA policy, it may have provided an opportunity to determine if Henrietta required support or signposting to services.

3.14.1 Following the second complaint letter, Henrietta contacted her Housing Officer to deny the noise between her and a male stating it was more likely her shouting at her son and that she would adjust her behaviour. As no further complaints were received from the complainant, no further action was taken. Again, this may have

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

been an opportunity to signpost or offer support related to relationship breakdown. Nor did the no further action consider the impact on the children and therefore a referral to CSC, which in turn may have elicited more information regarding domestic abuse. As Henrietta was young and this was her first tenancy, it may have been that she was attempting to ensure that the Housing Officer did not think Peter was living with her due to a perception that she would be required to let Affinity Sutton know if there were changes to those residing at the flat. Henrietta's sister reinforced the notion that she may well have been concerned to "be in trouble" with the housing provider.

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

3.14.3 Affinity Sutton does not regularly receive information from the police if a crime has taken place at their property. This was the case in early August 2015 when it was a neighbour who happened to report the police incident to the Housing Officer. The Housing Officer demonstrated appropriate curiosity to make enquiries with the police but did not take further action as a result of the information received in response to the enquiry and there being no further incidents being reported. Given this incident again indicated a relationship breakdown it may have been appropriate to consider proactively offering support and advice.

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

4. Lessons Learned and Lessons to be Learned

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

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

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

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

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

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

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

4.1.6 While it is clear that individual agencies and services offer safeguarding and DA training, in many instances these programmes of training are not offered on an ongoing basis. For this reason, and due to the fact that front line workers benefit from training with others from various services and organisation, the provision of multi-agency training should be prioritised. Further, this training should be

reviewed to ensure it adequately includes information and skills building to engage perpetrators of abuse. This would help address the "invisibility" issues outlined in this review.

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

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

4.2 **Acute Services, East Sussex Healthcare NHS Trust (ESHT)**
Mandatory training for all A&E staff in safeguarding procedures including domestic abuse is in place. This has resulted in a greater awareness and response to identifying and safeguarding adults and children where domestic abuse is suspected or confirmed.

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

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

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

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

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

4.3.1 Safeguarding supervision is now embedded in midwifery practice within East Sussex Healthcare NHS Trust. Reflective practice, professional curiosity and awareness have increased. Practitioners need to conscientiously move away from the reporting of 'all well, no concerns', to be replaced by a meaningful

engagement with women and supporters, demonstrating active listening and responsive reaction.

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

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

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

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

4.4 **Hastings and Rother Clinical Commissioning Group**

During 2016, Hastings and Rother Clinical Commissioning Group (CCG) Healthy Hastings & Rother Programme are piloting a service targeted at reducing health inequalities arising from domestic violence which will be in Hasting and St. Leonard's areas only. These pilots aim to improve identification, response and the use of appropriate referral to specialist services for people affected by domestic violence in health settings. While the activity delivered as part of this pilot will be provided by CGL, it will be aligned to the delivery of the wider specialist service provision in East Sussex delivered by The Portal. With reference to ESHT, this includes a Health Independent Domestic Violence Advisor (HIDVA) within A&E at the Conquest Hospital and (where appropriate) other delivery options for example the Maternity Unit and genitourinary medicine (GUM) clinic.

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

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

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

4.6 **Primary Care Services**

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

4.6.1 Given the findings related to GPs in relation to domestic homicide reviews[13] and other research and guidelines including the NICE Guidelines for domestic abuse, GP surgeries should do all they can to be domestic abuse aware and to link to local Safeguarding training and practice in relation to domestic abuse. All GPs should have materials in public spaces for their patients to access.

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

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

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

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

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

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

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

There is ongoing work to improve engagement of fathers within ESHT Community Services. The ESHT Health Visitor Service does encourage involvement of significant males and they are welcome at post-natal groups. There is some literature that has been developed specifically for fathers, some staff work flexibly to meet the needs of working parents and staff are aware of the Local Safeguarding Board course on involving males / information from Serious Case

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

Review Briefings and have access to a document produced by the Named Nurse Community which gives brief safeguarding advice on inclusion of men in a 'top ten tips format'.

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

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

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

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

4.9 **Sussex Police**

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

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

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

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

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

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

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

published their reports. Regarding Sussex Police this is entitled 'Sussex Police's approach to tackling domestic abuse'.

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

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

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

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

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

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

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

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

4.10 **East Sussex County Council (ESCC) Children Social Care (CSC)**
The following recommendations were made within the Individual Management Review for CSC which would serve to improve the aforementioned issues identified:

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

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

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

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

- To receive the DASH RIC from Sussex Police to enable the service to have a more accurate picture of risk prior to contact with standard risk victims (this will also allow Victim Support to more accurately identify Medium and High Risk Cases which should be referred to Specialist Domestic Abuse Services).
- To inform Sussex Police if a victim does not engage with the service
- Review the information provided about the sources of help and support locally, including the National Domestic Violence Helpline and local specialist services.

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

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

4.12 **Affinity Sutton**

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

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

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

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

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

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

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

5. Conclusions and Recommendations

5.1. Conclusions

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

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

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

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

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

5.1.6 The role of housing in the early identification of domestic abuse merits highlighting; Affinity Sutton is not alone is its lack of identification of domestic abuse and its mislabelling of this as anti-social behaviour. There are national standards of practice for domestic abuse in housing settings and all housing providers should adhere to these standards as they will have many tenants in a similar situation to Henrietta.

5.1.7 Importantly, it is not only professionals who require support and information about domestic abuse. Both Peter and Henrietta were surrounded by family and friends advising them and supporting them in the day, weeks and months before the murder of Henrietta. These family and friends knew much more accurately the situation and feelings of Henrietta. However, more needs to be done to ensure that

family and friends know pathways to support and when to encourage engagement with services, particularly in cases of first and recent separation.

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

5.2. Recommendations

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

5.2.19 **Recommendation 16: East Sussex Housing Operational Group**
Review practice related to the minimum standards for housing providers such as those promoted by the Domestic Abuse Housing Alliance[14] (endorsed in the national VAWG strategy).

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

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

Appendix 1: Domestic Homicide Review Terms of Reference

This Domestic Homicide Review (DHR) is being completed to consider agency involvement with Henrietta (following her death in late August 2015) and/or Peter (the alleged perpetrator).

In commissioning a DHR the East Sussex Safer Communities Partnership will:

1) Conduct the review in accordance with Section 9(3) of the Domestic Violence Crime and Victims Act 2004

2) Coordinate with any other review processes

3) Commission a suitably experienced and independent person to chair the DHR panel, co-ordinating the process, quality assuring the approach and challenging agencies where necessary; and to subsequently produce the Overview Report critically analysing the agency involvement in the context of the established terms of reference.

Statutory or non-statutory agencies that are asked to provide information for the purposes of the DHR will:

4) Note that a DHR places a statutory responsibility on organisations to share information. Information shared for the purpose of the DHR will remain confidential to the panel until the panel agree what information is shared in the final report when published

5) Secure all relevant records

6) Review the involvement with Henrietta and Peter during the relevant period of time: from the start of their relationship in 2009 to late August 2015

7) Review agency involvement prior to 2009, in order to search their records to ensure no relevant information was omitted

8) Consider issues of activity in other areas and review impact in this specific case

9) Provide:

    a) An **Individual Management Review**, using the template provided, identifying the facts of their involvement with Henrietta and/or Peter, critically analysing the service they provided in line with the specific terms of reference; identifying any recommendations for practice or policy in relation to their agency
    b) A **Chronology**, using the template provided, of agency involvement with the Henrietta and Peter during the relevant time periods, using the template provided
    c) Establish a clear action plan for individual agency implementation as a consequence of any Internal Management Review or panel recommendations

10) Agencies that have had no contact should attempt to develop an understanding of why this is the case and how procedures could be changed within the partnership which could have brought Henrietta or Peter in contact with their agency.

In undertaking the DHR:

11) The agencies that will participate as core panel members are:

a) East Sussex County Council - Adult Social Care / Children Social Care
b) East Sussex County Council - Safer East Sussex Team
c) Hastings and Rother Clinical Commissioning Group (who will manage any request for information or expertise from commissioned substance misuse services, mental health and other health services)
d) The Office of the Sussex Police & Crime Commissioner
e) A representative from 'The Portal', which provides support for survivors of abuse and violence in Brighton & Hove and East Sussex
f) Rother District Council
g) Sussex Police

12) The following agencies will be invited to participate in the panel, if this is appropriate:

a) National Homicide Service (to represent family of Henrietta, should they wish to engage with the review process)
b) NHS England Local Area Team
c) Other local commissioners were identified as relevant.

13) Take account of any parallel processes, relating to both the conduct of the DHR itself and the management of any disclosure issues, including: the criminal investigation, criminal trial, coroner's inquest or other reviews (e.g. by the Safeguarding Adults Board or Local Children's Safeguarding Board).

The panel will:

14) Explore the potential learning from this murder and not to seek to apportion blame to individuals or agencies

15) Critically analyse the incident and the agencies' responses to the family, specifically considering the following five points:

a) Communication, procedures and discussions that took place between agencies
b) Co-operation between different agencies involved with the victim, alleged perpetrator, and wider family
c) Opportunities for agencies to identify and assess domestic abuse risk
d) Agency responses to any identification of domestic abuse issues
e) Access to specialist domestic abuse agencies
f) The training available to the agencies involved on domestic abuse issues

And therefore:

g) Establish whether there are lessons to be learned from the case about the way in which local professionals and agencies work together to identify and respond to disclosures of domestic abuse
h) Identify clearly what those lessons are, how they will be acted upon and what is expected to change as a result and as a consequence
i) Improve inter-agency working and better safeguard adults experiencing domestic abuse.

The panel chair will:

16) Liaise as appropriate with the relevant criminal justice and/or other agencies responsible for any parallel processes as identified in 13 above.

17) Sensitively involve the family of Henrietta in the review, if it is appropriate to do so in the context of ongoing criminal proceedings. To explore the possibility of contact with any of Peter's family who may be able to add value to this process.

18) Conduct the process as swiftly as possible, to comply with any disclosure requirements, and provide an Executive Summary and Overview Report.

19) On completion, present the full report to the East Sussex Safer Communities Partnership.

The East Sussex Safer Communities Partnership will:

Establish a multi-agency action plan in response to any recommendations arising out of the Overview Report.

Appendix 2: Home Office letter

Home Office

Public Protection Unit
2 Marsham Street
London
SW1P 4DF

T: 020 7035 4848
www.gov.uk/homeoffice

James Rowlands
Strategic Commissioner
Partnership Community Safety Team
Brighton & Hove City Council
Hove Town Hall
Norton Road
Hove BN3 3BQ

15 December 2017

Dear Mr Rowlands,

Thank you for submitting the Domestic Homicide Review (DHR) report for East Sussex (Henrietta – Adult E) to the Home Office Quality Assurance (QA) Panel. The report was considered at the QA Panel meeting on 22 November 2017.

The QA Panel would like to thank you for conducting this review and for providing them with the final report. The Panel concluded this was a thorough review which is respectful to the victim and her family. The Panel particularly liked the sensitive representation of the victim's sister's views in the report. The Panel was also pleased to note that events are being planned to share the learning, which they considered to be good practice.

There were some minor aspects of the report which the Panel felt could be revised, which you will wish to consider:

- The action plan should be updated before publication;
- Please proof read for typing errors and missing words.
- Please also review anonymity as the real name and initials appear to have been used, e.g. paragraph 2.1.16. You may also wish to anonymise the ages and genders of the children in the report.

The Panel does not need to review another version of the report, but I would be grateful if you could include our letter as an appendix to the report. I would be grateful if you could email us at DHREnquiries@homeoffice.gsi.gov.uk and provide us with the URL to the report when it is published.

The QA Panel felt it would be helpful to routinely sight Police and Crime Commissioners on DHRs in their local area. I am, accordingly, copying this letter to the PCC for information.

Yours sincerely

Christian Papaleontiou

Chair of the Home Office DHR Quality Assurance Panel