Domestic Abuse Related Death Review

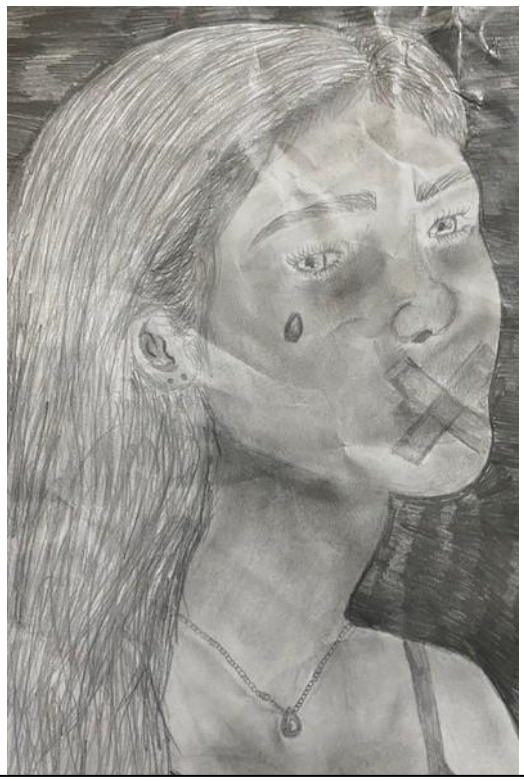
EXECUTIVE SUMMARY

St. Albans Community Safety Partnership

Claire

Born: January

Died: May 2024



Silence

Sometimes I find it hard to say what feelings I have on my mind.

I get scared people will judge so I sit in silence and keep my emotions to myself.

So this piece of artwork is about my emotions.

Artwork by Claire

Chair and Author: Christian Brazier

Date of completion: 11th February 2026

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Glossary:

Acronym	Name
ACMHS	Adult Community Mental Health Service
CAMHS	Child and Adolescent Mental Health Service
CIN	Child In Need
CGL	Change, Grow, Live (drug and alcohol support)
CPP	Child Protection Plan
CSC	Children's Social Services
CYP	Child and Young Person
DA	Domestic Abuse
DASH (RIC)	Domestic Abuse Stalking and Honour Based Violence Risk Indicator Checklist
DARA	Domestic Abuse Risk Assessment
DARDR	Domestic Abuse Related Death Review
DVPN	Domestic Violence Prevention Notice
DVPO	Domestic Violence Prevention Order
EH(W)	Early Help (Worker)[1]
ENHT	East & North Hertfordshire NHS Trust
FGC	Family Group Conference
HCT	Hertfordshire Community NHS Trust
IDVA	Independent Domestic Violence Advisor
IMR	Individual Management Review
ISVA	Independent Sexual Violence Advocate
LAC	Looked After Child
MACE	Multi Agency Child Exploitation Panel
MASH	Multi Agency Safeguarding Hub
MARAC	Multi Agency Risk Assessment Conference
MARM	Multi Agency Risk Management Meeting
NCD	Non Crime Domestic
SARC	Sexual Assault Referral Centre
SASH	Specialist Adolescent Service Hertfordshire[1]
SPA	Single Point of Access[1]
SWKR	Social Worker
TAF	Team Around the Family
ToR	Terms of Reference
YEF	Youth Endowment Fund

[1] Continuum of supoort for adolescent service

Preface:

The author and panel wish to express their deepest condolences to Claire's family and friends. Claire was much loved by many and will be sorely missed. The family's support of this review has been much appreciated in what is an incredibly difficult time.

Pen Portrait:

Claire was an intelligent, kind-hearted young woman, someone who cared about others and had a talent for drawing. Though she experienced many challenges in her adolescence, her kindness and care of others persisted. Those who knew her loved her, none more so than family. Family was important to Claire, and she was a much-loved granddaughter, daughter and sister.

The Review Process:

This Domestic Homicide Review (DHR) / Domestic Abuse Related Death Review (DARDR) is carried out in accordance with the statutory requirement set out in Section 9 of the Domestic Violence, Crime and Victims Act 2004.

The review must, according to the Act, be a review 'of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by:

a) A person to whom he / she was related or with whom he /she was or had been in an intimate personal relationship, or
b) A member of the same household as themselves, held with a view to identifying the lessons to be learnt from the death.

In this case, the victim was Claire.

Within Section 18 of the 2016 Multi Agency Statutory Guidance for the Conduct of DHRs, provision was made for DHRs to be conducted:

"Where a victim took their own life (suicide) ***[in the case of Claire, it has been referred to as an overdose and not as a suicide]*** *and the circumstances give rise to concern, for example it emerges that there was coercive controlling behaviour in the relationship, a review should be undertaken, even if a suspect is not charged with an offence or they are tried and acquitted. Reviews are not about who is culpable."*[2]

The purpose of the DHR / DARDR is to:

[2] DHR-Statutory-Guidance-161206.pdf (publishing.service.gov.uk)

- Establish what lessons are to be learned from the domestic abuse related death regarding the way in which local professionals and organisations work individually and together to safeguard victims.

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

- Apply those lessons to service responses including changes to policies and procedures as appropriate

- Prevent domestic violence homicide or related death and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working.

- Contribute to a better understanding of the nature of domestic abuse.

- Highlight good practice.

This review examines the circumstances leading up to the death of Claire (pseudonym), an 18 year old care leaver, who died via overdose of prescription drugs in May 2024 in Hertfordshire. The decision to undertake this review was made by the local Community Safety Partnership (CSP) on 2nd July 2024 having been notified of the death on 7th June 2024. This was due to the knowledge Claire had been in a domestically abusive relationship with Danny (pseudonym) for approximately 3 years prior to her death. The Home Office were notified of this decision on 3rd July 2024. A chair and author was appointed on 19th May 2025. This delay was due to the volume of domestic abuse related deaths requiring review.

The panel met for the first time on 6th June 2025 where IMRs (Individual Management Reviews) were requested from agencies and the terms of reference (ToR) was agreed. Initial information gained from the scoping exercise was reviewed and the timeframe of March 2021 – May 2024 was agreed as a relevant period of time to explore in greater depth. Subsequent meetings to discuss findings from IMRs and identify further learning and recommendations were held on the following dates:

Panel Meeting 2 - 15/09/25
Panel Meeting 3 - 20/10/25
Panel Meeting 4 - 01/12/25

Contributors to the Review

Those contributing to the review did so under Section 2 (4) of the statutory guidance for the conduct of DHRs / DARDRs. It is the duty of any person or body participating in the review to have regard for the guidance.

All individuals interviewed by the Chair were made aware of the aims of the DHR and referenced the statutory guidance.
The following agencies confirmed that they had had relevant, significant contact with either Claire or Danny (pseudonyms) and were asked to undertake Independent Management Reviews (IMR). These were:

- Children's Social Care
- Police
- CGL (Change, Grow, Live – Drug and Alcohol support)
- HPFT (Mental Health)
- ENHT (East & North Hertfordshire NHS Trust)
- Refuge (IDVA (Independent Domestic Violence Advisor) Service)
- GP (for Claire)
- Peabody Housing
- Emerging Futures (accommodation for those with drug and alcohol concerns)

A short report was considered from Danny's GP but following discussion, it was not deemed necessary due to limited involvement.

Claire's secondary school, which she left in July 2021, were met separately to gain their insight. Their contribution can be found in the family contribution section of the full report as can Claire's mother's contribution.

All IMR authors confirmed, via their report, they were independent of the case itself.

The Review Panel Members

The following agencies contributed to the review and were members of the panel.

Name	Organisation	Job Title
Christian Brazier	Independent	Independent Chair and Author
Ildiko Cseri	Hertfordshire County Council (HCC)	Commissioning and Monitoring Officer, HCC
Kristyna Vlkova	Hertfordshire County Council	Admin Support Officer, SPT, HCC
Kate Johnson	HPFT (Hertfordshire	Professional Lead for Safeguarding Adults

	Partnership Foundation Trust)	
DCI Anna Borella	Hertfordshire Police	Detective Chief Inspector, DHR Review Team
Leanne Naughton	CGL (Change, Grown, Live)	Senior Social Worker and Safeguarding Lead
Neil Kieran	St. Albans City and District Council	Prinicpal Emergency Planning and Community Safety Officer
Bryony Mitchell	Peabody Housing	Assistant Head of Young People Services
Carolanne Brannan	Herts and West Essex ICB	Deputy Director for Nursing Quality
Amanda Middleditch	Hertfordshire Community NHS Trust	Named Nurse for Children Looked after and Care Leavers
Louise Bayston	Refuge	Senior Operations Manager
Mandy Williams	Children's Services	Head of Safeguarding
Cecilia Stevens	Hertfordshire and West Essex ICB	Deputy Designated Nurse for Children
Dr Julia Morgan / Dr. Jane Ho	GP Surgery Representative	GP
Samantha Jeffery	Children's Services	Service Manager
Sarah Corrigan	East & North Herts NHS Trust (ENHT)	Head of Children's Safeguarding
Daley Calderon	Emerging Futures	Service Manager

The Author of the Overview Report

This report is chaired and authored by Christian Brazier. He is independent of all statutory and non-statutory services within Hertfordshire and never had contact with the family prior to this review.

Christian worked in frontline practice within the Police, Family Intervention and Domestic Abuse sectors for nearly 15 years. In 2016, he specialised in domestic abuse perpetrator interventions working within medium and high-risk domestic abuse perpetrator projects as a Skills Enhancer and Deputy Manager. Following this he worked for the national domestic abuse organisation Respect as a Drive Practice Advisor - high risk domestic abuse perpetrator intervention, and later as a Make A Change practice lead - an early intervention

domestic abuse intervention. Here he created tools and workshops for friends, family and colleagues who might be concerned about people using harmful behaviour towards their loved ones. He most recently managed the Pan London Drive programme with RISE Mutual. He is an associate trainer for the national domestic abuse charity Safelives facilitating their high harm perpetrators and MARAC sessions as well as their Engaging Those Who Use Harm training. Christian attended the Advocacy After Fatal Domestic Abuse Chair's Training in January 2023 and completed the Home Office Domestic Abuse Related Death Review Chair's Training in September 2024. He qualified as a journalist in 2013.

Terms of Reference

The panel, as well as those completing IMRs, were asked to consider the following:

- To review current roles, responsibilities, policies, and practices in relation to victims of domestic abuse with specific consideration of coercive control – to build up a picture of what should have happened.

- To review this against what happened to draw out the strengths and areas for improvement.

- To review national best practice in respect of protecting adults and children from domestic abuse.

- To draw out conclusions about how organisations and partnerships can improve their working in the future to support victims of domestic abuse.

A full term of reference forms the analysis in Section Four of the full report and can also be found in Appendix A at the end of this executive summary.

If any information of relevance prior to the scoping period became apparent, agencies were asked to share so more context could be gained and lessons learned.

Overview and Summary

Pseudonyms chosen by the chair and confirmed by Claire's mother were:

Name	Relationship	Age at time of Claire's death	Ethnicity
Claire	Subject of Review	18	White British
Danny	Partner at time of death	22	White British

Overview:

On a day in May 2024 Claire (pseudonym), an 18 year old woman and care leaver living in semi supported accommodation, was found deceased in her flat in Hertfordshire. She had died via an overdose of prescription drugs.

Claire had been known to many services: Children's Social Care having recently been a looked after child[3], CGL[4] (Change, Grow, Live, a drug and alcohol support service) and Mental Health Services to name but a few. She was well known to Police too, most recently due to experiencing domestic abuse from her ex-partner Danny (22). Weeks prior to her death Danny had been on police bail for criminal damage, common assault, and possession of a bladed article, all against Claire in April 2024.

Background:

Claire and her family were known to Children's Social Care (CSC) from 2004 (prior to Claire's birth) due to concerns about domestic abuse and neglect. The children in the family were subject to a child protection plan (CPP) in 2006, around the time of Claire's birth, with further CSC involvement in 2009 and 2011.

Police had multiple contacts with Claire prior to the scoping period for a variety of reasons. These included unsubstantiated allegations of sexual assault from a family member from the ages of 11 – 14. Allegations[5] of rape were also made towards male acquaintances of

[3] What is a looked after child?
[4] Spectrum Drug & Alcohol Recovery Services | Change Grow Live
[5] Please note, the term allegation is used due to a lack of criminal conviction.

Claire's just before and during the scoping period. This was labelled CSE (Child Sexual Exploitation) by services tasked with safeguarding. There were multiple reports of Claire going missing from home, several altercations with friends and concerns about home conditions and parental alcohol use.
It is important to consider the Covid 19 pandemic, associated lockdowns[6] and any potential impacts on Claire. During an interaction with police in Feb 2021 she told them that during the first lockdown (2020) she had taken an overdose due to issues at home. Both prior and during scoping, there are several references to Claire saying she would rather be dead than return home, her relationships with her parents being particularly problematic in her eyes. She told police if forced to go home she would lock herself in her room and cut herself as that's the only thing she felt she had control over.

In July 2020, aged 14, Claire had contact with the Crisis Assessment and Treatment Team at a local hospital after an overdose of Sertraline which she took from her nan. During her time at hospital, she told staff she'd had two friends die by suicide and her father had been unwell. She told the team about ongoing bullying and receiving anonymous messages telling her to kill herself. This team also noted concerns about Claire being exploited by older males and so safeguarding referrals were made, alongside a referral to CAMHS. There were concerns Claire did not fully appreciate or comprehend the risk to herself and a possible learning disability was queried though no substantiating evidence was identified to support this. When CAMHS input was discussed with Claire they felt she appeared ambivalent to working with this team though it was unclear why. Following this A & E attendance her level of risk appeared to reduce, at least initially.

Claire reported an allegation of rape in November 2020 and afterwards reported variable mood and suicidal ideation. Both prior and during the scoping period, Claire experienced sexual abuse from older men. Each time, there was a marked impact on her mental health.

In February 2021, just prior to the chosen scoping period, there was a police report of Claire attending a hotel with a friend and alleging a rape from a male acquaintance whilst there. When police arrived, they found three adult males present. She attended the SARC (Sexual Assault Referral Centre) for early evidence to be taken and for support to be provided. The outcome was for no further police action due to a lack of evidence.

This review aims to learn from the past to make the future safer. Due to this, it is important to consider the background of the primary person who allegedly caused harm to Claire during the scoping period.

Danny was known to services as a child, in particular Children's Social Care (CSC) and CAMHS who he was open to on at least four occasions between 2009 and 2011 when he would have been 8 – 10 years old. This was due to concerns about his concentration, hyperactivity and behavioural difficulties. A risk assessment in 2010 highlighted he had set

[6] timeline-coronavirus-lockdown-december-2021

two fires in 2006 / 2007, damaged property and hurt his siblings with one allegation of him trying to suffocate his baby brother with a blanket. His mother had described his behaviour as “out of control”. There were reports of domestic abuse within the parental relationship aswell as concerns about ‘poor parental supervision’.

Danny was opened to CAMHS again between 2013 and 2014 following an urgent GP referral due to concerns around low mood and suicidal ideation following the suicide of a close friend. When services attempted to support Danny, he denied any concerns. Records highlight how he framed his behaviour within the home as being the man of the house and in charge, despite him being 12 / 13 years old. On each occasion Danny was open to CAMHS the referral was eventually discharged due to “poor engagement”.

Concerns about Danny’s behaviour continued and in 2015 his GP referred for support due to suspected ADHD aswell as continuing concerns about his aggression and violence towards his siblings and mother. Following this referral CAMHS recommended ongoing parenting support and anger management input from CSC (Children’s Social Care).

As an adult, Danny continued to encounter services. In 2019, he attended hospital following an overdose of Sertraline and cannabis. Concerns about low mood and anxiety continued. In late 2020 he was referred to the ACMHS (Adult Community Mental Health Service) by the ambulance service following concerns about visual and auditory hallucinations aswell as problematic alcohol use. He was advised to engage with CGL (alcohol and drug intervention) and Young Herts Minds (therapeutic support for children, teenagers and their families) after saying he felt better and did not require ACMHS input. Later in 2020 he self-referred to the wellbeing team, now known as talking therapies, due to alcohol dependency and anxiety but was discharged due to non-engagement. He contacted the police in Sep 2020 saying he needed someone to speak to due to ongoing issues with his mental health and alcohol. During this call he also said he’d had a ‘minor disagreement’ with his sister. He was offered a referral to Catch 22 but declined.

Summary Chronology

The following chronology includes all contextually relevant information to aid future learning. Therefore, not all known information has been added.

The beginning of the agreed scoping period, March 2021, saw Claire open to:

- CAMHS (Child and Adolescent Mental Health Service) due to low mood, suicidal ideation and a potential eating disorder,
- Children’s Social Care (CSC) due to a concern of her being harmed by older men and

- the Police due to recent reports of sexual abuse by said men. She had additional support from a specialist police team called HALO[7] and a SASH worker (Specialist Adolescent Service Hertfordshire[8]).

Although her school attendance had started to decline by this point, she was still in touch with key education contacts such as the pastoral team and head of year who were a close support for her.

Due to concerns of Claire being sexually exploited and harmed by older men she was heard at the local MACE[9] (Multi-agency Child Exploitation panel) forum and risk assessments were conducted. These showed her at high risk of being sexual exploited. At this time, she reported being in a relationship with a man 4 years her senior (not Danny). She alleged he had raped her at a hotel and said he and his associate had given her vodka and "weed" which her made her sick.

During this time, and throughout the scoping period there were various missing person reports made to the police, both when Claire was living in the family home and when she was in care. Not all will be mentioned within this summary. However, in March 2021 her mother reported her missing to the Police saying her behaviour had changed over the last year. She felt Claire could be easily exploited and influenced and was vulnerable. Soon after this Claire called Police to say she had been on a phone call with a friend and her now ex-boyfriend had said in the background, *"If you speak to Claire, let her know I'll run a knife through her"*. No punitive action could be taken against him due to a lack of supporting evidence.

Soon after this, Claire contacted Police saying she had taken a lot of pills (her family member's angina medication) and didn't know what to do. She told the call operator "everything's so hard". Subsequently, she was taken to Watford General hospital where she was treated and recovered.

Following these concerns, a strategy meeting[10], aimed at bringing services together to identify whether immediate safety actions were required, took place between Hertfordshire and Bedfordshire services on 30th March 2021. The outcome of this was for Claire to continue to receive support from Social Care via a Child In Need (CIN) Plan.

During this time Claire reported abuse via social media to the Police such as "KILL YOURSELF, YOU FAILED LAST TIME WITH YOUR OVERDOSE" and derogatory messages about her allegedly being promiscuous. There was also a significant altercation with peers at school. Soon afterwards there was mention from her school of a snapchat video

[7] Hertfordshire Police have a specialist team called HALO that deals with child sexual exploitation. It proactively targets and disrupts those who are sexually exploiting young people and works closely with intelligence teams to safeguard those most at risk. It makes sure that Hertfordshire officers and external partners are aware of current risks and trends. Child sexual exploitation | Hertfordshire Constabulary

[8] Continuum of supoort for adolescent service

[9] Information on MACE

[10] What is a strategy meeting?

showing her going to a bridge with a rope saying she "can't do this anymore". She was found and returned home. She said she wanted help from CAMHS but they "didn't help her". Claire was open to CAMHS at the time and had seen them. The review has been unable to sufficiently expand on what she meant by them not helping her.

By July 2021 Claire had been heard at the MACE panel on three occasions. It was confirmed in one of these panels Claire was open to CAMHS and had attended 2 / 5 appointments. Family therapeutic support was offered but declined by both Claire and her family. CAMHS reduced their input at this juncture due to Claire's mental health reportedly stabilising (July 2021) and officially closed the referral in October 2021.

In August 2021 Claire was placed in emergency foster care for two nights under police protection saying she did not want to return home and she would harm herself if forced to do so. She said she did not want to go home as, in her words, her parents didn't care for her, she was not fed properly, and her parents were either drunk or on weed. She said she couldn't speak to her dad as he was always on weed and, if he had not used, he would be abusive towards her. Additionally, she alleged an assault from a friend where she'd been "dragged to the floor and stamped on the head" which contributed to her sleeping rough. This was investigated with no further action taken due to the friend arguing self-defence.

Support was brought in from the Adolescent Resource Centre to help with her reintegration to the family. Claire's mother told this review she contacted social care for help as she was concerned about the potential impact of Claire's behaviour on her two younger siblings – Claire was one of five children. A further strategy meeting was held where the missing person episodes were discussed. One panel representative voiced a concern about her appearing dishevelled and under-nourished. Subsequently, a Child Protection Plan commenced for Claire in September 2021 with her siblings placed on Child In Need plans.

Claire moved out of home and initially stayed with a friend before moving in with Danny and his family (siblings and parent) in November 2021. Danny was 19 at this time and Claire was still 15, an extremely significant age gap, especially considering the CSE concerns several months earlier. Throughout the course of the review, it remained unclear how Danny and Claire knew each other. All available information indicated they were connected via mutual friends.

Claire was visited every 10 days by social care in line with statutory timeframes. However, in February 2022 Danny's mother indicated she could no longer house Claire due to her disruptive behaviour. In the same month Claire overdosed on her contraceptive pill and was seen by the Crisis and Assessment Treatment Team[11]. Eventually alternative housing was gained for her via Herts Young Homeless[12]. In the coming months relevant support was

[11] The Crisis Assessment and Treatment Team (C-CATT) is a crisis service for children who work alongside the local A&E teams and Tier 4 services. The purpose of this team is to provide more immediate assessment and intervention on a short term basis.

[12] About Youth Homelessness - hyh - herts young homeless

offered to Claire, but she declined. Alongside this there was a concern her alcohol use was increasing.

The first known police information in relation to concerns about Claire and Danny's relationship was reported months later in August 2022 though some of these concerns related to behaviour in March 2022. These are summarised below:

March 2022 – argument about his alleged use of crystal meth which escalated with Danny allegedly pushing her and causing a cut lip.

June 2022 – argument related to Claire suspecting Danny was messaging another girl. He allegedly slammed her phone into her hand and aggressively "got in her face". In response, Claire slapped him in the face to which Danny threw her into a thorn bush causing cuts to her arms.

July 2022 - Claire thought she had seen Danny kissing someone he used to be in a relationship with. This began an argument at Danny's sister's house. Claire said he grabbed her by the hair and threw her to the floor cutting her lip in the process and leaving a scar. She left the house but he pleaded for her to stay which she did. Once back inside he grabbed her around the throat, scratching her neck before allegedly saying: "IM GOING TO KILL YOU, IF I CAN'T HAVE YOU NO ONE ELSE CAN". As she went to get her phone to contact Police Danny pushed her to the ground, smashed the phone and then stamped on her head. He then picked her up and pinned her against a door. She later told police she was scared he was going to kill her.

August 2022 - Claire told Police they had met up to smoke weed together in August 2022, argued and he kicked the joint out of her hand. He then allegedly grabbed hold of her hair, pulling her hair extensions out in the process. She slapped his face, got up and walked away as he shouted 'slag'.

Aswell as domestic abuse, familial issues continued for both Danny and Claire during this time. Danny was told to leave the family home and sought support from Hertsmere Council. He was referred to CGL for significant alcohol use though did not engage meaningfully in any work and minimised his usage. He gained accommodation with Emerging Futures[13] in June 2022.

Claire continued contact with her family though this remained tumultuous with one incident in June 2022 where she unintentionally hurt her sister after an argument with her mum. This conflict related to her mum wanting to know where she was getting her cannabis from.

The following month Claire attended hospital after ingesting bleach. She disclosed issues in her relationship with Danny to hospital staff but said *she* would lash out at *him*. Following this, Claire was allocated a CAMHS clinician, a psychologist, and offered a

[13] Hertfordshire - Emerging Futures

Choice[14] appointment. She struggled to engage with the therapeutic support offered and said she didn't want to engage with CAMHS. This was explored during the review and is further commented on within the conclusion. A safety plan was created between the social worker and CAMHS clinician prior to Claire leaving what was to be her last CAMHS appointment.

Following Claire's disclosure of domestic abuse to her housing support officer, Danny was arrested for ABH, criminal damage, common assault, threats to kill and coercive control. It was also alleged he made a fake Snapchat account to contact her and called her repeatedly via unknown numbers. These allegations were not progressed beyond arrest due to a lack of supporting evidence and Claire sending an e-mail to the officer in charge (OIC) requesting to drop all charges which was authorised by a DI (Detective Inspector).

Throughout June 2022 – January 2023 Danny was supported by Emerging Futures. He disclosed splitting up with Claire in August 2022 and said she had hit him. A few days after this disclosure Claire was known to be visiting him at his property. In November 2022 suspicions were raised of him using crack cocaine which, when confronted by Emerging Futures staff, he denied and became agitated at the suggestion. Due to continued concerned of Claire staying with Danny, in breach of his tenancy agreement, he was given a Notice to Quit[15] (NTQ); an attempt to encourage him to stop Claire staying over. Her behaviour had been disruptive to other tenants. Danny told staff felt he had nobody, only Claire. He would become distressed when talking about the relationship saying he "couldn't believe he had allowed a 16 year old to control him". Emerging Futures saw Danny as a victim of abuse and sent safeguarding concerns into the local authority to that effect.

Due to the domestic abuse disclosed by Claire in August 2022 their relationship was heard at MARAC in September 2022. Emerging Futures were unaware of this. The IDVA, who had already unsuccessfully attempted contact prior to this, managed contact with her on their 4th attempt. She told them Danny had physically and emotionally abused her which had been the story of her whole life as she had been abused by family members too. Additional information heard at this MARAC was as below:

- Claire feared bumping into Danny because of his previous use of violence.
- Potential depression due to the domestic abuse and falling out with her family subsequently.
- High levels of control with Danny not liking her talking to her family or going out.
- Financial abuse with him controlling access to money. The MARAC stated how Claire did not have a bank account and her money would go into his account.
- Strangulation where he put hands around her throat and threatened to kill her.

[14] Choice appointment p.4 - CAMHS A Choice appointment is an initial appointment to agree next steps.
[15] Notice to quit from the landlord - Shelter England

- Psychological abuse where Danny allegedly cut himself in front of her and then blamed her for it.

In September 2022 the decision to discharge Claire from CAMHS was made as no engagement appeared forthcoming. Children's Social Care (CSC) subsequently made a referral to the Wellbeing Team (WBT – now known as Talking Therapies)[16] but they declined on the basis of 'risk and complexity'. Due to this a further referral was made to Targeted CAMHS[17] in December 2022 which was declined as the team assessed they could not meet Claire's needs. During this time liaison occurred with CSC as to how best they could support Claire but there continued to be a lack of targeted, specialist intervention for her mental health needs.

Towards the end of 2022, within Claire's assessment with the HCT (Hertfordshire Community NHS Trust) - a process for all children who are newly looked after by the local authority - she was noted to have some understanding of her eating disorder and the impact on her body such as a slow pulse, fatigue and hair loss. Claire said she could go for days without eating when anxious.

In early November 2022 Claire reported she had been raped. She said she had been out in Watford with a friend where they met two men in a bar. They went to an address with them. One of the males allegedly took Claire to the bathroom where he raped her. He had produced a knife during the assault. Claire's clothing was seized for forensics and the perpetrator was arrested and interviewed though no conviction was forthcoming.

In early December 2022 Claire was spoken to by police directly and said Danny had dragged her around the bedroom and slapped her around the face. She said she had been in his bed asleep when he entered the room and screamed, *"Get the fuck out of my house"*. He was arrested for common assault and harassment after he continually called Claire following this incident. A MARAC referral was made by the attending officer but rejected. A DVPO (Domestic Violence Prevention Order)[18] was applied for but turned down by the Superintendent. This was further explored within the analysis in the full report.

Services met via a MARM[19] (multi agency review meeting) in late December. The social worker clearly stated their concerns: "*Claire is at very high risk of CSE (child sexual exploitation) and we have significant concerns about her 'boyfriend' and what she may be encouraged to do for drugs. Claire has been sexually abused by multiple men as she was having sex under the age of 16 and is currently in a 'relationship' with a 21 year old."* Due to

[16] The **Wellbeing Team (WBT)** is a primary care level team which offers evidence based psychological interventions delivered by trainee and trained therapists. This service can be referred to via Single Point of Access (SPA), internal HPFT teams and self-referral. This service is now known as Talking Therapies. This service works with people from the age of 16 in Hertfordshire.

[17] The Targeted Team

[18] Domestic violence protection orders - GOV.UK

[19] A MARM is a professional meeting held to address a high level of risk for an individual who has the mental capacity to make their own decisions but is at risk of serious harm.

the continued concerns about CSE risk, Claire was referred back to the MACE panel. The social worker also stated: ***"There is a risk Claire may accidentally or purposely overdose on medication or recreational drugs."*** Within the same meeting it was disclosed Claire might be pregnant.

Following Danny's eviction he went to stay with his sister. A week later, Police were called to that address due to a disturbance. They attended and arrested Danny due to a suspicion he caused a cut to Claire's nose. A counter allegation was made that she had bitten his shoulder. Bail conditions were put in place for him not to contact Claire but she allegedly used her social worker's phone to contact him. Another MARAC referral was made and this time was accepted. In the same month she was heard at MACE. No charges were brought against Danny for this allegation due to insufficient evidence and his bail conditions ended.

Claire's reported pregnancy influenced her decision to reduce her substance use and she engaged with CGL[20] (drug and alcohol support) to ensure she didn't unwittingly harm her unborn child. Sadly, in March 2023 Claire attended the maternity unit who found no signs of an active pregnancy. During this visit they saw physical injuries such as bruising to her neck, face and shoulder. She disclosed she had been assaulted by Danny whilst he was drunk. Police had arrested Danny a few days previously. He said Claire had turned up unannounced and they had argued over the baby. Police information indicated Claire had slapped Danny "a couple of times" around the face and Danny had grabbed hold of her, putting her to the floor, stomped on her right hand, strangled her and snapped her mobile. He was arrested and bailed with conditions including not contacting her or putting anything on social media in relation to her. Claire and Danny were heard again at MARAC at the end of March.

Claire and Danny's contact continued with Claire telling her social worker they both loved each other but both "have issues". By late May she told CGL she felt her mental health had improved as had her relationship with Danny. She said they would speak every day often on the phone for most of the day. This is the strongest indicator that Danny was breaching his bail conditions via daily contact with Claire, but police were not alerted to this by services.

Between late June 23 and mid-August Claire and Danny were seen, via CCTV, stealing food to the total value of £300 approximately from a local garage on eight separate occasions. Claire would later appear in court charged with all shoplifting offences. Around the same time CGL noted a marked decline in her physical presentation appearing thinner, more anxious and distracted.

[20] Spectrum Drug & Alcohol Recovery Services | Change Grow Live

On 24th July 2023 Claire's mother contacted the police. She said Claire had called her under the influence of alcohol saying: "*Mum I can't do this anymore, he beats me up on a daily basis, I have bruises all over my body. I don't want to live anymore and want to die''.* She told her mum she had been out collecting weed for Danny. Later that day he was arrested for assault due to an allegation of him grabbing Claire's shoulders and arms and resisting arrest at the same time. Though charged, the case was eventually withdrawn due to insufficient evidence. During the same incident Claire obstructed police by kicking a police officer in the stomach and biting an officer's hand. She was arrested for this and, together with the theft offences, would go on to receive a 12 month referral order. This led to her being allocated a youth justice worker. Danny was sentenced to compensation for the goods stolen only.

Multi agency work continued, one of the aims being to support Claire to expand her social circle and consider her future. To that end she began college in September 2023. Sadly, soon after starting she was suspended following an altercation with another student. Claire was alleged to have slapped the student around the face resulting in police intervention. Alternate accounts were given, Claire saying the student had insulted her by calling her a "crackhead" and another saying she had assaulted a vulnerable student after making comments about their weight. She would later tell services that the subsequent punitive action and looming court date added to her anxiety.

During this time mental health support continued to be sought. A referral to the ACMHS (Adult Community Mental Health Service) from the GP - an attempt to gain alternative provision as Claire was nearing her 18th birthday - was turned away due to Claire being too young. Claire continued to decline CAMHS. The lack of mental health provision continued.

Claire began her placement for 16 / 17 year olds in care with Peabody Housing, in late 2023. Within the referral to Peabody domestic abuse from Danny was identified with physical, emotional and financial abuse specifically mentioned. On her admission form she added Danny as her next of kin. She would frequently 'book out' to stay with Danny and wrote him down as her 'responsible adult' on the booking out form. He was also added as an allowed visitor, provided he left by 9pm. Peabody liaised with social care throughout Claire's time with them.

Social Care completed their pathway plan[21] for what was to be the last time with Claire in late 2023. Claire indicated Danny was her main source of support and she would go to him

[21] What is a Pathway Plan for Care Leavers? | Hertfordshire County Council This sets out what support the young person would like from Social Care or other professionals. It also looks at what the young person has already achieved. It is reviewed every 6 months.

above anybody else if she needed anything. At the same time Claire told Peabody staff Danny could say hurtful and aggressive thing to her but didn't hit her anymore.

In January 2024 another accommodation move was imminent due to Claire becoming an adult. During assessments Claire continued to talk about her relationship with Danny saying she did "not allow" him to work with women as she felt jealous. Staff overheard two arguments between them that month but no details were recorded meaning the content of these remain unknown.

Following her move to her new 'practice flat' Claire contacted Police at 2am on a night in February 2024, her first contact with Police in 3 months. She said she wanted "someone" removed from her flat. She was described as irate and distressed but hung up twice. On the 3rd call she said she'd made a mistake. Police did attend but Claire would not disclose further information. Several weeks later she said the 'someone' was Danny, they had argued and "things were smashed".

On 4th April 2024 police attended Claire's address. She told police "*He's doing his usual, screaming and crying*. *Every time he gets upset, he picks up a knife and threatens to hurt himself*. *He picked up a knife earlier* ". She said Danny had, on several occasions, taken a knife to his throat before pointing it at her. She said in the last three months he had broken her drawers, a lampshade and punched a hole in the ceiling. He'd also thrown a mattress at her, slapped her and pulled her by the hair. In investigating these allegations Claire's cousin was spoken to. She had a recording from March which showed red marks on Claire's face. The cousin told police Claire would *"end up dead due to Danny's controlling and abusive behaviour"*. Due to a previous negative experience with the police regarding her own domestic abuse experience, she declined to engage despite police encouragement. Danny handed himself into police on 8th April 2024, was arrested for threatening a person with a bladed article, criminal damage and common assault, and was given bail conditions not to contact Claire or attend her property.

CGL saw Claire soon after this and again had concerns about her presentation noting she was more underweight than usual and smelled strongly of cannabis. She said she was not eating "as much" due to stress in her relationship with Danny. She said he had been physically abusive towards her on numerous occasions recently and was "tired of the cycle". She felt broken down and described herself as Danny's "punch bag" when he is intoxicated. She said she was giving him one last chance not to drink.

The young person is central in creating the plan and are "in charge of the actions agreed". The plan includes goals / milestones for: accommodation, health, including mental and emotional health, practical life skills, including money management, education / training / employment, specific support needs, such as relationships etc, contingency plans for if something doesn't go to plan.

Claire informed Peabody, in April 2024, that she did not wish to see the emotional wellbeing worker who was male. She said, most of the abuse she had experienced was from men and she would prefer a female. Her PA (personal advisor), provided to her due to being a care leaver, was also a male. Peabody staff supported her to go back to the GP to get referred for emotional support. She continued to discuss her relationship with Danny, saying she found it hard to let go of him as he was the only consistency she had. Later that month, housing staff became concerned Danny might be staying in Claire's room, contrary to her license agreement. She denied this but following a room check they found him there. Staff noted a large bag with him which suggested he had been staying frequently. There is no record of the police being notified of this breach of bail and upon further examination Peabody state they were not aware of it. Ten days after this Danny was observed to have been at the accommodation again and seen exiting through a window. Peabody state they informed police this time via the non-emergency number but despite several checks under different information there is no record of this call on Police systems. Peabody staff recorded that when they informed police they were advised they could call back if Danny caused ASB (antisocial behaviour). Danny was placed on a visitor's ban and Claire was given a warning for breaching the scheme's license agreement. Subsequently she stayed out more. Staff continued to check on her welfare, but Claire did not consistently respond to their contact.

Danny's bail conditions were ended by the police in mid May 2024 due to insufficient evidence. Had Peabody been aware of bail conditions and reported breaches, Police would have had more information to consider evidence led prosecutions[22].

In late May 2024, a friend of Claire's, also a resident, entered her flat following Claire not answering her phone. Tragically she found Claire deceased. Paramedics found three packets of empty prescription medication which had been ordered on an emergency prescription two days before. The friend told Police she had seen Claire the previous night who said, "I DON'T WANT TO BE HERE, I WANT TO SEE MY GRANDAD, I WANT TO KILL MYSELF." Claire told the friend she had met Danny earlier that evening, they had argued before he'd said, "GO KILL YOURSELF LIKE YOUR COUSIN DID." When Claire went to leave, Danny allegedly grabbed her around the waste and pulled her hair before she ran away. During Police investigations another friend informed police Danny had told Claire to kill herself on two previous occasions following the death of her cousin. Following police enquiries, no charges were brought against Danny. During the course of this review it was queried whether a crime was recorded to specifically investigate the allegation of Danny telling Claire to go kill herself under Online Safety Act 2023 or any other relevant legislation. This was not completed at the time. It was looked at retrospectively by the Police who spoke to the Force Crime Registrar[23], a senior police role responsible for

[22] Evidence-led prosecution checklist for domestic abuse cases | College of Policing
[23] Force crime registrar - His Majesty's Inspectorate of Constabulary and Fire & Rescue Services

ensuring a police force accurately records crimes according to national standards. They said the allegation would be covered by the Suicide Act 1961 not the online safety act. Police were aware of the allegation due to 3rd party reporting and, due to this and other factors, felt it would not meet the necessary threshold for further actions. Police also felt, given Danny and Claire's known history, coercive control should have been explored during Danny's last arrest which is a learning point for officers in the future.

Conclusions

Relationships were of key importance to Claire - relationships with her family, her friends and Danny. When difficulties in these relationships arose, Claire felt these sharply as evidenced during Christmas 23 when she felt she felt rejected by her mother leading to a self harm incident. Claire was not alone in this. Research[24] details the importance of relationships and connectedness to the teenage brain in particular:

"findings across these studies provide support for the premise that adolescents are "wired to connect" and when that connection is positive, it results in better outcomes for youth both concurrently and over time. In contrast, when there is family dysfunction or peer victimization, adolescents are more likely to develop neurological circuitry that puts them at risk for psychopathology[25]."

There was a known risk of Claire ending her life either intentionally or accidentally, acknowledged and recorded by agencies explicitly. Danny would have been aware of her previous self harm / suicidal intent, which is important to consider alongside the allegation he told her to kill herself the day before she died. The acute emotional pain Claire felt when she perceived rejection was likely to lead to increased risk of self harming episodes, as evidenced by her actions, which in itself was more likely given the abusive relationship she was in. There was a lack of connection from services to loss and rejection as a trigger to her overdose / self-harm risk. This meant a lack of practical, domestic abuse informed, suicide / overdose prevention plans conducted with her directly.

In addition to several incidents of self harm, Claire experienced loss during the scoping period with the loss of her granddad who she was close to and the loss of her baby at the beginning of pregnancy aswell as a distancing from her family due to leaving home. This was in addition to continued abuse and arguments with Danny aswell as friction with friends. These incidents offered moments to re-evaluate risk of suicide / overdose but, based on agency submissions, this consideration does not appear embedded in agency practice as of yet.

[24] Adolescent Brain Development: Implications for Understanding Risk and Resilience Processes through Neuroimaging Research - PMC

[25] Psychopathology – The behavioural or cognitive manifestations of mental health issues.

Claire clearly voiced how she felt Danny was the only consistency she had in life and was struggling to break away from him, often voicing a reluctance to do so. She hoped he would change his behaviour and framed his abuse around his alcohol use or anger issue and how, when he sorted this out, everything would be better. As the Police IMR author detailed: *"Danny undoubtedly utilised Claire's vulnerability, which is reflected in the domestic abuse he committed against her"* again highlighting how Claire's hopes were unrealistic. Domestically abusive behaviour is difficult to effectively address without meaningful engagement in specific targeted work such as a domestic abuse perpetrator programme[26] (DAPP - see ToR 4.15 in full report). It is often engrained in attitudes, beliefs and patterns of behaviour. Addressing this behaviour effectively is unlikely to be achieved by alcohol or anger intervention alone. There is no record of this conversation being held with Claire nor of any consideration of a DAPP for Danny.

There were many multi agency meetings held such as MARAC, MACE and MARM. These meetings had varying levels of success dependent on whether all agencies were involved or aware of their occurence. In some, there was a lack of identfiied actions which could reduce risk both in the immediate future and longer term. There was an over reliance on the IDVA creating change and a lack of consdieration of how to address the perpetrator's behaviour. This is said with the knowledge these meetings are strictly time bound. But, direction from a MARAC (for example) for agencies to meet, analyse the domestic abuse and co-ordinate a consistent response is a tool available to them.

Concerns were not hidden. Agencies, for the most part, were speaking to each other, were sharing information and some support was offered, especially with Claire having contact with social workers, CGL, housing support staff, a youth justice worker and contact with an IDVA. Danny also had support whilst staying in Emerging Futures accomodation, for 6 months at least, was referred to counselling, interacted with CGL, albeit minimally, and was supported to gain medication from his GP.

A key time within this review was November 2021 when Claire moved in with Danny and his family. She was 15 at this time, a child, and on a Child Protection Plan with Danny a similar age to those who had been accused of sexually asaulting and raping her earlier that year. This review can not say either way whether Danny was connected to those individuals, just that he and Claire knew each other via "mutual friends". With regards to these living arrangements, there appears to have been a lack of consideration of:

- Demographics (age, sex)
- History of the family Claire was moving in with
- Contextual factors (Claire being at risk CSE from men of a similar age)
- Connection to Claire and her family.

[26] Evidence from a study of DAPPs

The latter point is especially important. The Home Office kinship care guidance[27] has multiple definitions of what may consitute a private fostering arrangement with the following appearing most relevant for Claire's situation at that time:

"A private fostering arrangement in which someone who is not a close relative of the child under the age of 16 looks after the child for 28 days or more (as per section 66(1)(a) and (b) of the Children Act 1989)"

This definition appears in contrast to the overall aims of this approach which is stated as: *A key principle of the Children Act 1989 is that children are best looked after within their families, with their parents playing a full part in their lives, unless compulsory intervention in family life is necessary.* It continues: *Kinship carers play a unique role in enabling children to remain with people they know and trust if they cannot, for whatever reason, live with their parents.*

There was a known social care history with Danny's family albeit at Child in Need level. Of particular relevance was his aggression towards siblings and alcohol issue. There appears to have been no risk assessment completed prior to or during Claire residing with Danny which considered her vulnerability and risk of CSE, nor Danny's age in relation to her. Although her parents consented to this move and it was not a local authority decision, one could reasonably expect a child on a child protection plan (CPP) to have a thorough risk assessment in relation to their, albeit temporary, living arrangements. Although no domestic abuse was known at the time, the age difference was stark, they presented as a couple soon after Claire moved in and Claire was a minor. Based on this alone, it was not an appropriate environment for Claire to live in and gave Danny and Claire a foundation to build an "intimate relationship". This is written in quotation marks to be clear that services should be extremely cautious of a girlfriend / boyfriend presentation between a 19 and 15 year old. The CSE (child sexual exploitation) concerns from earlier in the year compound this view. Although Claire left this housing arrangement in Feb 2022 due to it breaking down, that is at least 3 months with them together. The first months of any initimate relationship are key to creating and strengthening bonds so this is highly signifcant.

There are parallels between both Claire and Danny's upbringing as can be seen below:

- CSC (Children's Social Care) involvement due to neglect concerns
- Domestic abuse in the home
- Losing friend(s) to suicide as children (reported to professionals at the time)[28] which research indicates increases risk of suicide.
- Overdose of sertraline in adolescence.
- CAMHS involvement as children
- Both from large families (Danny one of six, Claire one of five)

[27] Kinship care: statutory guidance for local authorities

[28] Contagion of crisis: Associations between suicide attempts in the social network and suicidality among late adolescents - ScienceDirect

- Use of substances and / or alcohol in adolescence.
- Poor school attendance whilst in education.

This is listed to acknowledge the vulnerabilities of both parties and the complexities of their situations. It perhaps gives insight into how shared experiences and trauma can create a bond which becomes difficult to break away from.

A 2009 report from the NSPCC[29] highlighted associated factors, both for experiencing and instigating abuse in teenage relationships. It included previous experiences of child protection concerns, domestic abuse in the family and aggressive peer networks, all of which were present here. For girls, having an older partner, and especially a "much older" partner, was associated with the highest levels of victimisation. This research also found that, for girls, self-blame was prominent, especially in relation to sexual coercion which is of relevance, especially considering Claire's CSE experiences.

Individual Management Review (IMR's) indicated much of the domestic abuse intervention centred around educating Claire about healthy relationships, primarily from social care's healthy relationship work. There was anxiety from housing support around Claire disengaging from services if she felt pushed to end her relationship and Social Care referenced trying to "break the cycle" of their relationship. As referenced in the analysis (ToR 4.9), there is a nuance to this and how it's done which requires a thorough understanding from all agencies about what the consistent messaging will be *e.g nobody can tell you what relationship to be in, but these boundaries (bail cons, housing rules) are required to help you be safe and give you the space to focus on yourself.* Another example of said nuance is a programme in Chesire Without Abuse[30] offering domestic abuse intervention for couples where they were seen separately. Anecdotally they reported 80% of couples who started together had separated amicably by the end of the programme. There was a realisation from them that the relationship was not in their best interests.

Housing services tried to put boundaries in place e.g visitor bans, with the only real consequence for breaches being an eviction for Danny who consistently had Claire at his accommodation and by that point said he was sick of people telling him "how to live his life". There were similar warnings for Claire and also evictions (though these also related to her alcohol use and verbal abuse of staff). It is a key learning point of this review for services commissioned to house and support some of our most vulnerable, to consider these circumstances through a domestic abuse lens e.g if someone is known to experience abuse, evicting them as a result of the person causing harm relentlessly attending the property is perhaps not a just or reasonable response. Where there are bail conditions preventing someone from attending one of their properties, it is vital for housing services supporting the most vulnerable to be aware of this so they can help enforce

[29] Partner exploitation and violence in teenage intimate relationships (executive summary)
[30] About | My CWA, Cheshire

restrictions and offer support to evidence lead prosecutions. This is another key learning point.

This review also found a drift in mental health intervention for Claire which was, in part, due to agencies not agreeing on an alternative to CAMHS whom she did not want to engage with. Where a child / adolescent does not wish to take up this option, an available alternative is important to identify to avoid referrals being submitted with little chance of success. This is likely to require communication between those services to identify what is in the best interest of the child / young person. There was an emotional wellbeing worker available at her accommodation (para 3.97 of the main report) but, as he was male, this was a barrier to engagement for Claire.

Should the following saying, attributed to Mahatma Gandhi, be true: *"The true strength and morality of a society are reflected in how it treats its most vulnerable members",* then some hope for the future can be gleaned from the efforts of services to support and engage Claire both before and after she entered care. There is strong evidence of persistence and care from services. But analysing domestic abuse, co-ordinating and understanding next steps still requires embedding in agency processes. This includes being clear on the link between domestic abuse and increased risk of self-harm, overdose or suicide.

Section Six - Lessons to be Learned

Lesson 1 – History of suicidal ideation / overdose whilst experiencing domestic abuse heightens risk of death via overdose and / or suicide. This is relevant for all services to embed within practice but is especially important for GPs when making prescription decisions.

Narrative

Tragically, Claire died following an overdose of prescription medication. This appears to have occurred following an altercation with Danny who allegedly told her to kill herself. They had been in an on / off relationship for three years with their situation being heard at MARAC three times. Just prior to her overdose and the most recent abuse from Danny, she had been prescribed medication to alleviate low mood.

Lesson to be Learned

To reduce risk of overdose, a greater weight should be placed on the elevated risks associated with a presence of domestic abuse and a self-harm / suicidality history. These should be considered when deciding on medication prescription amounts. Contextual factors such as a patient's age, care leaver status and current relationship status are also important factors to consider in this regard.

Lesson 2 – Housing providers supporting the most vulnerable should be informed by Police if there are bail conditions relating to their tenants.

Narrative

April 2024 saw another serious domestic abuse incident from Danny towards Claire. As a result, he was given bail conditions not to contact her or attend her address. However, he was seen on at least two occasions by housing staff to be present in direct breach of these. The belongings found indicated he was staying regularly. Peabody were not aware of bail conditions. They did not report the first sighting to police. They stated they reported the second via the non-emergency number but there is no record of this on police systems. As a result, Danny never faced consequences for ignoring his bail conditions and Claire received a warning for 'allowing' him to stay.

Lesson to be Learned

Providers supporting the most vulnerable of our society should be aware when their tenants have protective measures in place so they can support breaches and criminal investigations including evidence led. Police should be aware of which premises are used to house vulnerable people locally and ensure the provider is alerted. It should be stated clearly within housing policies / guidance what action is expected if someone is breaching bail conditions e.g contact 999.

Lesson 3 – Identifying an alternative to CAMHS where a patient declines.

Narrative

Claire had very limited support from qualified mental health practitioners during the scoping period. This was in part due to her not wishing to engage with CAMHS. This resulted in drift of tailored mental health intervention with several referrals submitted to CAMHS despite Claire's reluctance to see them.

Lesson to be Learned

Where a young person declines CAMHS, services should work together to identify how they can effectively engage and support someone. In Claire's case she was a looked after child. Therefore, if similar circumstances arise, Social Services are well placed to lead these discussions to identify, alongside partners, what the next best specialist mental health support could be.

Lesson 4 – Review of supported accommodation visitor bans in domestic abuse situations

Narrative

Supported Housing for both Danny and Claire consistently tried to manage breaches of license agreements with unauthorised visits from partners via visitor bans. These bans

resulted, on a least one occasion, with the eviction of the person who was being constantly visited by their partner. The emphasis was placed on the tenant to manage their visitor and prevent them from attending. In a domestic abuse context this can be very challenging to do and where circumstances are unclear e.g are they 'allowing them to enter' or are they 'coercing their way in'?, caution is required to avoid unwittingly penalising those experiencing abuse.

Lesson to be Learned

Housing providers, especially those who support vulnerable young adults, should view continuous breaches of license / tenancy agreements, via one person's repeated unauthorised attendance, through a domestic abuse lens. They should work with the Police to consider whether harassment is occurring and utilise the criminal justice system.

Lesson 5 – MARAC to review actions available and include perpetrator consideration consistently

Narrative

Danny and Claire were heard at MARAC on three occasions. During discussions, a focus on how to challenge Danny's behaviour was minimal. The attention was predominantly on working with Claire to reduce risk. Where actions were identified they mostly revolved around the IDVA making contact or information sharing for local police.

Lesson to be Learned

MARAC is an opportune moment to galvanise those working with / aware of the primary perpetrator and consider whether it is safe for agencies to challenge the alleged behaviour constructively. Ensuring the professionals working with those using harm are aware of the MARAC, can contribute and take appropriate actions away is a crucial step in addressing domestic abuse over the short and longer term.

Lesson 6 – MARAC to retain list of rejection reasons

Narrative

MARAC rejected a referral in December 2022 following a police referral (See ToR 4.3). The reasons for rejection were inappropriate. In fact, this was an opportune moment to hear the case again as Danny was due to be evicted the following month, was due to begin talking therapy and had recently ended his medication. MARAC never became aware of this information as assumptions were made about the current circumstances.

Lesson to be Learned

To ensure accountability and scrutiny, MARAC must begin to record the rejected referrals with reasons for rejection recorded. This review can be used for learning purposes and to

remind professionals of the importance of not assuming. UPDATE – This has been actioned locally.

Lesson 7 – Police to review circumstances in which they decline DVPO applications.

Narrative

A Superintendent rejected a DVPO application from their DC (detective constable) which had already had the approval of their DI. The DC challenged this rejection and showed diligence and creativity in their approach to trying to reduce risk. The reason for rejection (ToR 4.14) was due to the Superintendent not believing Danny had threatened violence against Claire. The rejection from this Superintendent appeared subjective. This Superintendent has now retired.

Lesson to be Learned

Superintendents have the final say as to whether DVPO applications are made or not. This review should be shared to encourage reflection as to when to approve or reject an application from one of their officers.

Lesson 8 - Kinship care decisions require thorough assessment of the background, make up and connection of potential kinship carers

Narrative

Kinship care statutory guidance *"aims to improve outcomes for children and young people who, because they are unable to live with their parents, are being brought up by members of their extended families, friends or other people who are connected to them."* This review has found that a thorough exploration of one's future kinship care household is required to prevent opportunities for intimate relationships to develop or for exploitation to occur. As the conclusion details, Claire was staying with Danny when she was 15 and he 19. This created an opportunity for a relationship to form with the connection between them relatively unknown and Claire having been abused by men of a similar age earlier that year. Similar learning was highlighted within the extensive 2025 National Audit on Group-Based Child Sexual Exploitation (Casey report), which highlighted age difference and non-adultification (not viewing children as adults) as particularly important to capture within analyses.

Lesson to be learned

When assessing potential kinship carers, it's vital for services to recognise contextual factors which may have relevance to risk assessments. For example:

- Demographics (age, sex) of the household
- History of the family with social care
- Contextual factors (in this review Claire had recently experienced Child Sexual Exploitation.)

- The connection of the child to the family e.g how they met, how deep the connection is.

Lesson 9 – Pathway Plans for care leavers are an ideal time to reassess domestic abuse associated risk.

Narrative

Pathway plans are conducted every 6 months for care leavers with their leaving care personal advisors. Claire had what was to be her last review in December 2023. This plan looks at relationships and mental health amongst others . Claire voiced going to Danny if she needed help and support during this session which was an ideal opportunity to prompt a conversation about alternative support mechanisms and the danger of relying on Danny to be supportive, given the history.

Lesson to be learned

The Pathway Plan presents an ideal opportunity to review risk and suicide prevention / safety plans. This should be prioritised for those in domestically abusive relationships and with a known history of self harm / overdose. Care leavers should be supported to identify alternative support in times of need / crisis away from the known abuser.

Lesson 10 – Trauma informed and gender responsive services.

Narrative

Claire articulated she did not feel comfortable speaking to a male emotional wellbeing worker (para 3.97). She said this related to her difficulties with men which is understandable given her history of sexual exploitation and abuse. This preference led to her sessions being cancelled as there was no other option.

Lesson to be learned

Offering trauma-informed and gender-responsive services, including where possible, providing choice over the sex of practitioners is important to factor into commissioning and design of services. This can be particularly meaningful to those who have experienced sexual violence, abuse or exploitation.

Recommendations

National recommendation

Recommendation 1 – Home Office / Children's Social Care

Learning from this review to be shared with the Home Office for future iterations of their kinship care guidance. This review highlights the importance of a thorough assessment of a kinship care household prior to a child residing with them to reduce the risk of future harm.

Local

Recommendation 1 – Police (alerts to housing providers regarding bail conditions)

Police to inform housing providers supporting those in care / care leavers when bail conditions are in place preventing someone from attending their premises.

Recommendation 2 – Peabody / Emerging Futures (Review the use of visitor bans)

Housing providers supporting those most vulnerable to review the use of visitor bans. To consider learning from this review to incorporate a domestic abuse response when trying to prevent breaches of tenancy / license agreement / eviction.

Recommendation 3 – Peabody / Emerging Futures / Personal Advisors (Enhanced domestic abuse training)

Housing providers supporting residents such as Claire and Danny (e.g care leavers, those with alcohol / drug concerns) to consider enhanced training to support and challenge those using abusive behaviour in a constructive manner.

Recommendation 4 – MARAC (Capturing referral rejection data)

MARAC to capture referral rejection data and rationale for rejections to increase accountability and identify learning opportunities.

Recommendation 5 – MARAC (Broadening actions to include perpetrator responses)

MARAC to review available actions to broaden their approach to risk reduction and include perpetrator responses.

Recommendation 6 - Criminal Justice Liaison & Diversion Service HPFT (Utilizing the opportunity of custody to signpost and encourage engagement)

For L&DS to ask those arrested for domestic abuse offences whether they would like support to prevent a reoccurrence. L&DS to consider referral to local domestic abuse perpetrator intervention (e.g Chrysalis)

For a full break down of agencies single agency recommendations please see the full report.

Appendix A

Complete Terms of Reference

The review will also specifically consider:

Domestic Abuse

Whether Danny and Claire had any previous history of abusive behaviour towards each other or anyone else, and which agencies this was known to.

Whether Danny and Claire's domestic abuse related history was considered when assessing risk. Were appropriate referrals made from these assessments?

A review of any Multi-Agency Risk Assessment Conference (MARAC) / MARM involvement and it's effectiveness.

Whether family and friends were aware of any abusive or concerning behaviour between the perpetrator and victim (or other persons). Were there any barriers they may have experienced in reporting concerns if they knew how to and felt able to?

Risk assessment

Were services clear with who was doing what to whom within the relationship?

Were counter allegations robustly assessed?

Is further guidance and support required to assist frontline practitioners with accurately understanding the domestic abuse dynamic?

Support for young people in abusive relationships

Does local domestic abuse provision provide for those under 18? Is this sufficient?

Did those supporting both Claire and Danny have the required domestic abuse knowledge and training and were they able to have conversations to support change and reduce risk?

Mental Health

If known, were Claire's domestic abuse experiences considered within the mental health support she sought or was referred to?

Were suicide prevention plans made with Claire and did these consider the domestic abuse she was experiencing?

Disrupting perpetration

Were opportunities to support Claire to apply for legal orders (e.g non-molestation orders) recognised and utilised?

Were all opportunities for evidence lead prosecutions utilised?

Were opportunities to prevent Danny from contacting Claire utilised?

Were there services available locally for those using harmful behaviour and if so, were these known about and were there opportunities to inform and direct Dannyto these. Were practitioners who supported Danny confident in knowing how to ask these questions?

Additional:

An evaluation of any training or awareness raising requirements that are necessary to ensure a greater knowledge and understanding of domestic abuse processes and/or services in Hertfordshire, especially for younger people and those transitioning to adult services.

Communication to the general public and non-specialist services about available specialist services related to domestic abuse. This is particularly pertinent to looked after child provision and supported housing.

Whether the work undertaken by the services in this case is consistent with its own: professional standards, compliant with its own protocols, guidelines, policies and procedures.

Do the lessons arising from this review appear in other reviews held by this Community Safety Partnership?

Any other information that becomes relevant during the conduct of the review.

Key Line of Enquiry

Claire had been a looked after child months prior to her death. Did the transition from child to adult services impact upon the domestic abuse (DA) support provided and the DA awareness of all agencies?

Appendix B

HPFT definitions -

Single Point of Access (SPA) is the initial contact and triaging service for all referral entering HPFT from external sources. SPA will triage the content of the referral and consider risk before passing the referral to an appropriate team.

The **Adult Community Mental Health Service (ACMHS)** offers a multi-disciplinary service to adults experiencing severe and enduring mental illness. This service falls under secondary mental health services. These teams comprise of a range of professions: specialist medical professionals, nursing, social work, occupational therapy, psychological therapy, art psychotherapy, drama therapy, psychology, support workers and administrative staff. Each ACMHS covers a specific area of the county which is divided into quadrants with multiple teams within each quadrant. This service can be referred to via SPA and through internal HPFT teams.

Child and Adolescent Mental Health Services (CAMHS) is the children's equivalent of ACMHS and offers support for those children with a mental health need who require intensive and specialist intervention. CAMHS have different tier-based services available depending on the level of need and risk presented by the child, with referrals being made via SPA. This includes specialist teams such as Targeted CAMHS which is a service that work with Children Looked After (CLA). For the purpose of this report, it is of note that Leanne was under Tier 3 Community CAMHS and this service is referred to in the report as CAMHS for ease.

The **Crisis Assessment and Treatment Team (C-CATT)** is a crisis service for children who work alongside the local A&E teams and Tier 4 services. The purpose of this team is to provide more immediate assessment and intervention on a short term basis.

The **Wellbeing Team (WBT)** is a primary care level team which offers evidence based psychological interventions delivered by trainee and trained therapists. This service can be referred to via Single Point of Access (SPA), internal HPFT teams and self-referral. This service is now known as Talking Therapies. This service works with people from the age of 16 in Hertfordshire

The **Community Perinatal Team (CPT)** is a specialist multi-disciplinary team that supports women who are experiencing, or are at high risk of experiencing, moderate to severe mental health difficulties when they are pregnant and after having their baby

Street Triage is a service that is accessed by the Police. This service support with attending incidences when required by the Police in relation to a mental health concern and provide information and advice to Police Officers when required.

The **Criminal Justice Liaison & Diversion Service (L&DS)** is based within Police stations and sees people detained by the Police in custody. The practitioners in this team can review if there are additional mental health support required by the person and make onward referrals to HPFT services. This team are also in place to provide any advice on considerations around detention under s.136 of the Mental Health Act (MHA).