Domestic Homicide Review
Executive Summary

Under s9 of the Domestic Violence, Crime and Victims Act 2004

Review into the death of Annette
in November 2019

Report Author: Christine Graham
June 2024

Preface

East Sussex Safer Communities Partnership and the Domestic Homicide Review Panel wishes at the outset to express their deepest sympathy to Annette's family and friends. This review has been undertaken in order that lessons can learned.

The Review has been carried out in an open and constructive manner with all the agencies, both voluntary and statutory, engaging positively. This has ensured that we have been able to consider the circumstances that ultimately culminated in this homicide in a meaningful way and address, with candour, the issues that it has raised.

The Review was commissioned by the East Sussex Safer Communities Partnership on receiving notification of the death of Annette in circumstances which appeared to meet the criteria of Section 9 (3)(a) of the Domestic Violence, Crime and Victims Act 2004.

Contents

The Review Process

This summary outlines the process undertaken by East Sussex Community Safety Partnership (the CSP) Domestic Homicide Review panel in reviewing the murder of 'Annette' who was a resident in their area.

The pseudonym of 'Annette' has been used for the victim in this case. At the request of the family, this name was chosen by the report author.

Annette was 39 years old when she was found murdered in November 2019. She was a white British woman who was registered disabled and suffered from a range of chronic health conditions.

The perpetrator will be known only as the 'perpetrator' in this case. He was 41 years old at the time of Annette's murder and is a white British man.

The victim's body was found secreted in a 'wheelie bin' in November 2019. The police instigated a murder investigation, and the perpetrator was subsequently arrested and charged with her murder.

He pleaded not guilty at court, placing the blame for her death on others. He was found guilty of Annette's murder after a trial in October 2020. He was sentenced to life imprisonment and to serve a minimum term of 22 years before he could begin any parole process.

This Review process began with a meeting of the multi-agency Domestic Homicide Review (DHR) Oversight Panel on 28th February 2020. The panel considered the circumstances and formed the view that the criteria for a DHR were met. The East Sussex Safer Communities Partnership met on 27th March 2020 and this decision was ratified. The Home Office were notified of the decision.

All agencies that potentially had prior contact with the victim and perpetrator were asked to confirm any such relevant involvement and secure their records. A total of eleven local agencies confirmed prior contact. Due to the nature of the movements of both the victim and the perpetrator around the country, this number increased significantly as the review progressed.

Contributors to the Review.

The following agencies contributed to the Review by way of Individual Management Review (IMR):

- CGL – domestic abuse services
- East Sussex County Council (ESCC) - Adult Social Care
- East Sussex Healthcare Trust
- GP for Annette
- GP for perpetrator
- Lewes District and Eastbourne Borough Councils – Housing
- MARAC (Multi-Agency Risk Assessment Conference) Support Team (Safer Communities Team, ESCC)
- Sussex Partnership NHS Foundation Trust
- Sussex Police

The following agencies contributed by way of summary report:

- Victim Support
- Refuge

All report authors were confirmed as independent through the process of review.

Additional research was conducted by other area CSPs on behalf of this Review. Derbyshire Police also contributed to the Review by way of their support for the victim's family who lived in that geographical area.

The Review Panel Members

The Review Panel comprised of the following:

Gary Goose MBE	Independent Chair	
Christine Graham	Overview Report Author	
Richard Christou	Designated Nurse, Safeguarding Adults	Sussex Clinical Commissioning Group (CCG)
Gail Gowland	Head of Safeguarding and Named Nurse Safeguarding	East Sussex Healthcare Trust
Michaela Richards	Head of Safer Communities	Brighton and Hove City Council and East Sussex County Council
Natasha Gamble	Partnership Officer for Domestic Abuse and Sexual Violence and VAWG	East Sussex County Council
Nicola Spiers	MARAC[1] Team Leader Brighton & Hove and East Sussex	East Sussex County Council
George Kouridis	Head of Service Adult Safeguarding and Quality	East Sussex County Council -Adult Social Care
Adrian Walshe	Team Leader Tenancy Services	Lewes and Eastbourne Council
Harriet Fitzgerald	Senior Specialist Advisor, Neighbourhood Housing	Lewes and Eastbourne Council
Bryan Lynch	Deputy Director of Social Work	Sussex Partnership Trust
Jane Wooderson	Detective Sgt, Safeguarding Reviews	Sussex Police
Debbie King	CGL East Sussex Domestic Abuse Service Manager	The Portal (CGL)

All panel members were independent of direct prior involvement with either party and were of an appropriate seniority within their respective organisations.

The panel met, in full, on four occasions, with several additional meetings being held with different agencies and the CSP to address specific aspects of the review. The review was completed in October 2022.

The Review was not completed within six months because the Chair and Report Author were not able to meet with Annette's family until after the COVID-19 lockdown. The family were kept up to date with the progress of the review, prior to meeting, by telephone calls and letters from the Independent

[1] Multi-Agency Risk Assessment Conference

Chair. The family and the Chair agreed that it would be preferable to wait until an 'in person' meeting was possible, both also agreed that it would also be prudent to await vaccination before that meeting took place. In person meetings subsequently took place with the family to discuss the intentions of the Review and to seek their engagement with it, their views and any issues that they felt needed addressing. A further meeting took place to discuss the draft report and a copy was left with them to read in their own time and to feed back any suggestions for change.

The Independent Chair and Overview Author

The Independent Chair for this review was Gary Goose MBE. Gary was a former police officer completing his career at the rank of Detective Chief Inspector in 2011. From 2011 Gary was employed by Peterborough City Council as Head of Community Safety and latterly as Assistant Director for Community Services. The city's domestic abuse support services were amongst the area of Gary's responsibility as well as substance misuse and housing services.

The Overview Author for this review was Christine Graham. Christine worked for the Safer Peterborough Partnership for 13 years managing all aspects of community safety, including domestic abuse services. During this time, Christine's specific area of expertise was partnership working – facilitating the partnership work within Peterborough. Since setting up her own company, Christine has worked with a number of organisations and partnerships to review their practices and policies in relation to community safety and anti-social behaviour. As well as delivering training in relation to tackling anti-social behaviour, Christine has worked with a number of organisations to review their approach to community safety. Christine served for seven years as a Lay Advisor to Cambridgeshire and Peterborough MAPPA which involved her in observing and auditing Level 2 and 3 meetings as well as engagement in Serious Case Reviews.

Together, Christine and Gary have completed a number of DHRs and Serious Case Reviews across the country. A full resume of their training and qualifications can be found in the Overview Report.

Terms of Reference for the Review

Terms of Reference for the Domestic Homicide Review into the death of Annette

1. Introduction

1.1 This Domestic Homicide Review (DHR) is commissioned by the East Sussex Safer Communities Partnership in response to the death of Annette that occurred in October 2019.

1.2 The review is commissioned in accordance with Section 9, The Domestic Violence, Crime and Victims Act 2004.

1.3 The Chair of the partnership has appointed Gary Goose MBE and Christine Graham to undertake the role of Independent Chair and Overview Author for the purposes of this review. Neither Christine Graham nor Gary Goose is employed by, nor otherwise directly associated with, any of the statutory or voluntary agencies involved in the review.

2. Purpose of the review

The purpose of the review is to:

2.1 Establish the facts that led to the incident in October 2019 and whether there are any lessons to be learned from the case about the way in which local professionals and agencies worked together to safeguard Annette.

2.2 Identify what those lessons are, how they will be acted upon and what is expected to change as a result.

2.3 Apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate.

2.4 Additionally, establish whether agencies have appropriate policies and procedures to respond to domestic abuse and to recommend any changes as a result of the review process.

2.5 Contribute to a better understanding of the nature of domestic violence and abuse.

3. The review process

3.1 The review will follow the Statutory Guidance for Domestic Homicide Reviews under the Domestic Violence, Crime and Victims Act 2004 (revised 2016).

3.2 This review will be cognisant of and consult with the process of inquest held by HM Coroner.

3.3 The review will liaise with other parallel processes that are on-going or imminent in relation to this incident in order that there is appropriate sharing of learning.

3.4 Domestic Homicide Reviews are not inquiries into how the victims died or who is culpable. That is a matter for coroners and criminal courts.

4. Scope of the review

The review will:

4.1 Draw up a chronology of the involvement of all agencies involved in the life of Annette to determine where further information is necessary. Where this is the case, Individual Management Reviews will be required by relevant agencies defined in Section 9 of The Act.

4.2 Seek to identify the journey that both Annette and the perpetrator made around the country and the different agencies that have been involved with them.

4.3 Produce IMRs for a time period commencing 5th September 2017.

4.4 Invite responses from any other relevant agencies, groups or individuals identified through the process of the review.

4.5 Consider the challenges that Annette faced in her life and impact this may have had on her vulnerability to the perpetrator.

4.6 Consider the challenges that agencies faced in safeguarding Annette as she moved around the country and any barriers to information sharing that occurred across areas.

4.7 Seek the involvement of family, employers, neighbours and friends to provide a robust analysis of the events.

4.8 Produce a report which summarises the chronology of the events, including the actions of involved agencies, analyses and comments on the actions taken and makes any required recommendations regarding safeguarding of families and children where domestic abuse is a feature.

4.9 Aim to produce the report within the timescales suggested by the Statutory Guidance subject to:

- guidance from the police as to any sub-judice issues,
- sensitivity in relation to the concerns of the family, particularly in relation to parallel enquiries, the inquest process, and any other emerging issues.

5. Family involvement

5.1 The review will seek to involve the family in the review process, taking account of who the family may wish to have involved as lead members and to identify other people they think relevant to the review process.

5.2 We will seek to agree a communication strategy that keeps the families informed, if they so wish, throughout the process. We will be sensitive to their wishes, their need for support and any existing arrangements that are in place to do this.

5.3 We will work with the police and coroner to ensure that the family are able to respond effectively to the various parallel enquiries and reviews avoiding duplication of effort and without increasing levels of anxiety and stress.

6. Legal advice and costs

6.1 Each statutory agency will be expected and reminded to inform their legal departments that the review is taking place. The costs of their legal advice and involvement of their legal teams are at their discretion.

6.2 Should the Independent Chair, Chair of the CSP or the Review Panel require legal advice then East Sussex Safer Communities Partnership will be the first point of contact.

7. Media and communication

7.1 The management of all media and communication matters will be through the Review Panel.

Summary Chronology

This review is indebted to Annette's family who have helped us to understand the nature of the illnesses and disabilities which Annette endured from birth.

We have used that information, together with any additional information that has come to light from her conversations with health and other professionals over the years to provide the summary set out below. The level of detail is intended to assist reader of this review in understanding the challenges faced by Annette. Its inclusion helps us look at life from her perspective. We have been particularly

careful to scrutinise the information to ensure that any personal and sensitive information Annette may have been deliberately withholding from her family is appropriately avoided. The information that is included is thus done so with the full knowledge and blessing of her family.

Annette was born with two unrelated medical conditions, both of which were diagnosed within her first two years:

- Russell Silver Syndrome: a rare congenital disorder characterised by short stature and restricted growth.

- Sacral agenesis: an unrelated congenital disorder due to a malformation of the sacrum, a bone at the base of the spine.

Annette was registered as disabled as a result of the conditions that severely affected her mobility. She used a mobility scooter. She experienced chronic health difficulties including recurrent urinary tract infections and anxiety.

At the age of 18, Annette's parents described how she made the decision to get married. They said that it seemed to help her in allaying fears that her disabilities made her unattractive to the opposite sex. Prior to her marriage, it became apparent that she had made acquaintances in the drug world and drugs also featured in her married life. When that short-lived marriage failed, she left her home area and headed to the south coast to put distance between her ex-husband and herself.

In 2001 an incident resulted in a crushed lower vertebra after falling from an apartment block window. There were fears that her spinal column may have suffered irreparable damage and that she might not walk again. However, after a successful major operation, she was flown back to her home area for in-patient rehabilitation and physiotherapy. Her parents describe how, as soon as she had regained some mobility, her determination to live life by her own rules saw her discharge herself from the hospital into temporary housing. Unfortunately, the spinal injury took its toll and she continued to suffer recurring episodes of back pain.

Annette disclosed, in her interaction with different agencies, that she suffered with several ailments including depression and anxiety, self-harming, Post-Traumatic Stress Disorder as a result of domestic abuse and major bladder problems that required pain killers. She also took methadone as she had previously been addicted to heroin.

Annette had experienced domestic abuse from a number of partners (five known to agencies) within a four-year period leading up to her death. Each of the circumstances were similar in that she had known each of the men for a short period of time and they all had similar circumstances and histories – homelessness, substance dependency, criminal history involving violence/often domestic abuse and acquisitive crime.

The Review is aware that both Annette and the perpetrator moved separately around the country on multiple occasions. The panel agreed that there was a danger that the review could become side-tracked by seeking to follow these moves. It was agreed that only pertinent history would be included. There is no evidence that has been revealed either during this Review or to the police murder investigation that suggests Annette had met this perpetrator until late August 2019, only a matter of a few weeks before he killed her.

Annette arrived at a refuge in East Sussex in September 2017 from a refuge in another area of the country after concerns that her safety had been compromised there.

On her arrival in East Sussex, she was supported by the refuge and her case immediately referred to the local MARAC. She registered with a local GP and also registered as homeless with the local housing authority; she was in significant financial difficulty. At a subsequent meeting with her GP, Annette revealed that the partner from whom she had fled was subject to an indefinite restraining order. Various referrals to local support agencies were properly made.

In October 2017 Annette was asked to leave the refuge due to safety concerns for other residents after drugs were found in her room. She was placed in temporary accommodation by the local authority pending a homelessness application.

Over the course of the remainder of 2017 and into 2018 she remained in temporary accommodation and in January 2018 the local authority accepted a full housing duty towards her. Some of her behaviours caused concern however and she was warned about the danger of eviction if safety issues persisted. She moved to new accommodation at the end of January 2018.

When Annette moved, she registered with a new GP but then re-registered back with her previous one as she was unhappy with her medication regime. She remained supported by support workers who were helping her with what were clear physical difficulties as well as some behavioural issues. She began close friendships with others in the area who quickly appear to have taken advantage of her vulnerabilities.

Evidence of this emerged when she became involved with the local police in April and May 2018 after firstly reporting a theft of personal items by a man she had got to know and then assaults and domestic abuse by another man with whom she had embarked upon an intimate relationship. Both men were separately known by police for serious previous offending, and both were involved in alcohol abuse. Neither of these reports resulted in prosecutions although Annette's vulnerabilities were recognised by use of the DASH[2] risk assessment process, including evidence of drug use and potential self-harm. Appropriate referrals made through the safeguarding processes.

Further incidents of difficulties with others who lived in the area continued and in October she left that address reporting to the local authority that she could not keep safe. A tenancy with an adjoining local authority area began after a short period of temporary accommodation.

Unfortunately, the move to a different area did not resolve issues as by March of 2019 she reported being sexually assaulted by a man with whom she had begun a sexual relationship a few months earlier. The man was arrested but there was insufficient evidence upon which to base a charge. However, Annette was recognised as a vulnerable adult suffering previous domestic abuse with ongoing serious health conditions. A safety plan was put in place (arrest suspect, conditions if released, marker on address, consider DVPN[3], door jammer, alert neighbours). A DASH was graded as medium risk. Practical support was provided to help Annette obtain her medication which it was alleged that the man had taken and ingested a few days before the incident and collapsed. Referrals to the IDVA[4] service were made and further work by the IDVA service followed to try and find additional support for her.

Services continued to be involved with Annette, but it was not until late August that it appears she met this perpetrator.

[2] Domestic abuse, stalking, harassment and honour based violence
[3] Domestic Violence Protection Notice
[4] Independent Domestic Violence Advocate

The perpetrator himself had a significant prior criminal history and was known to a variety of services across the country. In a pre-sentence report for a court hearing in 2013 he was described as posing a high-risk of harm to others and was thought to be manipulative, threatening and intimidating. He was part of the street homeless community and had moved down to the south of England first coming to notice there in late July of 2019 when he presented as homeless; shortly before he met Annette. He was drug and alcohol dependent and self-reported mental health issues but despite much involvement with services was never diagnosed with a recognised mental health condition.

There is minimal recorded information about the two knowing each other. However, the perpetrator began to become visible in Annette's life when she reported concerns about a man with whom she had begun relationship. She reported that the man had assaulted her after she had caught him using drugs at her address and had asked him to leave. It appears that this perpetrator was known in the same circles around this time. The police became concerned that others were taking advantage of Annette and using her property to deal drugs: 'cuckooing' her in recently used terminology. There are records that suggest this perpetrator was staying at the address now as he was homeless. By late September, Annette reported to the housing authority that a friend, who had been living in a tent, was now living there as he was otherwise homeless. The information makes it clear that this friend was in fact this perpetrator.

Various safeguarding measures had been discussed by agencies and with Annette following the concerns around 'cuckooing.' The male against whom Annette had made the most recent report was still in the area and may have been responsible for nuisance calls that Annette reported in early October. When police called to see her about this, this perpetrator told officers how he had been threatened by the same man and this was recorded by police and referrals made to Victim Support.

All the above safeguarding work was continuing up to the point of Annette's murder. The very latest interaction was a visit from a housing officer in October who was aware of the issues that had been reported and who was also responding to the need for a final tenancy inspection and calls from neighbours who had been complaining of regular visitors to the flat and smell of cannabis emanating from it. All these issues were discussed with Annette who was the only person present in the flat at the time of the meeting. She spoke openly of the perpetrator being a friend who she was helping because he had been living in a tent in the nearby park. She insisted that he was only a friend and that she had rejected 'advances' from him and told him they could only be friends.

It is widely acknowledged from the resultant police investigation that Annette was killed a couple of days after this last visit. Her body was found several weeks later discarded in a bin.

Key issues arising from the Review.

The relationship between Annette and the perpetrator

A Domestic Homicide Review is charged with attempting to identify a trail of abuse. In this case, it is unclear when Annette met the perpetrator and the true nature of their relationship. The judge, in sentencing him for her murder, referred to them as hardly knowing each other.

We know that he told her that he was sleeping in a tent. She felt sorry for him and allowed him to stay in her flat. This was despite the fear that she had of being subjected to harm because of her disability and frailty. She was so fearful of being broken into (as she had experienced in the past) that she kept a hammer under her chair. This was the very hammer that the perpetrator used to murder her.

Annette was a vulnerable woman who was supported by social services and had a flat that met her physical needs. The perpetrator, according to the judge, was jealous of her situation.

We know that Annette had deduced the type of man that the perpetrator was. The judge, in sentencing, said that she told people that he was a compulsive liar. Only a matter of days before her murder, she had asked the perpetrator to leave because of the impact on her assured tenancy. The perpetrator was determined not to go. On the day of her death, Annette sent an email to the officer dealing with her complaint against another male and said, 'could you call me ASAP, {the perpetrator} is getting abusive towards me and I want him out.'

He then set up a web of lies. He went out of his way to get to know Annette's friends to keep them close, telling them lies about her having gone away to ensure that they did not try to contact her or report her missing.

The perpetrator then proceeded to continue to claim Annette's benefits and collect her prescriptions. He set himself up in her flat and attempted to change her utility supply into his name, as well as buying luxury items for the flat. He removed the one photo that Annette had of her children from flat. He then proceeded to blame an innocent man for her murder.

This Review has looked at the **following issues**:

The risk that this perpetrator continued to pose in the community.

It is clear that the perpetrator had the capacity to manipulate individuals and organisations. The level of risk he posed, as indicated in pre-sentence reports back in 2013, was not recognised further by others. He presented to agencies with 'learning difficulties' and yet no assessment backed this up and under the close inspection of the court process, it was shown not to have the level of impact he intended others to believe it did.

Efforts to safeguard Annette

The Review Panel were concerned that the police had produced nine SCARFs[5] in 19 months and, whilst each had been dealt with appropriately, the cumulative effect of these does not appear to have been identified and considered a cause for concern and intervention.

The panel felt that Annette may have benefitted from a problem-solving approach or co-ordinated multi-agency response to her circumstances to protect her from harm from herself and from others.

The Review notes that every organisation who received the SCARF acted on it within their organisation. However, whilst any organisation could have identified the repetitive nature of the interactions with Annette and called a multi-agency meeting to explore how she could be supported and safeguarded in a holistic way, this was never done.

The Review considers that it would be helpful for there to be a system to identify individuals who repeatedly come to attention of agencies for the same or similar reasons so that a holistic review can be undertaken to prevent reoccurrence. This would ensure that the safeguarding measures are reviewed and re-evaluated to consider their effectiveness.

[5] Single Combined Assessment of Risk Form

The attraction of seaside towns to vulnerable people

The perpetrator had moved to the area from other parts of the country and the Chief Medical Officer, in their annual report in 2021[6], looked at health in coastal communities and identified that some coastal areas experience in-migration of a transient, vulnerable younger population driven by the availability of cheap housing. Directors of Public Health and local government leaders raise concerns, in this report, about the challenges of poor quality, but cheap Houses of Multiple Occupation, encouraging the migration of vulnerable people from elsewhere in the UK, often with multiple and complex health needs, into coastal towns. This has implications for both service provision and support.

One of the issues that the study highlighted was a lack of understanding by people about the need for a 'local connection' to be eligible for housing.

Understandably, those moving to the area often have multiple issues and have moved to separate themselves from those issues. When they apply for housing, they will be encouraged to return to area that they have come here to 'escape' from those issues, and many do not see returning as a viable option.

Conclusions

The level of brutality used in Annette's murder had compressed her neck so violently as to have fractured the bones in her neck and the murderer then took the hammer, that Annette kept under the chair for protection from intruders and rained blows upon her.

The victim had suffered from a number of physical difficulties from childhood. She was registered as disabled as a result of severely restricted mobility. She used a mobility scooter. She experienced a number of other associated chronic health difficulties that affected her everyday life.

After leaving home in her late teens, Annette endured a number of severely abusive relationships in different areas around the UK, eventually leading to a refuge placement on the south coast. It was after leaving the refuge that she found herself in a flat in the area in which she was killed.

It appears that after taking up the tenancy of the flat she became targeted by local men who 'cuckooed' her resulting in interventions by local agencies such as the police and social care.

At some point, and it remains unclear, probably only a few weeks before her murder, the perpetrator came into her life and began to live at the property. He murdered her and left her body in a wheelie bin. He then set about trying to leave a trail of deception to escape capture. His arrival on the scene was largely unknown to the authorities.

A number of agencies were involved in supporting Annette and it is clear that efforts were made to safeguard her and help her with her lifestyle. Information was shared between agencies in this case but almost always electronically. The complexity of the situation would have benefited from a professionals meeting and an agreed partnership approach to dealing with the situation in which she found herself.

This review makes a number of recommendations to local agencies that we feel will better protect others in the future.

[6] Health in Coastal Communities, Chief Medical Officer's Annual Report 2021

Lessons Identified

East Sussex CCG on behalf of GPs

With so many GPs involved in Annette's care, usually for emergency appointments, a simple standardised coded template for recording any mention of safeguarding information would help to quantify the problem, and clearly establish that the patient was sufficiently safeguarded or would benefit from further referral. It would alert to changes in the patient's status and be readable on the Summary Care Record by other external agencies if the information fed into their assessment tools.

It would have helped the GPs caring for Annette to have had access to safeguarding information known to external agencies to contextualise the medical information and vulnerabilities she was presenting with. This would have been part of co-ordination of medical care and social needs.

East Sussex County Council – Adult Social Care and Health

Good case recording would have aided the assessment for future contacts with Annette.

The current guidance to ASC staff on 'flagging and tagging' individuals discussed at MARAC means that agencies could have been working with Annette without having important information that could inform assessment of risk and safeguarding decision making.

Information sharing with other agencies needs improvement.

Practitioners need to be reminded of the importance of professional curiosity when speaking to clients.

CGL The Portal – IDVA Service

IDVAs would be more effective if, rather than spending a lot of time ringing and emailing to other agencies, they called a professionals' meeting to explore the issues in a holistic way.

Rather than relying on other agencies to make a referral to MARAC, IDVAs should be proactive in doing this if their professional judgement deems it to be necessary.

Refuge

That case records should record in more detail the conversation held with the client. For example, it was not noted whether Annette had been asked what she wanted to get out of MARAC.

That when staff become aware of issues on the premises such as drug taking, as well as dealing with this from a tenancy point of view, staff should consider if any clients need extra support.

NHS England

There needs to be a properly functioning electronic transfer of full medical record information at registration. Whilst it is acknowledged that it is the intention of NHS England is to fully digitalise the GP information record, however with the frequent moves of Annette, a comprehensive historic record would only be available if it were fully summarised and coded before transfer on, and frequent moves would have prevented this. Immediate Electronic Data Transfer must be fit for purpose. Even if the

paper printout, of a failed electronic transfer, had been coded as a dataset, it would become useful information if the circumstances of the coded risks were accessible with the full consultation record at the time of consultation.

Cross agency learning

There are a number of references throughout this review detailing the concerns, particularly amongst the police, that 'cuckooing' was a feature of Annette's life. The review is aware that this is a subject that is part of the County's Modern Slavery Toolkit (see 3.3.30 of the full report) but would like assurance that staff across organisations comprising the county's safeguarding teams are aware of the nature of cuckooing in order that it can be identified amongst agencies other than police.

The Review has noted the term 'dwarfism' across different agency reports. In line with other local reviews, language is an area for development, and we would urge this review to link with a thematic review undertaken in Sussex where more appropriate language across agencies assists with setting a more trauma informed and empathetic interaction by cross-agency staff with those whom they come into contact with.

Recommendations

CGL East Sussex Domestic Abuse Service

That practitioners are reminded of their responsibility to ensure that a MARAC referral is submitted when professional judgement identifies the need. Work undertaken whilst this review has been ongoing to remind all practitioners that as the contracted service for domestic abuse in East Sussex, they have a responsibility to take action, inform the referrer of their professional judgement and their intention to submit a MARAC referral.

East Sussex Adult Social Care and Health (ASCH)

That ASCH finalise the legal advice so that they are clear on whether a record can be created if the alleged perpetrator is not known to ASC.

That, in order to raise awareness of professional curiosity, a workshop on Professional Curiosity and Disguised Compliance is included in the national safeguarding conference and literature about professional curiosity is published on the ASCH Single Source.

That all staff complete the domestic abuse e-learning and that the previous workshop provided to staff is updated and made available online.

East Sussex CCG on behalf of GPs

That there is a Sussex wide agreement of the Safeguarding Template Consultation Recording and Coding. This would make the information management more useful within the consultation and in the analysis and communication of the information within general practice and beyond. If this were successfully implemented in Sussex, it could form the basis of a template for embedding in the general practice Base Information Systems (Emis and System1), that would allow for adoption of the coded dataset Nationally, making transfer of risk data standardised.

That all GP practices should assure themselves that they have a complex care mechanism for co-ordinating the care of high risk and vulnerable patients, with a way of identifying and tracking this cohort of patients. This could be managed either through individuals, such as staff working in a care co-ordinator role, or through a group review mechanism, such as multi-disciplinary team, and involve the practice Safeguarding Leads.

That the CCG continues to work towards a long term, sustainable solution to the issue of sharing relevant MARAC information with GPs.

East Sussex Healthcare Trust (ESHT)

That integrated patient and nursing assessment documentation should include domestic abuse and an adult safeguarding assessment page.

That if patients disclose any history of domestic abuse, this should be re-examined at each patient contact to assess risk.

Home Works (now Brighton Housing Trust)

That Home Works reviews their practices to ensure that they are complying with the Pan-Sussex Safeguarding Policies and Procedures and access training as required.

Lewes District Council – Tenancy Services

That the council ensures that all work to be carried out because of domestic abuse is carried out as an emergency or within an agreed timescale.

That a housing specific Domestic Abuse Policy and Procedure is drafted so that all frontline services are clear about how they should manage cases of domestic abuse.

NHS England

That a Digital Data recovery mechanism needs to be available for patient records that have failed to transfer. NHS England and NHS Digital need to work with General practice information system suppliers to provide a process for migrating and merging records that are fragmented.

Refuge

That staff are reminded of the need to review the SafeLives risk assessment every four weeks or after an incident.

That staff are reminded that, when concerns are raised by other residents, these concerns may indicate a support need for other residents and that this should be sensitively explored.

Multi-agency oversight recommendations

That the CSP ensures that the nature and impact of ‘cuckooing’ is understood and recognised across organisations representing the multi-agency safeguarding network (Safeguarding Adults Board and East Sussex Safeguarding Children’s Partnership).

That this Review links with other local reviews and to build upon recommendations in those reviews in relation to language used across agencies. As an example, in this case the term ‘dwarfism’ is used, in other reviews the term ‘sex worker.’ More appropriate language assists in setting the nature of interactions in a more trauma informed and empathetic setting.

Appendix One: Action Plan

Definition	Abbreviation
Change Grow Live	CGL
Department for Health and Social Care	DH&SC
Domestic Abuse	DA
East Sussex Healthcare Trust	ESHT
East Sussex Safer Communities Partnership	ESSCP
Home Office	HO
Lewes District Council	LDC
Multi-Agency Risk Assessment Conference	MARAC
NHS Sussex Integrated Care Board	ICB
General Practitioners	GPs

	Recommendation	*Scope*	*Action*	*Lead Agency*	*Key Milestone*	*Outcomes*	*Target Date**	*RAG rating*
	CGL							
1.	**That practitioners are reminded of their responsibility to ensure that a MARAC referral is submitted when professional judgement identifies the need. Work undertaken whilst this review has been ongoing to remind all Practitioners that as the contracted service for DA in East Sussex, they have a responsibility to take action, inform the referrer of their professional judgement and their intention to submit a MARAC referral.**	Local	Staff informed of the actions following DHR Annette and recorded in the Team Meeting/IGTM.	**CGL**	Discussion held at Full Team Meeting/IGTM. Line managers review files in regular case management to ensure processes and protocols are being met. Evidence of Professional Judgement MARAC referrals held via MARAC recording processes. SafeLives accreditation audit and accreditation certificated completed in Dec 20 to Feb 2021. .	Service submits MARAC referral based on another professional's referral into service is part of our service protocols to ensure a multi-agency response to improve safety and reduced risk for victims of domestic abuse. Permission is requested to use Police SCARFs and other services information where this is the only information available to our service, and on which professional judgement is based to improve risk management for victims of domestic abuse and improve safety. All referrers are informed of our intention to refer to MARAC if they have not already, or do not plan, to do so, based on their information.		01/06/22 Revisited 17/08/22 Standard protocols reviewed: November 2021 and February 2022

	Recommendation	*Scope*	*Action*	*Lead Agency*	*Key Milestone*	*Outcomes*	*Target Date**	*RAG rating*
2.	**That staff are reminded of the need to use professional curiosity in assessment and case work. Discussions held should also be entered into case notes, including potential risk of harm or exploitation.**	Local	Include professional curiosity in the assessment tool as a prompt for practitioners. Reminders that Professional curiosity and challenge is part of CGL working practice and forms part of the risk and needs assessment,	**CGL**	Improved professional curiosity and discussion recording in case file notes. Discussions recorded in Dec 2019 in Service Quality Improvement Plan Referrals to MARAC on professional judgement based on other services referrals and information to be submitted.	Victims of domestic abuse are provided support and safety planning at the earliest point of engagement with professionals to reduce risk.		Reviewed 01/06/22
2.	**That staff are reminded of the need to use professional curiosity in assessment and case work. Discussions held should also be entered into case notes, including potential risk of harm or exploitation.**	Local	Discuss DHR recommendations in team IGTM meetings to ensure all staff are aware and reminded of the importance of recording all discussions.	**CGL**	Full Team Discussion: DHR thematic. A reminder of Professional Judgement and MARAC referral. Staff to follow our protocols and submit a MARAC referral where professional judgement differs to the referral and risk status submitted into service. in IGTM notes.	Victims of domestic abuse are provided support and safety planning at the earliest point of engagement with professionals to reduce risk.		Reviewed 26/01/22 Reviewed 17/08/22
2.	**That staff are reminded of the need to use professional curiosity in assessment and case work. Discussions held should also be entered into case notes, including potential risk of harm or exploitation.**	Local	Service Development, new roles have been created with ESCC/PCC/ ESHT/Housing to increase and support victims of DA, with complex or additional needs. New roles within service. 2020 to 2022.	**CGL**		Service Developments at Multiagency representation, fosters and enables professional curiosity, challenge and relevant information sharing.		2020-2022

	Recommendation	*Scope*	*Action*	*Lead Agency*	*Key Milestone*	*Outcomes*	*Target Date**	*RAG rating*
2.	**That staff are reminded of the need to use professional curiosity in assessment and case work. Discussions held should also be entered into case notes, including potential risk of harm or exploitation.**	Local	Service Development HIDVA post developed to support patients accessing ESHT hospitals in East Sussex	**CGL**	Health IDVA (HIDVA) post recruited to.	Dedicated worker to provide onsite support to patients and staff at Conquest and Eastbourne Hospitals – DA training delivered to ESHT staff, and 17 DA Champions recruited across both EHST sites		September 2021
2.	**That staff are reminded of the need to use professional curiosity in assessment and case work. Discussions held should also be entered into case notes, including potential risk of harm or exploitation.**	Local	Service development A community Development Worker employed to deliver DA Training across East Sussex	**CGL**	Service Development: The service recruited a Community Development and Training Worker. Commenced role September 2021. DA/DASH/MARAC Training delivered 2022/dates booked for 2023. Improved training offer DASH RIC/MARAC training developed and delivered across East Sussex services via the ESCC gateway/ platforms, in which there is an emphasis on why and how we complete DASH RIC assessments, including professional curiosity. This training is also offered as part of the induction process to new CGL DAS staff.	Improved support and increased safety for victims of domestic abuse and their families from all agencies		September 2021

	Recommendation	*Scope*	*Action*	*Lead Agency*	*Key Milestone*	*Outcomes*	*Target Date**	*RAG rating*
2.	**That staff are reminded of the need to use professional curiosity in assessment and case work. Discussions held should also be entered into case notes, including potential risk of harm or exploitation.**	Local	Service Development New Roles: 2021 Multiple Complex Needs Worker post created with an emphasis on engagement/outreach. CGL continued attendance at the Victim Hub, a multi-agency weekly discussion on cases where it's identified it's unknown whether the victim is being support by services (standard and medium risk).	**CGL**	MCN worker commenced role.2021 Completed SafeLives IDVA Training. 2022 2x DA Respite Room workers recruited 2021. Service manager completes research and attends weekly Victim Hub meeting. Trauma informed approach to lead agencies/ professionals agreed or identified within the Victim Hub and MARAC cases flagged.	A dedicated role to support Victims of DA with identified complex needs to improve support and meet all identified needs. To manage appropriate referral levels and demand into MARAC through a key multi agency panel. Service insight to practice and outcomes within the MARAC process to improve safety and trauma informed approach to multiple and complex needs.		April 2021 January 2022 December 2022
2.	**That staff are reminded of the need to use professional curiosity in assessment and case work. Discussions held should also be entered into case notes, including potential risk of harm or exploitation.**	Local	MARAC Triage Worker recruited. Dec 2022 to support resident MARAC chair with high demand of cases. CGL Co Chair to flag to CGL Manager if there are any practice or process issues identified within service and MARAC processes.	**CGL**	MARAC Triage Worker recruited.	High risk domestic abuse victims receive an effective multi-agency response to improve safety and reduce risk		December 2022

	Recommendation	*Scope*	*Action*	*Lead Agency*	*Key Milestone*	*Outcomes*	*Target Date**	*RAG rating*
2.	**That staff are reminded of the need to use professional curiosity in assessment and case work. Discussions held should also be entered into case notes, including potential risk of harm or exploitation.**	Local	Victim Hub representative Service Development. ESCC/PCC developed DA/Stalking/Sexual Violence key services hub, led by Sussex Police	**CGL**	Victim Hub commenced April 2021. Service manager attends weekly meetings. Victim Hubs/MARAC Triage/MARACS/MARM all provide contact points or leads for key agencies. Victim hub also provides improved access to OiC/required information/actions and client contact information. All core service DA case workers have completed SafeLives IDVA training.	All known victims of domestic abuse receive a multi-agency discussion to improve safety and reduce risk		April 2021
2.	**That staff are reminded of the need to use professional curiosity in assessment and case work. Discussions held should also be entered into case notes, including potential risk of harm or exploitation.**	Local	Service Development CGL MARAC sessional co-chair recruited in 2021.	**CGL**	MARAC Co chair recruited Aug 2021			August 2021
2.	**That staff are reminded of the need to use professional curiosity in assessment and case work. Discussions held should also be entered into case notes, including potential risk of harm or exploitation.**	Local	Develop a list of key agency points of contact improve for professionals meetings, to ensure that these meetings can be completed in a more-timely manner.	**CGL**	Service contacts and key workers strengthened. Service contacts developed.	Directory: Ongoing. Changing agency SPOCs and staff roles, and the development or closures of services, can be a barrier to keeping up to date information.		Dec 2022.

	Recommendation	*Scope*	*Action*	*Lead Agency*	*Key Milestone*	*Outcomes*	*Target Date**	*RAG rating*
	East Sussex Adult Social Care and Health (ASCH)							
3	**ASCH finalise the legal advice so that they are clear on whether a record can be created if the alleged perpetrator is not known to ASC.**	Local	ASCH to ensure that all backdated MARAC information is added to LAS, within legal parameters, as ASCH have confirmed that unknown alleged perpetrators cannot be recorded.	**ESCC ASC**	Substantial work has been completed to ensure all relevant information is held on the client database as agreed legally. Backdated information is completed on system and ongoing activity to remain up to date	Victims and perpetrators of domestic abuse are identified to identify and reduce risks of harm to the victim and to others		December 2022
4	**That, in order to raise awareness of professional curiosity, a workshop on Professional Curiosity and Disguised Compliance is included in the national safeguarding conference and literature about professional curiosity is published on the ASCH Single Source.**	Local	Future ASCH guidance to include information about professional curiosity and disguised compliance.	**ESCC ASC**	This has been incorporated into ASC training offer. Operational teams are also offered Domestic abuse briefings, reflective learning by Safeguarding development team bespoke to differing needs of teams.	Intervention and support are provided at the earliest opportunity to victims of domestic abuse Improved safety planning and risk management for victims of domestic abuse		December 2022
5	**That all staff complete the domestic abuse e-learning and that the previous workshop provided to staff is updated and made available online.**	Local	ASCH to follow up on compliance levels of staff completion of mandatory domestic abuse e-learning.	**ESCC ASC**	This online training on domestic abuse is mandatory for ASC staff and over 1000 staff have completed it by December 2022. Multi-agency domestic abuse guidance will be reviewed in 2023 as annually reviewed. Recommendation is met and ongoing offer of training.			December 2022
	NHS Sussex Integrated Care Board: primary care							

	Recommendation	*Scope*	*Action*	*Lead Agency*	*Key Milestone*	*Outcomes*	*Target Date**	*RAG rating*
6	**That there is a Sussex wide agreement of Safeguarding Template Consultation Recording and Coding. This would make the information management more useful within the consultation and in the analysis and communication of the information within the practice and beyond.**	Local	Specification Agreement on a new Local Commissioned Service (LCS) that is in development which will have standardised templates available for recording and coding.	**ICB / Local Medical Committee (LMC)**	Whilst the ICB will be able to offer an LCS, it is unable to enforce GP Practices to join. Therefore, the ICB 'milestone' would be the LCS offer. As joining is not compulsory, no target / compliance rate has been set. Individual Practices would have differing 'milestones' (dependent on if / when they join).	Easier and quicker identification within General Practice to code current and identify previous safeguarding risks for adults (within the GP IT infrastructure). In addition, to trigger practitioner curiosity and to ask relevant questions.	By end of Q2 23-24 (end of Sept. 2023).	
7	**That all GP practices should assure themselves that they have a complex care mechanism for co-ordinating the care of high risk and vulnerable patients, with a way of identifying and tracking this cohort of patients.**	Local	All GP Practices will be offered participation in the new Local Commissioned Service (LCS) which will require Practices to specify that there is an internal mechanism for co-ordinating the care of high risk and vulnerable patients (self-assurance). As per the recommendation, GP practices should assure themselves that they have a complex care mechanism with a way of identifying and tracking high risk and vulnerable patients.	**Individual GP Practices** (self-assurance) **ICB** (offering / administering the LCS).	Whilst the ICB will be able to offer an LCS, it is unable to enforce GP Practices to join. Therefore, the ICB 'milestone' would be the LCS offer. As joining is not compulsory, no target / compliance rate has been set. Individual Practices would have differing 'milestones' (dependent on if / when they join).	Improved holistic approach to meeting the health needs of victims of domestic abuse for improved mental and physical wellbeing Improved safety planning and access to support for victims of domestic abuse	By end of Q2 23-24 (end of Sept. 2023).	

	Recommendation	*Scope*	*Action*	*Lead Agency*	*Key Milestone*	*Outcomes*	*Target Date**	*RAG rating*
8	**That the NHS Sussex Integrated Care Board continues to work towards a long term, sustainable solution to the issue of information sharing with GPs.**	Local	Resources to be identified to strengthen information-sharing links between GP Practices and the MARAC.	**NHS Sussex ICB & MARAC Support Team**	Resource in place to develop link between GP practices and MARAC in East Sussex, both pre- and post-MARAC meetings	Improved risk assessment and safety planning for victims of domestic abuse	December 2023	Dec 2023: information sharing protocol pre-MARAC complete. Work continues on information-sharing post-MARAC
	East Sussex Healthcare Trust (ESHT)							
9	**That integrated patient and nursing assessment documentation should include domestic abuse and an adult safeguarding assessment page.**	Local	Head of Safeguarding to discuss with patient documentation group. Head of Safeguarding to discuss inclusion of safeguarding and domestic abuse with the team developing electronic records system.	**ESHT**	The trust will be moving toward an electronic record system in the future. The Head of Safeguarding has discussed inclusion of safeguarding and domestic abuse with the team developing electronic records system. Meetings set for April 2023.	Improved support and safety planning of victims at an earlier stage, and improved risk assessment and identification of safeguarding concerns for victims of domestic abuse	January 2025	
10	**That if patients disclose any history of domestic abuse this should be re-examined at each patient contact to assess risk.**	Local	Embed a culture of routine enquiry and to raise awareness about domestic abuse. Head of Safeguarding to review the trust Domestic Abuse policy.	**ESHT**	A rapid assessment screening tool is available to staff on some trust systems, the tool and a supporting Flow-chart direct staff to contact the HIDVA / safeguarding team. Head of Safeguarding to revisit KPI for the routine enquiry as part of the process.	Improved risk assessment and identification of safeguarding concerns for victims of domestic abuse	By end of Q2 23-24 (end of Sept. 2023).	

	Recommendation	*Scope*	*Action*	*Lead Agency*	*Key Milestone*	*Outcomes*	*Target Date**	*RAG rating*
	HomeWorks (now Brighton Housing Trust)							
11	**That Home Works reviews their practices to ensure that they are complying with the Pan-Sussex Safeguarding Policies and Procedures and access training as required.**	Local	Audit staff training compliance, to ensure that all managers and staff have completed mandatory safeguarding training which includes the Pan Sussex Safeguarding Policies and Procedures and importance of multi-agency working Identification of gaps in safeguarding and domestic abuse training and providing access to required training Team Managers to flag any safeguarding issues from the referral information to officers when allocating cases, request regular updates and following up in supervision.	**Home-works**	Training audit complete Formal process established for team managers flagging safeguarding concerns on allocation and follow up in supervision	Intervention and support are provided at the earliest opportunity to victims of domestic abuse Improved safety planning and risk management for victims of domestic abuse	July 2023	

	Recommendation	*Scope*	*Action*	*Lead Agency*	*Key Milestone*	*Outcomes*	*Target Date**	*RAG rating*
	Lewes District Council – Tenancy Services (LDC)							
12	**That the council ensures that all work to be carried out because of domestic abuse is carried out as an emergency or within an agreed timescale.**	Local	Ensure that all works are carried out within a specified timeframe, agreed by LDC. Ensure that referrals to Sanctuary Schemes for target hardening measures, where appropriate, are made at the earliest opportunity and works carried out within a specified timeframe, agreed by LDC.	**LDC**	Timescale for all works to be confirmed by LDC, with reporting by exception to Housing Leads Sanctuary Schemes to gather data on time to completion of target hardening works and report by exception to Housing leads	Improved safety for victims of domestic abuse	April 2023	
13	**That a housing specific Domestic Abuse Policy and Procedure is drafted so that all frontline services are clear about how they should manage cases of domestic abuse.**	Local	Domestic Abuse Policy and Procedure to be developed, in collaboration with the commissioned domestic abuse services for East Sussex and Housing Options IDVA Service LDC to explore with all other District and Borough Councils in East Sussex to develop a Domestic Abuse Policy and Procedure as good practice, with the Housing Options IDVA Service	**LDC**	Policy and procedure drafted	Victim of domestic abuse are supported at the earliest opportunity and improved safety and support for victims of domestic abuse		October 2023: Lewes Housing First Domestic Abuse Policy published
	NHS England							

	Recommendation	*Scope*	*Action*	*Lead Agency*	*Key Milestone*	*Outcomes*	*Target Date**	*RAG rating*
14	**That a Digital Data recovery mechanism needs to be available for patient records that have failed to transfer. NHS England and NHS Digital need to work with General practice information system suppliers to provide a process for migrating and merging records that are fragmented.**	Nationa l	ESSCP to share this learning and recommendation with the Domestic Abuse Commissioner's (DAC) Office, for raising with NHS England to explore a digital data recovery mechanism	**ESSCP with DAC Office**	Confirmation received that DAC Office have communicated this recommendation to NHS England	Improved information sharing and record keeping Improved risk identification and assessment and safety planning, for domestic abuse victims	June 2024	
	Refuge							
15	**Staff are reminded of the need to review the DASH risk assessment every four weeks or after an incident.**	Local	All refuge staff to complete Domestic Abuse risk assessment training provided by CGL	**Clarion Housing***	*Note: recommendation was for Refuge, prior to recommissioning of refuge service in East Sussex in November 2021. Actions set for new provider, Clarion Housing, to ensure learning is incorporated by the current refuge provider	Improved risk assessment and safety planning for victims of domestic abuse	April 2023	April 2024: Clarion experiencing issues accessing CGL training, continues to be explored
16	**Staff are reminded that, when concerns are raised by other residents, these concerns may indicate a support need for other residents and that this should be sensitively explored.**	Local	Key workers to explore all needs identified within key work sessions and updating support plans accordingly. Ensuring additional support, including for substance misuse and any other additional needs is provided via signposting and support with referrals.	**Clarion Housing***	Note: recommendation was for Refuge, prior to recommissioning of refuge service in East Sussex in November 2021. Actions set for new provider, Clarion Housing, to ensure learning is incorporated by the current refuge provider	Improved support for needs of victims of domestic abuse, including improved physical and mental health		April 2023: Clarion onward referrals and case studies for residents with additional needs are monitored via quarterly contract review

	Recommendation	*Scope*	*Action*	*Lead Agency*	*Key Milestone*	*Outcomes*	*Target Date**	*RAG rating*
	Multi-agency oversight recommendations							
17	**That the CSP ensure that the nature and impact of 'cuckooing' is understood and recognised across organisations representing the multi-agency safeguarding network (SAB, ESSCP and East Sussex Safeguarding Children's Partnership).**	Local	Incorporating diversity of types of cuckooing and the impact of in relation to 'think family' and case studies from other stat review (e.g. Adult S). Training packages are audited and diversity of types of cuckooing are included. Themed learning briefings/ podcast on cuckooing across stat reviews and disseminated across ESSCP, East Sussex Safeguarding Children's Partnership and the SAB for all those at risk of harm from cuckooing inc. learning disabilities and mental health teams. Agencies to ensure how to report cuckooing is clear on public facing websites. ESSCP team to share reporting mechanisms with all SCB agencies to ensure consistency of messaging.	**ESSCP**	Training packages are audited and updated Learning briefings are developed and circulated via the East Sussex SAB, ESSCP and SCP partners and agencies SAB, ESSCP and ESCC public facing websites are updated with clear and consistent guidance on reporting cuckooing	Victims of cuckooing supported an earlier stage to reduce risk of harm Increased support and more effective response for victims of cuckooing to improve safety	Included in training by July 2023 Staff to have attended training by March 2024 All other actions complete by April 2023	

	Recommendation	*Scope*	*Action*	*Lead Agency*	*Key Milestone*	*Outcomes*	*Target Date**	*RAG rating*
18	**That this review links with other local reviews and to build upon recommendations in those reviews in relation to language used across agencies. As an example, in this case the term 'dwarfism' is used, in other reviews the term 'sex worker.' More appropriate language assists in setting the nature of interactions in a more trauma informed and empathetic setting.**	Local	Practitioners to take trauma informed approach and use non- discriminatory language when communicating with clients, both written and verbal communications. Practitioners to consider the use of language within recording and support planning were relevant. The Safer Communities Team to work collaboratively with the Brighton and Hove SAB in developing actions for a similar recommendation from a Thematic Review in progress in relation to standardisation and bench-marking re trauma-informed approaches, including the use of language for a consistent approach.	**ESSCP**	To be developed in collaboration with Brighton and Hove SAB	Increased engagement with victims through improved communication between practitioners and victims of domestic abuse Improvements in trauma informed practice with victims of domestic abuse, including those with multiple and complex needs	August 2023	

***target date** – learning was identified as the review was in progress was incorporated into practice for agencies, prior to the completion of the review when the action plan was developed. Where there isn't a target date, associated actions were already completed and completion dates have been added to the RAG rating column.

Appendix Two: Report chair and author feedback response table

Area of Development	Evidence of Development Taken
It would be beneficial to explain who chose the pseudonym and whether the family approve the name.	1.4.3 added
It may be helpful to include the early recommendations police made in the individual management review (IMR), within the overview report, to show how their failings have been addressed.	We have reviewed the police section and do not think that anything else needs to be added. The position is clearly explained at 3.1.12
Financial abuse was identified as an aggravating factor however this is not explored in the analysis along with the impact it had on Annette.	Section on economic abuse added at 4.3.5
The QA Panel felt there was a missed opportunity to include a recommendation seeking to involve the veterinary professions/animal care community in the assessment of the risk to the public.	Noted but we do not think anything additional is needed
The references to Annette's pregnancy are confusing. Paragraph 2.2.5 refers to her seeing her GP in September 2017, and there is no further information relating to this pregnancy. Section 4.1.15 references her complicated gynaecology, multiple pregnancies, and miscarriages.	References to pregnancy were removed from executive summary.
Assessments were considered in isolation, e.g. the domestic abuse, stalking and honour based violence (DASH) assessment in August and social care referrals September 2019.	We do not agree that they were reviewed in isolation as the SCARF was sent to ASC from the DASH risk assessment
There were delays in GP records moving from one practice to another when Annette moved practices, a national recommendation should be made to address this.	This is fully explained at 3.2.3 – we did not find that it was a systemic failing
There was poor information sharing across all agencies in understanding the risks for Annette and putting safety plans in place for a victim with complex health needs and vulnerabilities.	This is fully explored at 5.2 and we do not feel any further additions are needed

Area of Development	Evidence of Development Taken
Some recommendations made within the report are not included in the recommendation's sections (E.g. Para 7.7.1 and 7.8.1).	Recommendation added from body of report at 7.9.2 Recommendation 7.8.1 has been added at 3.2.3 CSP will need to check that this was included in the action plan - actioned
There are some breaches of confidential information; date of death at page 34 and real initials at 3.8.9.	2.4.2 (page 34) changed 3.8.9 amended
It would be beneficial to define abbreviations/acronyms when first used or to provide a glossary for ease.	I have been through the report and have made sure that when an acronym appears for the first time, it is explained
The report requires a good proof-read, including checking structure (specifically inconsistency of dates in the chronologies), the tense used, ensuring the contents page matching the page numbers and marking the overview report with the appropriate confidential marking.	The report has been proof read and changes made