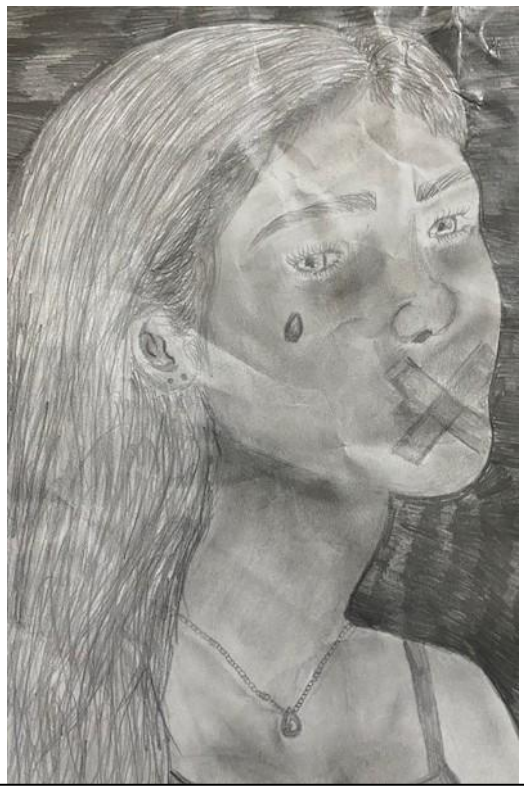
Domestic Abuse Related Death Review

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 and words by Claire

Chair and Author: Christian Brazier

Date of completion: 11th February 2026

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Glossary:

Acronym	Name
AAFDA[1]	Advocacy After Fatal Domestic Abuse
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)
CL	Care Leaver
CLA[2]	Child Looked After
CPP	Child Protection Plan
CSC	Children's Social Services
CSE	Child Sexual Exploitation
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
HCT	Hertfordshire Community NHS Trust
HPFT	Hertfordshire Partnership Foundation 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[3]
SPA	Single Point of Access[1]
SWKR	Social Worker
TAF	Team Around the Family
ToR	Terms of Reference
YEF	Youth Endowment Fund

[1] Home - AAFDA – Providing advocacy for family members who have lost a loved one to domestic abuse.
[2] Child Looked After – Children in Hertfordshire were asked for their preferred term and this was their chosen one.
[3] Continuum of supoort for adolescent service

Preface:

The author and panel wish to express their deepest condolences to Claire's family and friends. Their 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.

Section One

Summary of Circumstances leading to the review:

1.1.1 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.

1.1.2 Claire had been known to many services: Children's Social Care having recently been a looked after child[4], CGL[5] (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. Due to the known history of domestic abuse, it was agreed Claire's situation met the criteria for a DARDR (Domestic Abuse Related Death Review).

1.1.3 The key purpose for undertaking Domestic Homicide Reviews (DHRs) / Domestic Abuse Related Death Reviews (DARDRs) is to enable lessons to be learned. In order for these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each domestic abuse related death, and most importantly, what needs to change to reduce the risk of such tragedies happening in the future.

Reasons for Conducting the Review

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

1.2.2 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.

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

[4] What is a looked after child?
[5] Spectrum Drug & Alcohol Recovery Services | Change Grow Live

"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." [6]

1.2.4 The purpose of the DHR is to:

- Establish what lessons are to be learned from the Domestic Homicide / Victim Suicide 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 and share good practice.

Timescales

1.3.1 The Hertfordshire Community Safety Partnership (CSP) was notified of the death of Claire on 7th June 2024

1.3.2 On the 2nd July 2024 the Hertfordshire CSP decided the criteria had been made to conduct to a Domestic Abuse Related Death Review.

1.3.3 The Home Office were notified of this decision on 3rd July 2024

1.3.4 On the 19th May 2025 a chair and author was appointed. This delay was due to the volume of DHRs locally and availability of chairs.

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

1.3.5 Scoping documents were sent out to ascertain which agencies had some knowledge of the couple. Those services with contact were invited to a panel to discuss the review and their participation within it. Panel meetings were held via Microsoft Teams on:

- Initial Panel Meeting - 09/06/25
- Panel Meeting 2 - 15/09/25
- Panel Meeting 3 - 20/10/25
- Panel Meeting 4 - 01/12/25

Where additional information was required, individual meetings were held with services separately as deemed appropriate by the chair.

Confidentiality

1.4.1 The findings of each review are confidential until such a time as the review has been approved for publication by the Home Office. Information is available only to participating professionals and their line managers. A copy of the draft review was provided to Claire's family to feedback and comment on in November 2025.

1.4.2 To protect the identity of the deceased and her family, pseudonyms have been used throughout this review. These were chosen by the chair and confirmed by Claire's mother.

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

Methodology

1.5.1 During the initial panel meeting it was agreed for the scoping period to range from March 2021 – May 2024. Agencies were tasked with providing a chronology of their involvement between this time.

1.5.2 Agencies were asked to complete Individual Management Reviews (IMRs). IMRs are an opportunity to internally explore a service's work thoroughly, identify areas of good practice and any improvements. Agencies were asked to go beyond whether or not processes were followed and consider changes / enhancements for future practice.

1.5.3 Agencies were reminded the review process is not about blame but about learning - "illuminate the past to make the future safer".[7]

[7] DHR-Statutory-Guidance-161206.pdf Section 8

1.5.4 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 and their contribution can be found in the family contribution section of this report.

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

Terms of Reference

1.6.1 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.

1.6.2 A full term of reference forms the analysis in Section Four and can also be found in Appendix A. The family were met after the terms of reference had been agreed but were provided an opportunity to feedback. They also viewed the draft report.

1.6.3 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.

1.8.1 Involvement of family, friends, colleagues, neighbours and wider community.

The chair and panel would like to place on record special thanks Claire's mother for providing insight into her daughter's experiences. At what is a difficult time, this contribution is much appreciated and highly valued. Involving Danny in the review was considered by the chair but, due risk related information being received, was not considered appropriate in this instance.

Contribution from Claire's mother, Cathy (pseudonym).

Cathy (pseudonym) described Claire as a happy, kind hearted child growing up who had a talent for drawing. She was the middle child of 5 with three sisters and a brother who were like 'peas in a pod' in their early years. Cathy described Claire as having a close relationship with her parents and her elder sister especially. She would often call her mum even when living away from home. Sometimes this was to chat, others to cry, laugh or start an argument. Claire would often go to the local church down the road from the family home, to its youth club and had regular support from staff there. Although not religious this appeared meaningful to her and they knew her well.

In her younger years she "loved who she was" but as she got older and started secondary school her self esteem declined. She became very conscious of her appearance and weight. Cathy felt social media influenced this and pressurised her to feel and look a certain way. She could struggle to articulate how she felt and would be quick to anger sometimes.

As time progressed Cathy noticed changes in Claire's mood with her having, what she described as, extreme highs and lows. She gave an example of Claire not wanting to get out of bed for several days and then having lots of energy at other times. She felt she needed mental health input and possibly had bipolar[8].

Cathy spoke of involvement from agencies over the years due to difficulties at home and mentioned calling Social Care herself in 2021. This was because she felt Claire's behaviour had become so erratic she worried about the impact on her two younger sisters. Subsequent intervention from services proved problematic as there were many changes in social workers. This made it difficult to gain progress, resulted in repetition of stories or meant different views from different workers. Cathy gave examples of how agency advice undermined what she was trying to do. For example, on one occasion she took Claire's

[8] Bipolar - MIND

phone away as a consequence but the police told her to give it back. There were other occasions where social care / family workers would take Claire out to Mcdonalds or buy her clothes but this occurred directly after she had been reported missing. Cathy felt this was rewarding her behaviour. Additionally, Cathy said one social worker told her she didn't need to attend CAMHS (Child and Adolescent Mental Health Service) if she didn't want to which Cathy felt did not help her get the right mental health support in place.

There were occasions when Claire would ask to see her sisters but Cathy was reluctant to allow it until Claire had 'sorted herself out' meaning her behaviour was more stable. But there were still occasions when the family got together. There were other times where Cathy was happy to have her daughter home but she felt Claire did not want to return for reasons of pride or thinking the family would say "I told you so" as things were not working out for her living independently.

Cathy spoke about Danny and Claire's relationship and gave an example of the behaviour she witnessed from Danny to Claire. Having been through a difficult time, a concerted effort was made for the family to get together to celebrate Claire's 18th birthday. This had been going well but Claire received relentless calls from Danny throughout the day. This resulted in her saying she said she would need to go and see him. When she did, they argued, and he left her stranded in a remote part of Hertfordshire. Cathy also witnessed name calling from him and was told by Claire he would wake her up during the night if he was hungry or wanted drugs / alcohol. Cathy heard Danny's temper when on phone calls. On one occasion, when she went over to his house Danny stopped his temper immediately upon seeing Cathy, evidence perhaps of his ability to control himself.

Two months prior to Claire's death Cathy wanted to give her daughter and Danny a chance and invited them over for dinner. Having initially been a nice evening, Claire became agitated when seeing Danny and her mum walk together down the road. Cathy found it difficult to understand but has since reflected how Claire may have wanted her to 'call Danny out' for his behaviour rather than get on with him, but had felt unable to say it. Cathy also saw a jealousy from Danny to Claire and vice versa with arguments triggered if one or the other saw pictures of the opposite sex on their phones.

Contribution from Claire's Secondary School

Claire attended a secondary school in Hertfordshire situated in an affluent part of the county. This created some disparity / disconnect to other pupils as Claire was not from affluence. School described her as intelligent and being aware of how she differed from other students. Her older sister, who attended the same school (year above), was described as softly spoken and quiet whilst, in contrast, Claire could be quite stubborn and have a sharp reactive tongue but was kind-hearted. She often reflected and apologised after some time if she'd felt she'd gone too far. She tended to gravitate towards more vulnerable pupils who had their own issues and initially formed part of a group of four children before two of those left, limiting her social circle.

When she arrived at secondary school she and her siblings were on a Team Around the Family (TAF)[9] plan, meaning there was some awareness of concerns about family wellbeing and / or circumstances requiring agency support. She would occasionally voice concern about her younger sister's wellbeing to teaching staff and could become upset in this regard. Claire continued to be open and spoke about issues to teaching staff throughout her time there.

Whilst she did have friendships at school there were frequent falling outs between them which would often stem from online comments. Claire would also get involved in arguments which did not initially involve her, such as a time when she defended someone who she felt had experienced racism. A sense of injustice was a key trigger for Claire's emotions to heighten.

School felt Covid was a key time for her and the family as post the first lockdown her attendance declined rapidly. There had been previous attendance concerns but not to the extent of post Covid. Claire would contact school asking to come in but due to her father's health issues there was anxiety from the family about her encountering anybody who had Covid. This meant she did not attend even when school was beginning to return to normal. The family were provided laptops to engage but these were not utilised. Regardless, school attempted to contact home every 2 days as Claire was on their vulnerable list. It was felt this period had a significant impact on her general wellbeing and risk-taking behaviour which increased afterwards.

School were aware of issues with online interactions dating as far back as September 2018 when Claire, aged 12, spoke to an older man on Instagram. On this occasion she fell out with friends due to them disclosing it to teachers. Aside from this Claire was often very open about home and social life. There was a particular spot in the school grounds where she would sit and talk loudly to friends knowing full well that teachers could hear. She'd also allow her phone to be checked regularly.

There were sometimes contradictions in Claire's behaviour. For example, in July 2020, following her first overdose, Claire posted online about it. However, she then said did not want people to be talking about it at school and the potential rumour mill became a reason for her staying away. Following this overdose she e-mailed her teacher saying, *"You don't care about me. It took for me to nearly kill myself for you to give a damn".* Missing person episodes increased with, at times, significant campaigns to try and locate her. When Claire did contact school, e-mail communication was her preferred method. School felt it gave her time to think and articulate herself.

In Dec 2020 Claire was admitted to hospital due to alcohol / cannabis use. Her teacher reflected how these self-destructive incidents appeared to happen prior to a holiday periods.

School were very much part of the multi-agency network throughout Claire's time with them. In March 2021, many other agencies became involved due to increased risk of CSE

[9] team-around-the-family-meetings.pdf

(see chronology). School observed Claire having positive relationships with the HALO[10] (specialist police team) worker, SARC[11] (sexual assault referral centre) and SASH (social care) workers. They felt the listening skills of these professionals were key in developing those relationships. They felt where interventions relied on parental consent it became difficult as sometimes that didn't happen. As missing person episodes increased, parental involvement also increased.

After March 2021, Claire's engagement with school declined rapidly with Claire, on one occasion, telling her teacher she was a "two faced bitch" and to "fuck off". She later apologised saying she felt embarrassed for saying it, as was her pattern. However, this and the perceived rumours contributed to her feeling she needed to leave school and start again. The fair access protocol[12] was initiated to support Claire to find an appropriate placement (mid 2021).

School offered counselling throughout Claire's time with them. This was on a drop-in basis. After Claire attended one she would then say she no longer needed it resulting in no consistent therapeutic input via school. As with all students she would have been involved with protective behaviours sessions in Yr 7, if in attendance.

School were very aware of Claire and clearly cared a great deal for her. This came through in their persistence in engaging her, wanting to listen and support and going above and beyond with their communication efforts. On reflecting on her time with them they felt she deeply struggled with her self-esteem and resilience, and this could be seen in some behaviours which could be described as needy or attention seeking. As an observer, school felt there was a push and pull between CSC (Children's Social Care) and Claire in 2021 with CSC telling her to go home and Claire clearly saying she did not wish to return.

Contributors to the Review

1.9.1 Those contributing to the review do so under Section 2 (4) of the statutory guidance for the conduct of DHRs, and it is the duty of any person or body participating in the review to have regard for the guidance.

1.9.2 All individuals interviewed by the Chair were made aware of the aims of the DHR and referenced the statutory guidance.

1.9.3 The following were panel members an were independent:

Name	Organisation	Job Title

[10] 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

[11] The Sexual Assault Referral Centre (SARC) offers free, confidential healthcare and compassionate support, in Hertfordshire, to people of all ages, who have experienced sexual assault, including rape. Herts – SARC

[12] Fair access protocols: advice for local authorities and school admission authorities

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 Partnership Foundation Trust)	Professional Lead for Safeguarding Adults
DCI Anna Borella	Hertfordshire Police	Detective Chief Inspector, DHR Review Team
Gina Titmus	CGL (Change, Grown, Live)	Senior Social Worker and Safeguarding Lead
Neil Kieran	St. Albans City and District Council	Principal 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	Associate Designated Nurse for Children in Care and Care Leavers
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

Those writing IMRs had no direct involvement with those referenced in the report.

The Author of the Overview Review Report

1.10 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 co-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 and been Senior Practice Advisor within Respect. 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.

Parallel Reviews

1.11.1 The Coroner awaited this review to be finalised before commencing their work.

1.11.2 A serious child safeguarding notification[13] was submitted in May 2024 due to Claire being a care leaver at the time of her death.[14]

1.11.3 Other than those mentioned within the chronology there were no further domestic abuse related investigations from the police.

Equality and Diversity

1.12.1 Section 4 of the Equality Act 2010 defines protected characteristics as:

- Age
- Disability
- Gender reassignment
- Sex
- Sexual orientation
- Marriage and civil partnership

[13] Report the death or serious harm of a child or care leaver - GOV.UK
[14] Child Safeguarding Practice Review Panel: guidance for safeguarding partners

- Pregnancy and maternity
- Race
- Religion or belief

All characteristics were considered but those deemed relevant to this review were:

1.12.2 **Age** – At the beginning of the chosen scoping period Claire was 15, a child[15], with Danny approximately four years her senior. With the age of consent[16] for sexual activity being 16 in the UK and the known concerns of Child Sexual Exploitation for Claire from adult males (predominantly 18 / 19 in age) in early 2021, consideration has been given as to whether it is correct, during the course of this review, to describe this as an intimate relationship. The NSPCC[17] write:

Guidance across the UK makes it clear that sexual activity between children who are close in age and understanding should not automatically result in prosecution. Instead, a range of factors should be considered to determine whether it would be in the public interest. These include:

- *whether the sexual activity was entered into willingly*
- *any power imbalance, coercion or exploitation*
- *the children's relative age, maturity and level of development.*

As Claire resided with Danny whilst on a child protection plan, with the consent and knowledge of her parents and presented as "girlfriend and boyfriend" to agencies, their connection was considered an intimate relationship by some services involved at the time (approximately November 21 onwards). The reluctance in describing it as such now, with hindsight, is Claire was considered to have been sexually exploited by another man of a similar age, earlier that same year. This resulted, in part, in her appearance at the MACE (Multi-Agency Child Exploitation) panel to reduce risk and protect her from harm.

An intimate relationship can be characterised by emotional intimacy, trust and safety, physical and spiritual closeness and mutual vulnerability[18] and many of these were compromised by the age difference and vulnerabilities at play. The origins of Danny and Claire's connection have remained unknown to the panel. At the end of the scoping period Claire was 18 and Danny 22 and, having been in a relationship for three years at that point, there is a stronger argument to describe this as an intimate relationship.

Whether a situation is defined as domestic abuse rather than CSE (child sexual exploitation) is dependent on services, such as children's social care and police analysing

[15] Children and the law | NSPCC Learning
[16] What is the age of consent - Lawstuff
[17] Children and the law | NSPCC Learning
[18] The 7 Elements That Define an Intimate Relationship | Psychology Today United Kingdom

any power imbalances, age differentials, coercion, grooming behaviours, and / or patterns of control. With the above being said, the term relationship will be used but with the aforementioned strong caveat.

Furthermore, a report from the Youth Endowment Fund (YEF)[19] stated nearly half of teenage children who have been in a relationship have experienced violent or controlling behaviours from a partner. This behaviour includes:

20% say they were pressured or forced into sexual activity against their will.
19% reported being physically assaulted (e.g. hit, kicked or shoved).
17% had explicit images or videos of themselves shared online without their consent.
27% said they were made to feel afraid to disagree with their partner.
26% said their partner made them feel scared to break up with them.

Sex - In considering the above characteristics sex was a significant factor. Domestic abuse and domestic homicide are crimes that disproportionately affect women. Women make up the majority of victims and with the majority of perpetrators being male. For the year ending March 2025, the Crime Survey for England and Wales (CSEW) estimated that out of the 3.8 million (7.8 %) people aged 16 or over who experienced domestic abuse, 2.2 million were women (9.1%) and 1.5 million were men (6.5%). As the office for national statistics[20] states: *"Females were disproportionately represented among victims of domestic abuse-related crimes, as in previous years, with 72.1% of all victims being female in the last year"*. This fact does not diminish the importance of addressing same sex domestic abuse, familial abuse or any other form of domestic abuse but is important to consider and is relevant to this review.

Furthermore, in a review of the 32 published Domestic Homicide Reviews (DHRs) where a victim had taken their own life, 25 of the 32 victims were female.[21]

Child Sexual Exploitation (CSE) is referenced in this review. Government research highlights that *"Females were over-represented in the population of children assessed as having been affected by CSA (Child Sexual Abuse) and CSE (57% and 67% respectively) compared with all children in need (43%). The majority of children assessed as having been affected by CSE were aged 10 and over (81%)."* Furthermore *"Two thirds of children who were assessed as having been affected by CSE in 2024 were persistently absent from school and almost a fifth had one or more suspensions from school."*[22]

[19] Half of teens in relationships suffer violence or controlling behaviour, reveals new report | Youth Endowment Fund
Based on a survey of 10,000 children aged 13 to 17 across England and Wales, the report examines how boys and girls experience violence.
[20] Domestic abuse in England and Wales overview - Office for National Statistics
[21] LEARNING LEGACIES: An Analysis of Domestic Homicide Reviews in cases of domestic abuse suicide
[22] Release home - Children in need: A focus on sexual abuse and exploitation - Explore education statistics - GOV.UK

1.12.3 **Pregnancy and maternity** – During the scoping period Claire became pregnant but shortly afterwards lost her baby. This was another significant loss for Claire having also lost her grandfather during the scoping period. She had also left home, with her connection to family diminishing. Claire received support from hospital services. Community services were also aware of the distress and upset caused by losing her pregnancy.

1.13 Dissemination List

The following will receive copies of the review report:

- Claire's parents.
- Review Panel members
- The Home Office
- The Domestic Abuse Commissioner
- Police and Crime Commissioner

Additionally, Hertfordshire County Council will conduct a "DHR briefing" for every case that has been published. This will be sent to panel members to disseminate at their future meetings and learning events. Briefings are finalised once a review has been quality assured and approved for publication by the Home Office. When publishing, key dates to avoid will be discussed with the family.

Section Two

Background prior to scoping period

There is a significant history prior to the agreed scoping period. Claire's 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[23] of rape were also made towards male acquaintances of Claire's just before and during the scoping period. This was labelled CSE[24] (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[25] and any potential impacts on Claire. During an interaction with police in Feb 2021 she told them

[23] Please note, the term allegation is used due to a lack of criminal conviction.
[24] Child Sexual Exploitation is defined by the NSPCC (CSE - NSPCC) as sexual abuse and something that happens when a child or young person is coerced, manipulated or deceived into sexual activity in exchange for things that they may need or want like gifts, drugs, money, status and affection.
[25] timeline-coronavirus-lockdown-december-2021

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, an anti-depressant, which she took from her nan. During her time at hospital, she told staff she'd experienced 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[26] (Child and Adolescent Mental Health Service). 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 saying she found it hard to trust professionals and open up. Nevertheless, she was placed on the waiting list for support.

Claire reported an allegation of rape in November 2020 and afterwards described variable mood and suicidal ideation to professionals. 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 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

[26] CAMHS

though the exact nature of this, nor who was doing what to whom is unclear, 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[27] (attention deficit hyperactivity disorder) 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 AMHS (Adult 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 and Young Herts Minds (a talking support service) after saying he felt better and did not require mental health input. Also, in late 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[28] but declined.

[27] ADHD and Mental Health | YoungMinds
[28] Home | Catch22

Section 3

Chronology

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

Beginning of Scoping Period:

3.1 Claire was 15 years old in March 2021 and was known to the following services:

- CAMHS (Child Adolescent Mental Health Service) due to low mood, suicidal ideation and a potential eating disorder,
- CSC (Children's Social Care) due to her being harmed by older men (see background information),
- and the Police (due to recent reports of sexual abuse).

Additionally, she had support from the SARC (Sexual Assault Referral Centre), a specialist police team called HALO and a SASH worker (Specialist Adolescent Service Hertfordshire[29]). Although her school attendance had started to decline by this point she was still in touch with key education support such as her head of year. Although this period appears particularly traumatic for Claire, her school and family report she had good relationships with professionals involved who she felt listened to her and cared.

3.2 On 11th March 2021, following meeting Claire at her school to discuss the rape allegation at the hotel in February 21, Police completed a Child Risk Assessment (CRA) which was graded as high[30]. This meant, should Claire be reported missing in future, she should be considered at high risk of child sexual exploitation. A friend of hers and her father were also spoken to. They said Claire had been "up and down" over the past year.

3.3 A week later Claire reported a further rape having taken place at another hotel. This time, she was with her boyfriend at the time (not Danny) whom she said raped her. Aswell as being 15, she said had not been in a fit state to consent to sexual activity having been provided vodka and weed which had made her sick.

3.4 There were many missing persons reports for Claire during the scoping period. Not all will be mentioned within this chronology. But, on 21st March 2021, her mother contacted

[29] Continuum of supoort for adolescent service

[30] Police Child Risk level are as follows:

- High – At risk of significant harm.

Child at risk of imminent significant harm of sexual, physical, emotional abuse or neglect.

- Medium – In need of support services.
- Standard – No ongoing support needs identified.

police to report her missing. She said her behaviour had changed drastically over the last year. She felt she was now easily lead, influenced by money / nice things and could be easily exploited. Claire was later found and confirmed she had been at a hotel with the aforementioned boyfriend.

3.5 A day after this, police were contacted by Claire herself to report 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"*. This was investigated by police with no further action taken due to a lack of supporting evidence. SIG markers[31] were placed on her home and school addresses by police with notifications sent to relevant agencies.

3.6 Days later, Claire contacted police saying she had taken a lot of pills (a family member's angina medication) and didn't know what to do. She told the call operator *"everything's so hard"*. Police intelligence checks established the following:

- *History of self-harm since aged 7.*
- *One known previous overdose.*
- *Concerns over social media bullying.*
- *Death of two peers by suicide.*
- *Father ill.*
- *Potential triggers for how she sees and values herself and life.*
- *Remains at risk of self-harm and potential attempts on her own life.*

Subsequently, she was taken to Watford General hospital where she was treated and recovered.

3.7 Following these concerns, a strategy meeting[32], aimed at bringing services together to identify whether immediate safety actions were required, took place between Hertfordshire and Bedfordshire services on 30th March 2021 showing good cross border practice. The outcome of this was for Claire to continue to be supported by Social Care via a Child In Need (CIN) Plan due to the missing person episodes continued concerns of CSE.

3.8 In early April 2021 Claire's mother again contacted police to say Claire had been receiving abusive messages on Instagram. One message said: "KILL YOURSELF, YOU FAILED LAST TIME WITH YOUR OVERDOSE". Claire spoke to police directly and disclosed further messages such as: "YOU SKET, GYPSEY, WHORE" and "YOU FAIL AT EVERYTHING IN LIFE INCLUDING TRYING TO KILL YOURSELF". Police addressed this via the Malicious Communications Act 1988[33] although no charges were brought as the suspect was not

[31] SIG markers refer to a marker on a police system indicating risk or vulnerability associated with that address/name/telephone number, which serves as an early warning indicator of history when further incidents are reported. This will automatically alert the force control room (FCR) to any previous call/event history so that the response can be judged accordingly, for example in respect of urgency, resource deployment, and safeguarding.

[32] What is a strategy meeting?

[33] Malicious Communications Act 1988 (c. 27)

identified and Claire did not wish to pursue charges. It was strongly suspected the perpetrator was her ex-boyfriend. Police advised Claire to delete social media and to not respond to messages. Since this report there is a new law, Section 184(1) Online Safety Act 2023[34] which creates an offence of encouraging or assisting serious self-harm which will be explored further within the analysis.

3.9 Not long after this Claire's school, not for the first time, reported her missing saying she hadn't turned up for lessons. There was reference to a Snapchat video showing her going to a bridge with a rope saying she "can't do this anymore". She was found and returned home in the early hours of the next morning. Claire received a follow up call from police the next day in which she said she wanted help from CAMHS but they "didn't help her". Claire was open to CAMHS at that time and had seen them. The review has been unable to expand on what she meant. Police provided information about the Samaritans[35].

3.10 Concerns regarding Claire's peer group continued in late April 2021. Her school reported she was "jumped" by a group of five students and separately, her mother reported an acquaintance of Claire's had posted an abusive, derogatory TikTok video about her suggesting she was promiscuous. This video had been altered to be personal, targeted and hurtful.

3.11 During multi agency discussions in April 2021, concerns for Claire's weight were raised and discussed with the CAMHS team doctor. Advice was provided to Claire's mother to support her in addressing this. Physically seeing Claire was challenging for CAMHS as in total, she missed five appointments out of nine. Another action identified at this stage was Social Care referring grooming and CSE concerns to the National Referral Mechanism (NRM)[36]. This was picked up by specialist teams within the police who were already aware of the concerns and conducting their own CSE related investigations.

3.12 In mid-May 2021 both Claire and her father contacted the police separately following an altercation at home. Claire said her dad had assaulted her by "slamming her head into a wall" as she tried to leave the house. Her dad reported trying to prevent Claire from leaving the house as she'd said she was going to meet a friend in London. This had previously been a pre-cursor for missing person episodes. He said he had been advised to do this by services. He acknowledged he had grabbed her arm. No further police action was taken.

3.13 In a separate missing person episode Claire's nan contacted police saying Claire had messaged her the following: *"Can I stay with you please, not for long just till I get my shit*

[34] Online Safety Act 2023
[35] Contact Us | Samaritans
[36] The National Referral Mechanism (NRM). The NRM is the UK's framework for identifying potential victims of modern slavery and human trafficking, and for ensuring they receive appropriate support and protection.

together. I just don't want to go home. With everything that's going on, I just need to get my shit together.

3.14 Claire was heard at MACE[37] (Multi-agency Child Exploitation panel) on 21st May 2021 for the first time following a referral from SASH. This panel is responsible for coordinating information sharing and multi-agency interventions to reduce the risk of "child sexual exploitation, criminal exploitation, harmful sexual behaviour and serious youth violence". Though it was good practice to hear Claire at this meeting it was 3 months after the concerns about Claire being exploited at a hotel. The Social Worker disclosed the following during this meeting:

- Claire had been reported missing six times since August 2020
- There had been concerns about poor home conditions and parental alcohol use / wellbeing.
- Where arguments occurred, at home or school, Claire tended to "run".
- Claire had had three suicide attempts known to SASH.
- She was experiencing online bullying from the alleged perpetrator of the rape.
- There were concerns about Claire's perception of risk with her meeting up with people she finds online.
- All screenings from SARC (sexual assault referral centre) had come back clear.

There was one action officially recorded from this meeting which was to consider approaching Claire's mother to commence alcohol support. The value and effectiveness of these meetings will be commented on further in ToR 4.3.

3.15 Claire was heard again at MACE a month later for updates. At this meeting SASH stated she appeared to be "coping better" although it is not clear what had changed. She was said not be attending school, but alternative provision was being sought. She did not want to pursue the criminal investigation into the rape which brought her to the MACE panel. It was noted she had been "spoken to about her internet activity". Actions from this meeting revolved around gaining answers to gaps such as whether her siblings were also at risk.

3.16 A third review was held via MACE in July 2021. Within the meeting CAMHS updated the following: (updates as stated in minutes):

- *Last 5 appointments, Claire only attended two*
- *Offered family work but declined*
- *Removed from CAMHS high risk pathway*
- *Offered face to face appointments on alternate weeks*

Several updates were provided by SASH including:

[37] Information on MACE

- *Work needs to be done around her sexual health, appointment made with GP.*
- *She is underweight but CAMHS want her to make an appointment to see if she is ok, mum says she has a good appetite*
- *Parents do drink but are now more open to discussion on this, they state they do not get drunk.*
- *She was removed from role at her school and parents wrote a letter for Claire to attend a new school.*

3.17 As the update from CAMHS indicates, they reduced their involvement at this juncture. Claire's mental health concerns had reportedly stabilised, and she was meeting with children's services workers. Additionally, she told her Social Worker that, on one occasion the CAMHS practitioner had been on their phone which had annoyed her and contributed to her not wishing to work with them. Her reluctance to engage with CAMHS on an ongoing basis was a theme during the scoping period. CAMHS officially closed this referral in late October 2021. The HPFT have reflected how ending their involvement here was potentially a missed opportunity to continue therapeutic work as Claire was meeting with them, albeit sporadically. Her lived experiences and presentation would have required more than the four sessions she attended in total to have a lasting, meaningful impact. See ToR 4.10 for further exploration.

3.18 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. The trigger was an alleged assault from a friend where she'd been "dragged to the floor and stamped on the head" which contributed to her sleeping rough in Luton. The friend was interviewed and argued self-defence. Following the two nights in foster care, Claire did return home, and additional support was brought in from the Adolescent Resource Centre to help with the reintegration to the family. However, due to the continuing concerns, child protection investigations commenced in earnest. It is around this time, Claire's mother reports she contacted social care for help as she as concerned about the potential impact of Claire's behaviour on her two younger siblings.

3.19 Due to this, a further strategy discussion was held. One representative within this meeting noted what an "*incredibly sad case"* it was, and Claire was *"a child becoming more and more vulnerable."* They voiced concerns about the home environment contributing to Claire going missing and felt she looked dishevelled and under-nourished. Body Worn Video (BWV) footage of the police interviewing Claire was incorporated into considerations and provided her voice. Within this she said she did not want to go home as her parent's 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. She felt she received differing treatment to her siblings who would be provided with what they needed and she would be shouted at. Another panel attendee noted how home conditions were a "driving factor for her vulnerabilities"

contributing to her "putting herself at risk". The decision was made for a Child Protection Conference[38] (CPP) to be held to identify whether the children in the household would be likely to suffer significant harm if the situation remained the same and whether protective measures were required.

3.20 Following an Initial Child Protection Conference (ICPC) on 8th September 2021, Claire was placed on a Child Protection Plan (CPP) under the category of neglect. All of her siblings were placed on a Child In Need (CIN) Plan, which is a voluntary agreement between parents. The Family Safeguarding Service became involved meaning Claire had a change in worker. The frequency of different workers allocated to Claire is something reflected upon in the analysis.

3.21 Claire continued to receive online threats in early September. She called police saying she had received a phone call from the friend who had assaulted her in August which said: "DONT LET ME FIND YOU, IM GOING TO COME TO YOUR HOUSE I'LL FUCKING KICK YOUR HEAD IN YOU SLAG". Due to no supporting evidence this was closed with no further action.

3.22 Whilst on a Child Protection Plan, Claire left the family home initially staying with a friend. Her mother has told this review they needed her to "sort herself out" as her behaviour was becoming a risk to her siblings. Due to her friend's family not being able to accommodate her anymore, she moved in with Danny and his family in November 2021 under a private family arrangement[39]. She was 15 at this time and Danny 19. The ages are noted for their legal significance but also the similarity in age gap with those who were allegedly exploiting Claire earlier in 2021. The connection between Claire and Danny has been explored both with family and the panel with the only available information indicating they knew each other via 'mutual friends', though who these were is unknown. Claire's family consented to this arrangement and provided Danny's mother money for her keep. There is no evidence to suggest there was a longstanding connection from Claire to this family, This arrangement was a temporary kinship care arrangement. The Department of Education[40] describes this as: *"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."* As soon as Claire moved in, she described her relationship with Danny as girlfriend and boyfriend. Five days after this move a review child protection conference (RCPC) was held. There is no mention or consideration of the age gap within the minutes from this meeting.

[38] What is a Child Protection Conference?
[39] Private arrangement and private fostering - Family Rights Group
[40] Kinship care: statutory guidance for local authorities

3.23 During this time, visits to Claire were made by Social Care in line with statutory timeframes[41] e.g every 10 days. They recorded her seemingly sleeping on a sofa in the living room. There is no further information from agencies such as police and health services over the following months. However, by February 2022 her living arrangement with Danny and family had broken down with Danny's mother saying she could no longer cope with Claire in the house due to her alleged disruptive behaviour.

3.24 At roughly the same time Claire was being told to leave Danny's address she was seen by C-CATT (Crisis and Assessment Treatment Team)[42] in mid-February 2022 after overdosing on her contraceptive pill. This team attempted to engage Claire in stabilisation care which proved difficult due to her placement breaking down. They referred to CAMHS.

3.25 Alternative housing was gained for Claire in supported accommodation. This was a bed via Herts Young Homeless[43] who provide provision for homeless 16 / 17-year-olds in the Hertfordshire area[44] aswell as support to help tackle the root cause of homelessness. Claire's time here was problematic and over the coming months support services offered to Claire were declined and agencies noted an increase in her alcohol consumption.

3.26 The first known police information in relation to concerns about Claire and Danny's relationship was reported months later in August 2022 but related to several incidents, the first being from March 2022. Although Claire was not staying at Danny's family home at this point, she had been there and argued with him about his alleged use of crystal meth. During this argument it was alleged he pushed her causing a cut lip.

3.27 Although the above directly relates to violence in their relationship, there was police information about Danny and Claire from a separate incident in March 2022. The couple had, once again been at Danny's family home and his mother had asked Claire to leave because she was drunk. This resulted in Danny becoming angry. He smashed a window and threw a box at his sister. During his subsequent arrest for common assault and criminal damage, Claire was present and tried to prevent his arrest. She was also arrested, for assaulting a police officer. She would later be given a conditional caution for this which required her to complete 2 hours unpaid work, a victim awareness course and write an letter of apology to the officer she had assaulted. Danny admitted his offences saying he was drunk but family members withdrew their support for any police action and subsequently the crimes were filed NFA (no further action).

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[41] Social Care statutory timeframes

[42] 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.

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

[44] Housing Support 16 - 18 year olds | Hertfordshire County Council

3.28 In April 2022 the Child Protection Plan for Claire ended with her becoming a Child In Need[4546] instead. This was decided as the harm Claire was experiencing was not linked to risks within the home any longer.

3.29 Danny was referred to CGL (Change, Grow, Live) in late April 2022 by Hertsmere Council for problematic alcohol use. It was noted he required housing support as by this point his living arrangements with family had also broken down. During his time with CGL he denied any serious concerns with alcohol and appeared keen to gain housing support only. That was despite acknowledging during his initial assessment drinking 1 litre of vodka or gin daily. During this period CGL recorded him as living with his sister and he was attempting to gain accommodation via Emerging Futures[47].

3.30 There are records of continued difficulties between Claire and her family in June 2022 where she unintentionally hurt her sister after an argument with her mum. This was after her mum wanted to know where she was getting her cannabis from, but she refused to say. On this occasion she left the home distressed but was later found by police after being reported missing. This is evidence of continued attempts by Claire to have relationships with family.

3.31 Additionally in June, (though information was reported to the police in August 2022), Claire visited Danny due to suspecting him of messaging another girl. This prompted an argument wherein Claire alleged Danny had 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 on her arms.

3.32 Between June 2022 and January 2023 Danny resided in Emerging Futures (EF) accommodation, "staged accommodation support to empower and encourage people with a range of housing needs to achieve independence". EF work with people who are street homeless and those who are stable and abstinent from drugs and alcohol, offering a "person-centred and strengths-based approach to meeting their needs". Information from EF will be summarised in three parts.

Danny Emerging Futures information Part 1:

- Early entries recorded how Danny was not staying at his property putting his tenancy at risk. Staff encouraged him to accept support and not worry how Claire would cope without him which they felt was his reason for staying away. Staff viewed Claire as 'very controlling and coercive'. For example, within his initial

[45] continuum-of-needs-for-children-and-young-people
[46] Child in need - Family Rights Group
[47] Hertfordshire - Emerging Futures

assessment with EF, Claire was present and staff observed her guiding his answers and speaking for him.

- Assertive engagement is evident with staff attending properties (such as Danny's sister) to try and convince him to return to his accommodation. On one such occasion Claire was with him and was seen to whisper in his ear to which Danny reportedly became distressed and cried infront of EF staff. This was interpreted as Claire attempting to convince Danny not to return to EF accommodation.

- Staff recorded significant contact with Danny's mother who felt her son had been doing well prior to meeting Claire. She felt he had lost all friends due to his relationship with Claire.

- Information indicated when Claire was at EF property, she was asking other tenants for weed.

- In July 2022 Danny indicated he would only be seeing Claire once a week though soon afterwards it transpired he had been staying at her accommodation instead.

3.33 In July 2022 (incident again reported to Police in August 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. As a result, Danny and Claire were referred to the local MARAC (Multi-Agency Risk Assessment Conference) to identify how services could reduce the risk of further harm.

3.34 In early July 2022 Claire arrived at hospital after harming herself via ingesting bleach. HPFT (Hertfordshire Partnership Foundation Trust) records noted continued challenges for her mental health in relation to previous sexual assaults and the recent ending of her relationship with Danny. When discussing the latter she said she sometimes "lashes out" at him.

Following this, Claire was allocated a CAMHS clinician, a psychologist, and offered a Choice[48] appointment to identify what mental health support would be most helpful to her. She did not attend the first two but attended her third with her Social Worker, evidence of

[48] Choice appointment p.4 - CAMHS A Choice appointment is an initial appointment to agree next steps.

good multi agency working and persistent and assertive engagement. She was offered trauma related support but struggled to engage with it, so much so she left the meeting early and said she would not work with CAMHS. (see ToR 4.10 for further details) A safety plan to reduce the risk of further self-harm incidents was created following discussion of self-harm triggers, strategies to manage urges, and who to contact in a crisis. It is written below as it was recorded within social care records:

Safety Plan
- Reach out, go for a walk, who would she reach out to? (name of housing support) or whoever is on duty that day.
- Safe people. Even sending emoji text if she is struggling. Helplines etc.
- 5 things to do first.
- Triggers?
- Cannabis use – depressant. Long term impact. Financial impact.
- Trauma work – needs to be in a safe place and feel safe for this to be productive.
- One month – keep open. Attempt again to engage her.
- Duty number. 9-5pm
- Out of hours [mental health] helpline

The above plan reflects the session conducted with Claire prior to her leaving and was completed between CAMHS and the social worker. CAMHS records indicate the social worker agreed to discuss it with Claire and her housing placement. There is a lack of evidence to indicate whether this occurred, whether a physical copy was provided to her, whether it was reviewed / updated or was domestic abuse informed (e.g aware of Danny's abuse so as not to unwittingly encourage Claire to contact him if in need).

As Claire did not wish to engage with CAMHS further, it was agreed to keep the referral open for a month before reviewing. CAMHS records following this appointment consistently highlighted Claire declining their support.

3.35 In late Aug 2022 Danny was arrested for ABH, criminal damage, common assault, threats to kill and coercive control. This was following several pieces of information (see 3.26, 3.31 and 3.33). Claire's accommodation had called the police reporting Danny was "physically and financially abusing her". They said there were ongoing attempts by someone to contact Claire as she was having multiple missed calls from an unknown number which they felt likely to be Danny. It was also alleged he was making fake Snapchat accounts.

3.36 Aswell as the above domestic abuse allegations 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 extensions out in the process. She slapped his face, got up and walked away as he shouted 'slag'. The result of all allegations

was no further action (NFA). Claire sent an e-mail to the officer in charge (OIC) requesting to drop all charges which was authorised by a DI (Detective Inspector).

3.37 Danny Emerging Futures information Part 2:

- In late August 22 Danny informed housing staff he had split up with Claire as he could not "cope with her shit" anymore. He said he had blocked her number and alleged she had hit him on several occasions. EF staff supported Danny to re-start anti-depressant medication as part of a package of support. A few days after his disclosure to housing staff he was arrested (see 3.35).

- Despite the assertion they had split it up, not long after this disclosure Danny threatened another tenant saying "if you have said anything you're going to get it" in relation to him having Claire back into his property. He was asked several times why he continued to allow her to stay and stated he was lonely. He felt Claire was manipulative and would say all "the right things to get him to do what she wants".

- Four weeks later Danny told staff he had stopped his medication as he didn't need it anymore.

3.38 Over several months, concerns from housing support staff in Claire's accommodation had grown regarding her behaviour. She had been verbally abusive to members of staff and had been smoking cannabis in her room. Due to this she was evicted and temporarily stayed with a cousin. A Child Looked After placement was then found for her under Section 20 of the Children Act 1989[49] and she moved in shortly afterwards.

3.39 CSE (Child Sexual Exploitation) concerns continued for Claire around this time following a report of an adult male giving her and her friend pizza, vapes, cigarettes and money. There were also concerns she had taken drugs at the same male's hotel room.

3.40 Following the MARAC referral in August 2022, Claire was heard at MARAC in September 2022. Within the summary of risks, the conference detailed:

- 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.

[49] Children Act 1989 – Section 20

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

3.41 One of the agreed actions was for the IDVA (Independent Domestic Violence Advisor), who had already been referred to prior to the MARAC, to contact Claire to discuss opening a new bank account. They were successful in speaking to her on their 4th contact 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. She said that, at age 15, Danny had beaten her, and she had lost her pregnancy as a result. The review has seen no further evidence of this. She said she could not do this anymore, felt worthless and wanted all the support she could get. Although she acknowledged Danny knew where she lived, she was in independent living and did not feel ready to move. She reported not eating or sleeping well. The IDVA advised her to contact her GP and encouraged her to change her number. They agreed to make referrals to We Protect[50] for a Non-Molestation Order, the mental health team and to the Freedom Programme[51]. The IDVA advised her to open a new bank account.

The IDVA conducted another DA (domestic abuse) risk assessment with her which was deemed high risk of serious harm. Claire said she had recently separated from Danny and that she had suicidal thoughts "all the time". She was offered counselling which she declined but said she was in safe accommodation and had support from a friend. Safety advice was provided, and she was encouraged to contact the IDVA again if she required support.

Following this phone call there were 8 attempts to contact Claire via phone between October 22 and mid January 23 with one contact where Claire said it was not a good time to speak. All other attempts were unsuccessful but there were no recorded attempts to contact via agencies as had previously been suggested by the SWKR. (Social Worker)

3.42 Additional actions from this MARAC related to updating Claire about the MARAC discussion and ensuring a restraining order[52] was applied for if Danny was charged with any crime which he wasn't.

3.43 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)[53] but they declined

[50] WEPROTECT | Legal Support For Domestic Abuse Victims
[51] The Freedom Programme. Learn about domestic violence and abuse
[52] Restraining order on conviction
[53] 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

on the basis of 'risk and complexity'. Due to this a further referral was made to Targeted CAMHS[54] 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 Claire. She was prescribed propranolol[55] (40mg twice daily) for her anxiety in mid September by her GP.

3.44 Around the same time Claire attended HCT (Hertfordshire Community NHS Trust) clinic for her Initial Health Assessment (IHA) which is a process for all children who are newly looked after by the local authority. She attended with her support worker from her accommodation and a friend who remained outside during the meeting. When the support worker left the room Claire disclosed being raped aged 15, an indication of how significant a trauma this was for her. Within this assessment 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. An area of alopecia was found by the doctor. Claire said she could go for days without eating when anxious.

3.45 Claire was referred via children's social care (CSC) to CGL (drug and alcohol support) for support with her use of cannabis in early October 2022. After initial difficulties in engaging her, CGL utilised CSC to make contact. However, Claire declined involvement and was closed in December 2022. Prior to closing, CGL received information about Claire's potential heroin use. Naloxone[56] was given to staff supporting Claire who were trained on how to use this incase of opiate overdose which was good practice.

3.46 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. He denied any offences but admitted being with Claire. Ultimately no charges were brought but she would later be due to receive criminal injuries compensation for this.

3.47 In late October, the GP reviewed Claire's medication and prescribed Fluoxetine (20mg daily) for low mood/anxiety. However, in late November Claire had overdosed on these prompting the GP to cease this medication. It is clear November 2022 was an especially tumultuous time for Claire. Aswell as the rape, there were at least five reported missing person episodes. In mid November she called her mum and repeatedly said "I love you

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teams and self-referral. This service is now known as Talking Therapies. This service works with people from the age of 16 in Hertfordshire.

[54] The Targeted Team

[55] Propranolol: medicine for heart problems, anxiety and migraine - NHS

[56] Supplying take home naloxone without a prescription - GOV.UK

mum" before hanging up the phone. Prior to her Fluoxetine overdose, she had written five long notes to a friend, Danny, mother, father and sisters saying she couldn't cope and there was no easy way to say goodbye. When subsequently spoken to by police at hospital she reportedly said she didn't intend to be alive by the end of the day.

3.48 Danny Emerging Futures information Part 3:

- Information was disclosed to EF staff that Danny was using crack cocaine in mid / late November 2022. When's Danny's alleged drug use was raised with him he denied it and became agitated.

- During room checks in mid December 2022 there was clear evidence of Claire staying with him and alcohol use such as prosecco bottles. He was given a Notice to Quit[57] (NTQ) in an attempt to highlight the seriousness of concerns and encourage him stop having Claire at his property.

- Tenants complained about Claire's behaviour at the property in mid Dec saying she was "causing havoc" and continuously staying over. Danny became aggressive when addressed with him resulting in a staff member leaving property due to feeling unsafe.

- Danny continued to say he felt he had nobody, only Claire. He would become distressed when talking about the relationship saying he "can't believe he has allowed a 16 year old to control him". Concerns increased in late Dec about illicit drug taking and the couple stealing to fund this.

- Also in Dec 2022 Danny voiced looking forward to his counselling which was due to begin in Jan 23. He said he struggled to articulate how he felt. He said he didn't know why he put himself in positions where he got himself into trouble. He acknowledged being drawn to Claire but not knowing why.

- Danny left EF in Jan 2023 after the NTQ ended and he declined any further support. He said he was sick of being told what he could and couldn't do and would find his own way.

During his time with EF, they referred Danny to Hertfordshire Partnership Foundation Trust (HPFT) on four occasions between Aug – Dec 2022 due to concerns around his low mood and requesting mental health support. Safeguarding concerns were also raised for him

[57] Notice to quit from the landlord - Shelter England

regarding concerns around his relationship with Claire. The referrals referenced concerns about manipulation and coercive control from Claire towards Danny. Of these referrals, two (August and November) were opened formally under safeguarding processes with decisions being made to close following discussion with Danny who did not disclose any concerns. The other two safeguarding concerns were not formally reviewed under a safeguarding framework and no other action was taken.

3.49 In early December 2022 Claire's accommodation called police saying she continued to stay at Danny's accommodation which they'd been told to report by her social worker. Soon after this call 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"*. She would not disclose which accommodation this occurred in but it was strongly suspected to be Danny's supported accommodation. He was arrested for common assault and harassment after he continually called Claire following this incident. Whilst in custody, he was spoken to by L&DS (liaison and diversionary service). This was an opportunity to speak to Danny about his behaviour and signpost accordingly which was missed. A referral to MARAC was made but rejected and will be reflected on in the analysis. Additionally, the officer in charge applied for a DVPO (Domestic Violence Prevention Order)[58] to gain Claire some legal protection, away from Danny for 28 days. This application was rejected by a Superintendent and will also be reflected on in the analysis.

3.50 In December 2022 there were 20 (twenty) calls from Claire's placement to the police saying she was staying at Danny's accommodation.

3.51 A MARM[59] (multi agency review meeting) was held on 28th December 2022. Emerging Futures contributed towards this saying: "*Claire is not permitted to stay there under our resident's licence agreement, she is allegedly taking crack and heroin and is drinking heavily. When in the property she is causing lots of problems and has previously made threats to a resident in one of our other properties, complaints from neighbours have been due to Claire screaming and shouting, banging doors"*. Separately, the social worker noted: *"Claire is at high risk of CSE. She is a young lady who is desperate to belong and the only people showing her this are adult men who are using her."* Throughout the risk assessment the word relationship is in quotation marks indicating a concern from services about how to frame the connection between Claire and Danny. This is summarised in the overall risk summary as follows: "*Claire is at very high risk of CSE and we have significant concerns about her 'boyfriend' and what she may be encouraged to do for drugs. Claire*

[58] Domestic violence protection orders - GOV.UK

[59] 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.

has been sexually abused by multiple men as she was having sex under the age of 16[60] *and is currently in a 'relationship' with a 21 year old."* Due to the continued concerns about CSE risk, Claire was referred back to the MACE panel.

3.52 Within this panel meeting and on the associated risk assessment, the social worker clearly states the risk of overdose, intentional or otherwise:
"There is a risk Claire may accidentally or purposely overdose on medication or recreational drugs. *She may overdose accidentally on drugs at any stage. She is at constant risk of CSE and domestic violence due to her 'relationship'. Her mental health is likely to get worse due to her family longing, drug usage and losing college."*
This was clear, precise language and good practice from this social worker to ensure agencies had an accurate understanding of risk. It was also disclosed within this meeting that Claire may be pregnant.

3.53 The Child Looked After (CLA) nurse who was in attendance noted how Claire wanted to maintain the relationship with Danny and direct work would begin with her around healthy relationships and keeping safe from Social Care. There were no notes indicating any work proposed with Danny.

3.54 Danny's eviction came into force on 10th January 2023. He moved in with his sister.

3.55 On 18th January 2023 a neighbour of Danny's sister called police due to a "loud domestic next door". Both Danny and Claire were seen by police with neither supportive of police action. However, Danny was arrested 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 attend her address or contact her. Soon after this, Claire used her social worker's phone to contact Danny. The SWKR had not been made aware of Danny's bail conditions. These conditions ended shortly afterwards on 21st January 2023 as Claire repeatedly told police and social services that she "wanted to be with the father of her unborn baby and that he is all she has in this world".

3.56 Claire was heard at a MACE (Multi Agency Child Sexual Exploitation) panel on 20th January 2023 following a referral from her social worker. This was primarily due to concerns around an alleged rape in November 2022 from an adult male (not Danny). Other concerns noted were:

- *Claire's possible pregnancy after a recent inconclusive test,*
- *A difficulty in services meaningfully engaging her,*

[60] This is captured in the minutes and the author wishes to highlight the importance of language. This phrase would more accurately be described as rape / sexual assault. Consent can be provided by an individual under 16.

- *Finances - social care mentioned they'd given Claire money to get passport photos but she had spent the money on "something else"*
- *Claire not staying in her placement and potentially staying with Danny at his sisters or with a friend in Enfield*.

Domestic abuse concerns were clearly noted from Danny towards Claire and an action was set to *"E-mail team for DA (domestic abuse) to see if she can be referred to MARAC"*. There were 11 actions agreed in total which will be reflected on within the ToR. One key action was for CAMHS and Social Care to arrange a joint appointment to discuss a plan for Claire's mental health intervention. This meeting did not take place and this panel has been unable to ascertain why. This was a missed opportunity to gain clarity on what mental health support was required and who would be best placed to provide it. Claire was also referred back into the IDVA following this meeting. The IDVA did not have a successful contact with her until March 23 (para 3.66). CGL were also referred back into to support Claire her with reported cannabis, crack cocaine and heroin use. This time she met with them regularly in the community and in her placement. This appeared to be influenced by Claire becoming pregnant and not wanting to use Class A substances due to the impact on the unborn.

3.57 Although no meeting between CAMHS and CSC (Children's Social Care) took place following MACE as agreed, there is evidence of CAMHS asking whether CSC trauma focussed work could be offered internally by them. Around this time, the CPT[61] (community perinatal team) became involved, due to Claire being pregnant. No face-to-face contact commenced though an unsuccessful home visit to her supported accommodation was made.

3.58 In early February 2023 CGL were in the rapport building stage with Claire. Within early conversations she said she was enjoying her pregnancy, other than the nausea. She spoke about living at her placement which had been necessary as she felt her parent's alcohol use had escalated during the pandemic. Having social workers in her life was normal for her as they had been there throughout most of her childhood. She said there had been occasions where her mother had rewarded her for not talking to social workers. She said since age 13 she had been drinking vodka and smoking cannabis daily. She said she met Danny in 2021 who was "a drinker" at that time. She said he then started to use crack cocaine and heroin. He could be "very violent towards her" and stated "he had beaten her black and blue before". She said she wouldn't allow this to happen now she was pregnant and said Danny was no longer using. Before finding out she was pregnant she acknowledged using crack cocaine and heroin on a daily basis but had subsequently

[61] 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

stopped, including cannabis. In a conversation with another agency at a similar time she was recorded as saying she felt a baby would be good for Danny.

3.59 Claire attended a maternity booking in appointment with her accommodation support worker. She said she felt low in mood and consented to a referral to the perinatal mental health service which was good practice. A 'routine domestic abuse enquiry'[62] took place at the booking appointment but Claire stated there wasn't any abuse in her relationship. It was noted a strategy meeting was being organised for the unborn baby for mid March 2023 due to the potential risk of harm. Claire was recognised as a vulnerable child and enhanced midwifery was initiated which was also good practice.

3.60 Due to the incident in January 2023 (para 3.55) Claire and Danny's situation was heard again at MARAC in February 2023 with Danny named the perpetrator and Claire the victim. Four actions were identified to reduce risk, one being for the IDVA to contact Claire again.

3.61 In early March 23 police were called again by neighbours of Danny's sister to say they could hear screaming and shouting from next door with a woman sounding scared and shouting "get off me". They said it was the 6th time it had occurred that evening. When police arrived Danny had blood on his hands from a cut to his hand. He said Claire had turned up unannounced and they had argued over the recent loss of 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 the following bail conditions until 8th June 2023:

- Not to put anything on social media in relation to Claire.
- Not to enter or go within the location of Claire's address for any reason.
- Not to contact or interfere with, either directly or indirectly, any prosecution witness namely Claire.

3.62 Around this time Claire attended the maternity unit who saw physical injuries such as bruising to her neck, face and shoulder. She disclosed she had been assaulted by Danny whilst he was drunk and he was currently in police custody. She said this was the 6th incident of violence overall. Her blood tests taken that day indicated she was not showing any signs of an active pregnancy. She was seen by the hospital IDVA that day. She said she did not want support for this. The IDVA / ISVA (Independent Sexual Violence Advisor) called Claire's accommodation to see if she would like further support from the ISVA but she declined further contact. The concerns identified by the hospital were shared with Claire's social worker & Community Health Services.

[62] Improving Routine Enquiry for Domestic Abuse: An ILP Quality Improvement Project - Quality Improvement - ELFT

3.63 Also in March 2023 the WBT (Wellbeing Team) received two referrals, one from Children's Social Care and ten days later from the IDVA. They were both passed to CAMHS. There is no record of any contact from CAMHS with Claire following these referrals nor any correspondence to the IDVA following their referral. Soon after this another referral was received from the GP via the SPA (Single Point of Access) which was sent to the CPT (Community Perinatal Team) and CAMHS. There was no record of any review of this from CAMHS nor liaison with the GP.

3.64 On 20th March 2023 a Social Worker spoke to Claire following another missing person episode. She said she was in love with Danny and wanted to be with him all the time. She denied being assaulted by him and wanted him to stop taking drugs. She said they both love each other but both "have issues". She said she wanted professionals to understand her and for police to allow her to see Danny.

3.65 Due to repeated incidents and increase in risk, Danny and Claire were heard again at MARAC on 29th March 2023. The HPFT have commented how this was not evident on Danny's mental health notes though HPFT were in attendance. Four actions were identified which related to the IDVA contacting Claire and local police being aware of Danny's bail conditions. There is no record of Claire's accommodation being present at this meeting. Following this meeting the Deputy Manager for MARAC emailed the police OIC regarding concerns Danny was breaching his bail conditions.

3.66 The IDVA was successful in contacting Claire a few days later after contacting her accommodation support staff. This was good practice but it had taken some time to do so. Claire said she felt safe currently. She said she did not want to support police actions (e.g provide a statement and go to court) but hoped they would have enough without her statement. She said she would still like mental health support and the IDVA said they would refer her to the wellbeing team (as per para 3.63). Claire asked the IDVA to call her again next week so she could think about potential further support.

3.67 CGL spoke to Claire again at roughly the same time and she spoke to them about the recent assault from Danny. She said he had put one hand round her neck and the other over her mouth so no one could hear her scream but neighbours heard and called the police. She said when told about the pregnancy loss she was sad but was now feeling better as Danny "could not be trusted with his anger issues". She said she had been smoking cannabis daily but had not used any other substances. They arranged to meet again the following week.

3.68 The day afterwards Claire saw her GP and was again prescribed Propranolol (40mg twice daily) for anxiety. A referral was made to Child and Adolescent Mental Health Services (as

per para 3.63) regarding depression and anxiety. A later note said Claire stopped taking her medication as it made her feel tired.

3.69 On 11th April 2023 CGL held an internal meeting to discuss Claire and associated concerns. The advice given was to discuss 'Tommy's Charity'[63] for support around miscarriage, provide naloxone, complete safety planning in relation to domestic abuse and re-visit IDVA support. It is unclear from records whether all of this occurred although Tommys Charity information was later provided. At the same time a further multi agency meeting was held (MARM) as Claire needed to find alternative accommodation due to her placement ending.

3.70 In mid-April CGL, who were becoming a significant support for Claire, met her in the community. She said she was moving to another placement tomorrow which would be solo accommodation which she preferred as she would be living alone. She reported using around 7 grams of cannabis every 3-4 days and drinking alcohol 2 / 7 days, typically vodka or wine. No other illicit substance use was acknowledged. She declined a swab drug test. Claire reported struggling with her mental health and had said she had recently self-harmed by cutting her hands. She said she had reached out to her mum for support on the anniversary of her grandfather's death, but she thought her mum had blocked her which made her feel worse. She discussed Danny and reported not being happy with him as he had accused her of cheating on him. She believed he was cheating on her and said she hadn't seen him "that much." The CGL worker agreed to look at online Tommy's Charity support in their next session.

3.71 CGL met Claire a fortnight later who was smoking cannabis when the worker arrived. She reported to being in a good mood and had found out she was due to receive a significant amount of compensation following a case of sexual assault in 2022 which she could access when 18. The worker took Claire to McDonald's and noticed she was on the phone to Danny during their conversation. She was asked to end the call. She said she did it to prove to Danny she was at a CGL appointment, and not with another male. The CGL worker discussed controlling behaviours with Claire but she said she did the same thing to him. She said 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 CGL.

3.72 Claire was heard at MARM (Multi-Agency Risk Management) in early May 2023. This meeting indicated a reduction in concern regarding her mental health but ongoing concerns regarding domestic abuse and her vulnerability. It was noted she was engaging with CGL but there was still a gap with specific mental health provision. There was an

[63] Saving babies' lives | Tommy's | The pregnancy and baby charity

action from MARM for CAMHS to refer to WBT or Targeted CAMHS. A discussion took place with Targeted CAMHS in late May but the referral was not progressed. The reason was, due to Claire not being seen in 10 months and the current risk and presentation was "unknown". Given the engagement with social care, CGL and housing, this was not entirely accurate. CSC, CAMHS and Targeted CAMHS would later meet in July where a decision would be made to discharge her from mental health services officially to "focus on safeguarding".

3.73 On 8th June 2023 Claire met with her CGL worker at her placement. She was described as cheerful when talking about seeing Danny who was no longer on bail. This was confirmed by police. The CGL worker spoke to Claire about keeping herself safe if Danny exhibited coercive behaviour or aggression towards her and to leave if he did so. She was confident he had changed his behaviour following bail conditions. Claire shared frustrations and worries towards her mum and her parenting of her younger sister. This triggered memories of her own experiences where she was bought things after she had experienced abusive behaviour from her parents. Claire reported feeling lonely throughout the day and experiencing suicidal thoughts frequently. She said she had no plans to end her life but described "fleeting" suicidal thoughts such as jumping in front of a train to "make the pain stop". The CGL worker called the wellbeing team during appointment however was advised her file had been closed.

3.74 The day after this appointment her placement called the police to advise Claire had not been feeling good yesterday and had referenced not wanting to "be here anymore". She had told staff she was going to stay with a friend but staff strongly suspected this was Danny.

3.75 Between late June 23 and mid August Claire and Danny were seen, via CCTV, stealing food to the total value of £300 approx from a local garage on eight separate occasions. She would later appear in court charged with all shoplifting offences aswell as possession of cannabis and assault an emergency worker (see para 3.78). She was given a 12 month referral order meaning she was allocated a youth justice worker. Danny was sentenced to compensation for the goods stolen.

3.76 On 3rd July 2023 Danny's sister called police to say Danny and Claire were fighting and Claire had punched him. She said it was continuous. Police attended and were told an argument had begun after Claire saw a female model as the wallpaper on Danny's phone. Claire's mother informed this review how this example of jealousy was present from both Claire and Danny towards each other on multiple occasions. Police took no further action with this incident.

3.77 The day after, CGL spoke to Claire who said she was no longer in her placement and was staying with Danny at his sister's house. She insinuated something had happened between

them but couldn't speak as Danny was present. They agreed to speak again the following week.

3.78 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 with this, the case was withdrawn due to insufficient evidence in late August 2023. During the arrest Claire tried to obstruct police and kicked a police officer in the stomach and bit an officer's hand. She was arrested for this.

3.79 The day after, the CGL worker attended Claire's placement and noted a marked decline in her physical presentation. She was noticeably thinner aswell as being anxious and distracted. She told CGL about the information from the previous day. She acknowledged drinking more alcohol than usual and smoking cannabis daily.

3.80 Within all of the multi-agency work, the importance of increasing Claire's social circle and expanding her prospects was not forgotten and in September 2023 Claire began college.

3.81 In early September 2023 the GP referred Claire to ACMHS (Adult Community Mental Health Service) due to low mood and suicidal ideation. This was passed from ACMHS to CAMHS due to Claire's age and being too young for this service. It was hoped by the GP, given her reluctance to work with CAMHS, a new service would stand a better chance of engagement. CAMHS tried again via CSC (Children's Social Care) to facilitate contact but, once again, Claire declined them asking for alterative mental health provision. This resulted in Claire being discharged back to her GP without specific mental health support by which point she was no longer eligible for CAMHS services due to being an adult.

3.82 A further MARM was held on 28th September 2023. Within CGL records they noted how Claire had been attending college but had been called a "a crackhead" by someone possibly known to Danny and "stories" had been spread about her around the college. Clarie allegedly attacked the person who insulted her and was subsequently excluded but was told she could return to a different course. This resulted in police involvement which, several months later, Claire told housing support staff she was extremely worried about. Police records of this incident indicate a different scenario where Claire assaulted a vulnerable student with a EHCP (Education Health Care Plan). She allegedly stopped him in the corridor and made comments about his weight before slapping him around the face.

3.83 In mid-October 2023 an Asset +[64] assessment was completed by the Youth Justice worker assigned to Claire. This cited her being in a controlling relationship but did not highlight any physical violence. This would indicate the assessment had not considered all of the risks accurately or was not party to all available information.

3.84 In early November 2023 Claire was interviewed successfully for a place in supported accommodation for 16 / 17-year-olds in care. The accommodation consisted of a self-contained bedsit with 24 / 7 access to support staff. Within her referral domestic abuse from Danny was identified with physical, emotional and financial abuse referenced aswell as the ongoing police investigation in relation to her assault on another student at college. Self-harm, an eating disorder and suicidal ideation were noted. During interview, Claire expressed wanting to move away from where she was due to "exploitation concerns". She felt the location of this housing was ideal as she could visit Danny via public transport. She said she did not want CAMHS involvement but wanted CBT (Cognitive Behavioural Therapy) support. On her admission form, Claire put Danny as her next of kin.

3.85 Over the course of Claire's placement with Peabody Housing she frequently 'booked out', meaning she stayed elsewhere. On her booking out form she wrote Danny as the 'responsible adult'. Danny was also added as an allowed visitor provided he left by 9pm. Peabody liaised with social care throughout Claire's time with them.

3.86 On the 11th December 2023 staff at Peabody conducted a routine risk assessment which identified Claire as medium risk in relation to substance use and maintaining healthy relationships. This assessment did not identify risks in relation to self-harm or emotional wellbeing. The direction following the assessment was for staff to take the lead in building 'trusted adult' relationships with Claire to enable her to share concerns. This was good practice and important to do in the circumstances. Staff records highlighted how, whenever Claire was seen at the accommodation, she was on her phone speaking to Danny. She stated she continued to use cannabis daily to help her sleep and stimulate her appetite. During the course of her stay, Claire was noted to keep her flat clean and tidy and ate her own meals without issue. The main concerns were an issue with her budgeting as she was regularly provided food bank vouchers.

3.87 Around the same time Social Care completed their pathway plan[65] for what was to be the last time with Claire. This set out what support they would like going forward. Within this,

[64] AssetPlus: assessment and planning in the youth justice system - GOV.UK

[65] 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.
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

they asked Claire who she would contact if she required support. She said Danny over and above family or friends.

3.88 During a weekly support meeting at Peabody healthy relationships discussed. Claire said Danny could say hurtful and aggressive things to her but he didn't hit her anymore. Staff discussed how abuse is more than physical violence and Claire agreed to speak more about this. Several days later she said she struggled to communicate with Danny and she didn't feel he listened or really cared about her. Staff encouraged her to focus on looking after herself. A day after this Claire disclosed how she had self-harmed a few days earlier via cutting on several areas of her body. This was triggered after her mum said she couldn't come over for Christmas and hadn't called her when she said she would. She'd also had a disagreement with her sister.

3.89 Claire met with her CGL worker in early January 2024. Due to her soon becoming an adult, another property move was imminent. Claire's preference was for a "practice flat", as she felt this would support her to learn independent living skills. During this discussion Claire disclosed feeling jealous over Danny and said she did "not allow" him to work with women due to this. She described apprehension around her upcoming birthday due to fear of her mum not saying happy birthday to her – see family contribution for further information in relation to this. She spoke of her future saying she would like to move away with Danny and complete a lash technician course.

3.90 On 16th January 2024 it was reported to housing staff that Danny and Claire were having a loud argument. Staff checked to ensure she was ok which she was. She attended her support plan review a week later and had met all induction actions. Both on the day and at her review, there were no further notes about this argument nor its context. A week after this there was another incident where staff overheard Claire arguing loudly with Danny over the phone. Again, there is no further context available.

3.91 Claire moved into new accommodation in Feb 24 as is the process for those transitioning from child to adult services. She was now a care leaver[66] which entitled her to support such as continued help from a personal advisor[67] (PA). There was good communication from social workers, her personal advisor and support staff at this time. Claire showed housing staff a new ring on her wedding finger and said she had been engaged to Danny since she was 16. Two days after this she spoke to her new keyworker during a meeting to go through trust fund and criminal injury compensation forms (the latter in relation to compensation from her sexual assault case 2 years earlier). During this meeting she said

money management, education / training / employment, specific support needs, such as relationships etc, contingency plans for if something doesn't go to plan.

[66] Support for care leavers
[67] What is a personal adviser (PA)?

she was having a difficult time with “controlling behaviour” in her relationship. She was signposted to domestic abuse services and encouraged to access them when she felt ready to.

3.92 In late Feb 24 police were contacted by Claire at 2am. Of note, this was the first contact with police in 3 months. In this call Claire said she wanted someone removed from her address before hanging up. She called again 2 hours later saying she was being followed by men. She was “irate and distressed”. She called a 3rd time saying she had made a mistake. Later information indicated she’d had an argument with Danny where “things were smashed”. He had left but returned later banging on the door although Claire did not let him in. On the day, police did attend but Claire would not say who the argument had been with.

3.93 Claire was required to attend court in late March 24 in relation to her assault of a pupil at college in September 2023. The notes recorded how distressed she was about this. She said if she was fined she wouldn’t be able to pay it due to her financial situation. She said she felt like getting herself sectioned. In response Claire was supported by housing staff at the court appearance the following day. In any case, the court date was adjourned.

3.94 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.

3.95 Claire attended her appointment with her CGL worker on 9th April 2024. There were more concerns about her physical presentation, her seeming more underweight than usual and she 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.

3.96 The following day Claire had a keyworker meeting with her housing support staff. Further exploration of her budgeting difficulties occurred, and she said she gave her money to Danny as, if she didn't, he would become angry and aggressive. Within the same conversation she said she was no longer seeing him, and he didn't visit her accommodation.

3.97 On 17th April 2024 Claire did not attend her appointment with her emotional wellbeing worker who was male. She was able to articulate to staff she did not feel comfortable speaking to a male as many of her problems involved men. Her PA (personal advisor) was also a man. She was advised to speak to her GP to get referred for emotional support with a woman as the male wellbeing worker was the only counsellor available. As a result, her future emotional wellbeing sessions were cancelled. Claire asked for support to contact the GP and subsequently requested medication for her anxiety and depression which she had previously stopped. She spoke to Peabody staff about self-harming in a previous placement and being provided a safety kit which she subsequently used to self-harm and was, according to Claire, evicted from the placement. She felt this eviction made it more difficult for her to disclose self-harm as she worried it would affect people's perception of her ability to live independently. Staff reassured Claire and reaffirmed their support of her to develop her healthy coping strategies. She discussed domestic abuse and expressed how hard she found it to let go of her relationship with Danny as it was the only consistency she had. She reflected on domestic abuse in her parent's relationship and how this had potentially lead to her normalising domestically abusive behaviour.

3.98 A day later Claire was informed by her PA that a cousin of hers had died from suicide but, frustratingly for her, her PA was unable to tell her which one. This had actually occurred a month previously, but Claire had been unaware. She reported feeling upset as she was hearing it second hand and none of her family had let her know about it. She said she did not have the relevant contact numbers to contact them. Family have told this review this related to a distant cousin whom Claire did not know well. Therefore, it appears the distress was possibly more due to lack of contact from her family about it. Within the same conversation she said she could not contact her family on social media as Danny would not allow her to use it. Due to the distress Claire felt, staff placed her on 'observations' meaning they would ensure daily contact. The relative died of suicide which is of potential relevance to this review.

3.99 Several days after this, in late April 2024, 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 indicated 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 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.

3.100 Several days after Danny had been seen exiting Claire's flat via a window she reported they had broken up. She was encouraged to report his financial exploitation to the Police by housing staff but she declined to do so. A week after this, Peabody completed a risk assessment which assessed her as high risk of harm due to exiting an abusive relationship. This was good practice. Actions identified were for a re-referral to a wellbeing worker, support from the leaving care team including identifying a new PA (Personal Advisor) and referral to domestic abuse support services. The scheme manager contacted social services to arrange a meeting to discuss current concerns including her growing rent arrears and recent behavioural warnings in relation to having Danny stay. There was also an occasion where she lost her keys and damaged her door to get back into her flat leaving it insecure.

3.101 Danny's bail conditions were ended by the police on 16th May 2024 due to insufficient evidence.

3.102 On 19th May 2024 Claire had an altercation with another resident who was playing his music loudly. This resident allegedly slapped Claire.

3.103 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'd 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 waist 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.

3.104 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 and will be explored further within the analysis. (ToR 4.14)

Section Four
Analysis

The terms of reference agreed by the panel has been used as the basis for this analysis.

Domestic Abuse

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

Domestic abuse within the couple's relationship was widely known by the multi-agency network with information shared regularly via MACE, MARAC, MARM, core groups, child protection conferences and day to day conversations between agencies. This review can conclusively say there *was* domestic abuse related information shared between agencies. But there were gaps, one significant one being Danny's main support at Emerging Futures having a different understanding of the risk and dynamic than Claire's support. Emerging Futures recorded several concerns about Claire's controlling behaviour towards him. However, there was a wealth of information available which indicated serious concerns about his behaviour towards Claire including significant physical and psychological abuse. There appears to have been very little intervention focussed on Danny to tackle this, other than bail conditions which were not enforced. Whilst Danny was living in Emerging Futures accommodation, it was an ideal opportunity to engage him in domestic abuse perpetrator intervention, not just for Claire but future relationships too.

Much of the information known to agencies was available because several key services built trusting relationships with Claire which encouraged her to disclose and was good practice. For example, Claire told CGL she had / was experiencing domestic abuse from Danny. At the same time, she acknowledged feelings of jealousy and said openly he was not allowed to work with women as a result.

Police were involved frequently. Where they arrested Danny, Claire would initially speak to them before declining to press charges. The Police IMR highlighted how some officers got to know Claire and fostered a care and concern for her. On one occasion she voiced hope the Police would be able to charge without her evidence, but this was not possible due to a lack of alternative evidence meaning the threshold for a charge was not met.

Within her housing placement Claire expressed concerns about her relationship with Danny but also said it gave her consistency. She told them she did not wish to engage with domestic abuse services although, at times during the scoping period, she did speak with an IDVA where she disclosed further abusive behaviour and was assessed as high risk of serious harm. When she discussed Danny's behaviour towards her with housing support staff, she openly considered breaking away from him and had an awareness of how

abusive his behaviour was but appeared to believe if he sorted his alcohol and / or "anger issues" her relationship would improve.

Housing services have reflected how a more 'directive approach' might have led to Claire disengaging from staff or even draw Danny closer to her which they were trying to avoid. Social Care worked extensively to "disrupt their relationship" and "break the cycle". They conducted healthy relationship work with Claire over several years, attempting to "deter her from the relationship" (from Social Care IMR). They noted how Claire continued to feel Danny was the only one who would support her and would be there for her, despite the domestic abuse. The tact taken by services to address this is an essential learning point of this review. A co-ordinated, consistent approach which considers enforcement of banning orders and bail conditions is required, as is how this is communicated to the couple. (see Conclusion)

Via MARAC, domestic abuse histories were disclosed. Danny had a history of several violent incidents towards family members where he allegedly assaulted his mother and sister and had an ongoing problem with alcohol. It was also disclosed how Claire had been domestically abused / exploited by another man she called her boyfriend before Danny. When a couple are so young, the likelihood of a domestic abuse history is less due to lack of time to accumulate such a history. Therefore, information such as this must be analysed to understand its relevance to intimate relationships and how it may shape them in the future.

4.2 Were appropriate referrals made from risk assessments and did these consider the context / history sufficiently?

Prior to Claire's relationship with Danny, she was believed to have been exploited by an individual whom she called her boyfriend and who committed at least three known offences towards her. Within the Police IMR they state this man *"was not a pleasant individual who appeared to have utilised Claire's vulnerability against her. Her vulnerability also put her at risk of CSE (Child Sexual Exploitation) reflected in the rape and sexual assault offences from Nov 2022. Those individuals responsible also utilised her vulnerability when committing their offences."* This history was shared with services involved in her care under statutory safeguarding legislation as was the relevant history about her homelife, safeguarding concerns and missing person episodes. Her vulnerability was well known to services. Risk related information was also shared at MARAC which indicates agencies recognised the high risk of harm from domestic abuse. Relevant referrals were made such as specialist police teams exploring CSE related criminality aswell as safeguarding opportunities. Minutes from meetings highlighted consideration of Claire's mental health and need for support, sexual health, internet safety, her risk of exploitation, her home life and whether further referrals and intervention was required to protect her and her siblings. Frequently, contact with an IDVA, or another attempt from an IDVA, was the main action point at MARAC.

Records indicate that, in early / mid 2021, Claire had several positive relationships with professionals such as police, SARC and SASH workers whom she felt listened to her. This was even more important considering her links to school were diminishing due to lack of attendance.

Internal risk assessments from social care were conducted and were clear about her risk of overdose as stated in the chronology. The concern about her relationship with Danny was also clearly recorded, as this excerpt from the MARM meeting in December 2022: "*Claire is socially isolated, she has limited friends and is in a very toxic 'relationship' with a 21 year old man who has previously beaten her and given her class A drugs. Claire has recently been spending more time away from placement, with her 'boyfriend'".* The use of apostrophes around the word boyfriend perhaps indicates a discomfort with using the term boyfriend.

Regular risk assessments from the police were also utilised around domestic abuse such as the DASH[68] (later DARA) which scored standard, medium and high levels of risk depending on the circumstances throughout the scoping period or whether either party wanted to engage in the assessment. Therefore, risk assessments *were* being completed, identified similar concerns consistently and lead to referrals to specialist services when required. There is good practice evident, especially at the start of the scoping period from March 2021 – July 2021 where the circumstances were complex with many issues co-occurring.

A key exception to this: Following the breakdown of family relationships in 2021, Claire refused to return home due to allegations of neglect and went to live with Danny and his family in November 2021. Danny was 4 years her senior, and she was 15 years old, under the legal age for sexual consent. They were said to have known each other via mutual friends but immediately presented as girlfriend and boyfriend. Given the concerns of exploitation from men of a similar age, this was a flag of concern. The review has found no evidence one way or the other as to whether Danny was connected to the men who exploited Claire in early 2021. But this does not appear to have been explored at the time. It remains an unknown. It is important to reiterate; Claire was on a Child Protection Plan. There is a quiet period within the chronology between November 2021 and February 2022 with little information. But Social Care visits to Claire at Danny's family home did take place, noting her seemingly sleeping in the living room.

There was a known social care history with Danny's family which involved his aggressive behaviour towards them (see further context in Section 2 Background Information). Children's Social Care feel the history, as it was Child In Need *not* Child Protection level, would not have met the threshold for disclosure to Claire or her family. Claire moved into the address under a private family arrangement[69] with her parents providing money to Danny's mother for her upkeep. This meant that legally, Social Care did not make the decision about where Claire would live, it was her parents. After 28 days a viability

[68] Dash risk assessment resources for professionals - SafeLives
[69] Hertfordshire Kinship Support Offer | Hertfordshire County Council

assessment needed to be completed to assess the appropriateness of Claire staying in this arrangement longer term. This did not happen. It was suggested during panel meetings this was due to the placement already breaking down and it being untenable. The following excerpt is taken from viability assessment good practice guidance[70] from another local authority:

It is essential that social workers, alongside parents, make it a priority to identify any potential carers from the child's network of family and friends to determine whether they will be able to provide safe care to meet the child's needs until they reach adulthood.

There does not appear to have been the necessary checks to assess whether this living arrangement was safe in the context of Claire's background and the known history on the address. Claire was a vulnerable child looking for connection and belonging. Proximity is a factor with how intimate relationships are formed and she was placed with someone who she clearly wanted an intimate relationship with. This is a key learning point of this review. The safeguarding history of the family she was moving to, demographics (e.g age), connection to the individuals in the home and contextual factors (in Claire's case the CSE risk), should be considered when, as the above guidance indicates, the social worker, alongside parents, identify who would be able to provide *safe care*. Panel discussions considered whether Clare's Law (Domestic Violence Disclosure Scheme)[71] could be a useful tool in these circumstances. For example, an application could be made to seek information about one's domestic abuse history prior to a kinship care arrangement being made. However, due to the young ages of those concerned, a history is unlikely and an absence of one may be misleading.

Within CGL's internal review they acknowledged a missed opportunity in Feb 2023 where they had an in-depth conversation with Claire about her relationship with Danny. Within this she spoke about previous domestic abuse but said she "wouldn't let that happen now she was pregnant". CGL felt this was an opportunity to encourage domestic abuse intervention and support her to understand how this wasn't her 'letting it happen'.

4.3 A review of any Multi-Agency Risk Assessment Conference (MARAC) / MARM involvement and its effectiveness.

MARAC (Multi Agency Risk Assessment Conference)

The first MARAC in September 2022 was triggered following a referral from the police following the completion of a DASH (Domestic Abuse Stalking and Harassment Risk Indicator Checklist). There is evidence of good information sharing and risk identification within this forum but actions are limited. Financial abuse is identified and an action set to support Claire with gaining financial independence. This action was allocated to the IDVA.

[70] viability-assessment-practice-guide-june-2021docx.pdf
[71] Request information under Clare's Law: Make a Domestic Violence Disclosure Scheme (DVDS) application | Metropolitan Police

In December 2022 the police made another referral to MARAC. This time the referral was rejected for the following reasons:

- Claire and Danny wanted to remain in a relationship,
- report of allegations was from a third party,
- relevant support agencies already in place,
- Claire was last heard at MARAC in September and did not engage with IDVA.

None of these are justifiable reasons for rejecting a MARAC referral and it is a recommendation for MARAC to record reasons for rejection so this can be monitored and addressed in future. To be clear, at the time of this rejection, Danny was in supported accommodation and, had there been a perpetrator focus, several actions could have been set to consider homelessness prevention and challenge his behaviour. Consideration of the primary perpetrator was lacking in all MARAC minutes. It has been acknowledged by Police, during the course of this review, the referral should have been accepted. In addition to the above rejection reasons, it was also rejected due to being submitted under the incorrect referral criteria.

The second appearance at MARAC was in February 2023 where it was disclosed Claire was pregnant. This was again via a Police referral and due to repeated incidents occurring. Again, there is evidence of good information sharing where additional details such as drug and alcohol use were raised aswell as the risk of exploitation. Four actions were identified, one which requested further attempts for the IDVA to contact Claire.

The third and final time this was heard at MARAC was a month later due to an allegation of strangulation, ABH and criminal damage from Danny towards Claire. The referral indicated Claire had lost her pregnancy and both parents were grieving the loss of the child. It detailed how Claire had gone to Danny's address (he was with his sister at the time), whilst he was on bail, and let herself in. He then became violent towards her. The actions are limited. Within this meeting the housing provider for Danny's sister, whom he was staying with said: *There are concerns that Danny's sister is also a victim of domestic abuse from Danny.* There is no record of safeguarding actions being identified or any action on Danny from the housing provider. This is another potential opportunity to engage him and challenge his behaviour.

MACE (Multi Agency Child Exploitation Panel)

Claire's circumstances were also heard at MACE on four occasions in total. This is a forum set up to reduce the risk of child exploitation and supports one of the four priority objectives within Hertfordshire's Serious Violence Strategy and Delivery Plan[72] e.g criminal exploitation of young people[73]. She was heard three times from May – July 2021, prior to her relationship with Danny, where relevant information was shared. Evidence from services involved at this time indicates agencies were galvanized to support Claire and her family to reduce the risk of CSE and try to engage her meaningfully. It was returned to panel each

[72] Hertfordshire Serious Violence Strategy & Delivery Plan
[73] Prevent children and young people from being involved in criminal exploitation and serious violence

month to gain updates and answers to gaps in information. Following Claire being discharged from MACE she left the care of her family and three months later would be living with Danny and his family.

After a break of 18 months Claire's situation returned to MACE after she reported a rape in November 2022 from older males. In contrast to the first time Claire was heard at MACE (one action), there were 11 actions identified from this meeting. One was for Social Care and CAMHS to meet to identify the correct support although this meeting did not initially happen and there was some drift.

MARM (Multi Agency Risk Management Meeting)

The notes seen from the MARM in Dec 2022 clearly state the concern around Claire overdosing. They reference her family "longing" and the intimate 'relationship' being abusive. Based on the meetings' minutes, key issues are acknowledged and there is shared agency concern about Claire's wellbeing on a number of levels, including the risk of CSE, education, domestic abuse, emotional and physical health.

The author of this review has flagged the number of actions stemming from these meetings. To some degree this is a side issue as relevance and appropriateness of actions are of more concern. But it is noted to illustrate a lack of identifiable ways to reduce risk from these meetings. During panel discussions the police used the word unproductive to describe some of these meetings. For the MARAC especially this appears accurate. Actions are mainly centered on the IDVA attempting to contact Claire which in some circumstances they were doing already. The perpetrator focus is lacking overall and there is no direction from MARAC for agencies to meet and analyze the domestic abuse dynamic to identify which service(s) will work to reduce risk with each individual.

4.4 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?

In April 2024 Claire's cousin told police she had a video showing Claire with red marks on her face believed to have been caused by Danny. The cousin commented that "*Claire will end up dead due to Danny's controlling and abusive behaviour*". The cousin would not provide a statement or engage further. She was reluctant to get involved and was anti police due to no action being taken for her own previous experience of domestic abuse. Police tried to encourage involvement but to no avail.

Overall, during the scoping period, both sides of the family appear to have contacted police at differing points to report a variety of concerns regarding the relationship. Additionally, neighbours of Danny's sister reported noise disturbances and concern for wellbeing relating to Danny and Claire. His sister also called police directly. It appears both family and friends had numerous concerns, albeit they were seeing them through a Danny or Claire lens. There were no apparent barriers with regards to them contacting agencies, but it is of note that no abusive behaviour was ever charged. Where reports are made but no charges brought, this can often lend itself to reporting fatigue though there is no direct

evidence of it here. Evidence of police actively trying to encourage third party information on more than one occasion was good practice.

Risk assessment and Analysis

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

As referenced in ToR 4.1, Emerging Futures (EF) had concerns for Danny's welfare and Claire's alleged controlling behaviour of him. Claire acknowledged feeling jealous of him working with women and also acknowledged behaviour which could be considered violent resistance[74] (e.g slap Aug 2022). However, when looking at the overall picture, the vast number of concerns related to Danny's physical, psychological and financial abuse of Claire. Significant information was shared via MARAC on several occasions which indicated high risk of serious harm / death and the majority of services were aware of this. However, Emerging Futures were not present, which is especially pertinent given they were submitting their own safeguarding concerns at the time of the first MARAC in Sep 2022 indicating Danny was at risk from Claire. It is vital all services attend this meeting or are at least able to access minutes and share information. Those who house and support the most vulnerable, such as Danny and Claire's housing support can contribute greatly to information sharing and in risk reduction efforts. EF would have had some influence over Danny engaging in meaningful work around his behaviour in relationships. It is possible he would have been open to this, if framed correctly, as in late 2022 he showed an interest in attending talking therapy.

For further clarity – Claire was disclosing not only experiencing abuse but also *her* abusive behaviour of Danny. E.g being jealous of him, not allowing him to work with women, "lashing out". Claire also voiced her want for Danny to get help with his alcohol use and anger issues. This is in contrast to an absence of Danny acknowledging his own use of abuse and no evidence to suggest he wanted Claire to get support for her own needs. There are, what in hindsight could be construed as, self-pitying expressions from Danny such as *"how could I let a 16-year-old control me?"* where he presents as a victim of abuse. All of the above are examples of behaviours which could be analyzed by the services involved to identify who the primary perpetrator is so interventions can be directed accordingly.

When considering attachment theory, one could consider both Danny and Claire had insecure anxious attachments[75] leading to them feeling they needed each other and extreme reluctance to end the relationship. Services such as CGL, Housing, Youth Justice and Social Care attempted to increase Claire's knowledge of healthy intimate relationships. Social Care in particular conducted sessions with her over several years. When the IDVA had contact, they too tried to increase awareness of what constitutes abuse. But the pull of the intimate relationship was incredibly powerful and would have required a focused coordinated response to agree on a strategy to reduce the risk of further

[74] Sage Reference - Encyclopedia of Interpersonal Violence - Violent Resistance
[75] Insecure Attachment, Dysfunctional Attitudes, and Low Self-Esteem Predicting Prospective Symptoms of Depression and Anxiety During Adolescence - PMC

domestic abuse. This is especially pertinent when considering Claire's *space for action*[76], a term coined to highlight how one's ability to increase self esteem, confidence, independence, social circles etc can be severely hampered if in a domestically abusive relationship which limits these activities.

Domestic abuse was recognized. Information was shared with *most* services. But the analysis of what needed to happen next was limited. The strength of the attachment between the two created an uncertainty for some frontline practitioners with how best to address domestic abuse for fear of unintentionally pushing them closer together. A coordinated plan of action which considered aspects such as what to do if there are bail conditions and / or visiting bans and how to communicate them to the couple could have helped create a consistent message and increase Claire and Danny's understanding of what was happening. Within this work Claire's jealousy of Danny also needed to be addressed as it too was harmful and may well have impacted on her future intimate relationships. Where services have information about these behaviours it's vital for it to be shared so a plan of how to tackle it in a sustained, meaningful way can occur.

4.6 Were counter allegations robustly assessed?

From a criminal justice standpoint, counter allegations when disclosed were assessed and addressed appropriately. In Sep 22 and Jan 23 Police received information concerning Claire's behaviour towards Danny. When he was spoken to, he denied any concerns. This information was assessed in the context of all other information available which included a growing list of allegations including assault, stalking and financial exploitation from Danny to Claire.

To robustly assess counter allegations, context and good information sharing is required. Whilst there were gaps as previous ToR points have raised, overall there was good information sharing between services and it was contextualized with Claire's vulnerabilities being recognized. This meant, for example, punitive action such as arrests and detention appeared targeted at the individual who required arresting. Housing actions such as visitor bans and eviction notices were the exception. Other than Emerging Futures not seeing the whole picture, there are no further concerns with counter allegations being misunderstood or leading to inappropriate interventions.

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

As discussed, this was a particularly complex relationship, but the dynamic was relatively clear and understood at all multi agency meeting records seen. However, basic domestic abuse awareness training would be limited in supporting practitioners to move cases forward with such attachment styles and behaviours. Single agency recommendations from individual agencies identified some training needs. But it is important to recognize the need for a coordinated analysis focusing on who will do what next (e.g agency actions) and what the consistent messaging will be. For example:

[76] Costs_of_Freedom_Report_-_SWA.pdf

- Who will speak to the primary perpetrator about their behaviour and is it safe to do so?
- What interventions are available to challenge those using harm and how can these be framed to increase chances of engagement?
- How can services increase compliance from the couple with visitor bans / bail conditions to see the benefit to them both.
- Are there beliefs that need to be challenged such as *"it will be better if he stops drinking"*.

This is more about analyzing the available information to identify meaningful actions. With the exception of Emerging Futures, it appears services were aware of the dynamic within the couple's relationship, understood Claire's vulnerabilities, but were working against a backdrop of both individuals seemingly wanting to be together regardless of whether there were bail conditions or banning orders in place. See ToR 4.9 for further detail.

Support for young people in abusive relationships

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

As the chronology highlights, this was not just a teenage relationship. Claire was especially vulnerable for many reasons. A report from the Youth Endowment Fund[77] (YEF) highlighted how certain vulnerable groups are at significantly higher risk of experiencing relationship violence. Within this study, 79% of those who showed signs of exploitation reported experiencing violent or controlling behaviour. Children supported by social workers were also more likely to face relationship violence than their peers. Therefore, Claire was clearly in the vulnerable category with a heightened risk of experiencing domestic abuse.

The same research highlights gaps in provision to address teenage relationship abuse. Although 76% of teenage children received lessons on dating and relationships at school (from a survey of 10,000), there were gaps in the content. Over half (55%) had lessons on sexual consent, 43% on harassment and 40% on building healthy, respectful romantic relationships. Even fewer teens received practical advice on recognising or addressing unhealthy relationships. Given Claire was out of education for a significant amount of time, this left the education on abusive relationships to other services. Danny should also be considered in this regard. Given he also had school attendance issues, he would likely have been lacking in this area. YEF research also highlights how children who reported perpetrating sexual violence were significantly less likely to say they had received lessons

[77] Half of teens in relationships suffer violence or controlling behaviour, reveals new report | Youth Endowment Fund

on consent — 39% compared to 55% of all 13 to 17-year-olds. They were also less likely to report having lessons on sexual harassment (31% vs. 43% of all children).

Refuge reflected on their involvement in this case and felt there was a lack of recognition of Claire's age or her care leaver status within their interventions. They felt there could have been greater emphasis on making their service accessible to her such as meeting her at her housing placement or liaising with agencies whom she had a positive relationship with. The risk assessment used was the standard SafeLives risk assessment (DASH). They state it is best practice to use a young person's risk assessment when working with young people aged 13 to 17 years old which was not done. They provided further context:

"Between 1st August 2022 and 15th August 2025, the IDVA service received 37 referrals for young people aged 13-17 in Hertfordshire and supported 14 of those young people, which is 38% of those referred, this is slightly less than adults referred to the service where there 40% of those referred accessed the service. The numbers referred are low, and the team does not have a dedicated IDVA for working with young people, as the service was not commissioned this way. In other services Refuge has a model of supporting young people via Young Person's Advocates (YPAs) who carry smaller caseloads and have more time to invest with young survivors in terms of outreach and face to face meetings, relationship building and significant multi-agency work with other professionals. With the volume of referrals that the IDVA service receives (approximately 2,250 per year on average) referrals for young people could get lost in the many adult referrals being dealt with and having reviewed this case it is apparent that the service adopted the same approach to working with Claire as they would have an adult survivor. The approach adopted does not reflect a best practice model in terms of working with young people, the IDVAs should have been more proactive in reaching out to and working with multi-agency partners to support Claire especially the social worker who made a referral."

Although the same contract remains in place, Refuge have made some changes such as employing a Senior Programme Lead to focus on the support provided to children. Their work has included ensuring support for children and young people is embedded into internal training on risk assessment and safety planning, which is mandatory for all new staff.

Claire also had support from other services such as the Youth Justice Worker, CGL, Social Care, a PA (personal advisor) and housing support staff. However, none of these professionals were specific domestic abuse provision as an IDVA would be.

A hospital led ISVA (Independent Sexual Violence Advisor) service offering support for victims of Domestic Abuse aged 16 and above was commissioned in 2023 for the East & North Hertfordshire Trust (ENHT). This service recognised a further gap in services and so funding for a CYP (Child and Young Person) sexual abuse and exploitation worker was obtained with the role beginning in 2024 just after Claire presented following her pregnancy loss (Feb / March 2023). This role provides specific support for children up to the age of 18 who have experienced sexual abuse & domestic abuse. They provide expertise on engagement, risk assessment and longer-term support (up to aged 18). The ENHT informed

the panel this service has seen a significant increase in the identification, provision and outreach of support for vulnerable patients. It appears it would have applied to Claire's situation and this review provides more evidence of it's need.

4.9 Did those supporting both Claire and Danny have the required domestic abuse knowledge and training and were they able to have conversations to support, challenge and reduce risk? (to be considered alongside ToR 4.7)

Those supporting Claire most significantly were social workers, housing support staff and CGL. It is evident all professionals were doing their utmost to support both individuals. A concern and passion for them to do well comes through within the internal reviews seen. But as ToR 4.7 details, the situation was complex and there was a lack of analysis identifying next steps. The approach collectively taken was to deter them from the relationship and educate Claire about what abusive behaviour is. Whilst the term collectively is used here, it does not appear to be a coordinated approach and there is a nuance around the phrase "deter them from the relationship". This can be done in multiple ways such as helping one see the pros and cons of a relationship, but retaining the individual's autonomy within that process is important. This may sound like a contradiction when bail conditions are in place to prevent contact, but each agency has a different role to play to reduce the risk of harm and encourage longer term future engagement.

Peabody's aforementioned concern about not wishing to unwittingly push Claire and Danny closer together, or their worry Claire would "shut down" if they encouraged her to separate, is important to record and is often a common underlying worry for frontline practitioners. This service reported how Claire was seen on the phone to Danny most of the time and their ability to be apart from each other appeared lacking. Both Claire and Danny lacked the skills to be able to function in a healthy relationship and would have benefited from longer-term programmes to address this. Gaining their interest in this would have benefitted from coordinated focused discussion on how best to do so. Of note, a longer-term intervention was offered to Claire via the IDVA but was declined. Whether this was an age appropriate intervention however, is debatable.

From June 2022 – Jan 2023 especially, when both Claire and Danny were in supported accommodation, there was a golden opportunity to work with their support staff and influence their engagement in domestic abuse related interventions. Relationships where banning orders / bail conditions appear to be breached and / or ignored are especially challenging for agencies to work with. Where there is potential co-dependency[78] additional guidance could be beneficial for services to help navigate next steps and shape meaningful interventions. One such approach piloted by the domestic abuse charity Safelives was Engage - an approach to support couples or families who want to remain in a relationship, where it has been identified that the perpetrator of abuse is motivated to change. More recently (April 2025) they released the Verge-of-Harming-Phase-2-practice-resource.pdf for those working with those using harmful behaviours. P.28 references sessions on jealousy which appear to be relevant for both Claire and Danny. These are

[78] Codependency | Psychology Today United Kingdom

noted for their relevance in this case and for agencies to consider internal promotion / training for frontline staff.

Mental Health

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

Agencies were aware of Claire's mental health needs and attempts were made to gain and identify the right therapeutic support. This is evidenced by numerous CAMHS (child and adolescent mental health service) referrals, Talking Therapies referrals and latterly a referral to a wellbeing worker. Progress was hindered by several factors. Claire was reluctant to work with CAMHS for several reasons. A CAMHS case note in July 2021 expanded on her reluctance: *"Claire told the therapist she did not respond to her problems by talking about them. This, she said, was partly a family trait. She said she attended as her mother wanted her to. The therapist documented that her life remained unsettled and it may not have been the best time to unearth feelings about trauma. They felt that by attending therapy when she was unwilling to engage may do more harm than good."* The review panel has discussed this in more depth. It is not unusual for individuals to find it difficult to speak about trauma, especially children and young people. Mental health practitioners are trained to work with resistance and consider creative approaches to building one's motivation to engage. It is beneficial for mental health services to factor in resistance to their longer-term support of an individual with trauma in their background as it is likely to take time to reach the point where they can discuss it, if ever. Immediate safety planning with that individual would be helpful to prioritise in these circumstances, especially in a known domestic abuse context such as this. The panel also discussed the labels of 'therapy' and 'trauma' and how these terms may impact one's motivation to meaningfully engage if used directly with the young person. There is a limit to this review's ability to comprehensively explore these nuances but all services have a role to play in being mindful of their language when discussing mental health support with young people and adults alike. Breaking down what is meant by therapy can be helpful in dispelling any misconceptions.

Another factor hindering progress was talking therapies deeming Claire's needs too complex for their service. Additionally, the wellbeing worker with her housing provider was male which she felt was a barrier for her. There was drift with referrals being made, assessed and declined over many months. The issue does not appear to be a lack of awareness of Claire's need for mental health support, or the domestic abuse she was experiencing. It appears more about getting the expertise in place to support in a targeted, trauma informed way which fully appreciated the acute emotional distress she felt at perceived rejection or loss. Her presentation was steeped in a history of attachment issues stemming from childhood and during the scoping period Claire never had the specialist support to begin to meaningfully address these issues. Whilst in education, her school indicated she had unrealistic expectations of therapy when she attended one counselling session and then vocalised how she now longer required it. This is not an uncommon

presentation for younger people's experience of therapeutic intervention. As identified by CAMHS, it would have been helpful to keep her referral open longer in 2021 as there had been some signs of engagement, albeit sporadic. A MACE panel meeting in July 2021 identified how she was no longer on the high risk pathway[79], which was premature given the history. The majority of specialist mental health provision was her four appointments with CAMHS in 2021 which was clearly not a significant amount of time to delve into pertinent subject matter or develop coping strategies.

Where Claire had made it clear she did not want CAMHS there was a lack of a co-ordinated discussion looking at what the next best specialist support could be. This left a hole in focussed mental health provision. This is not to say services were not supporting Claire. She had extensive input from social care, a personal advisor, youth justice worker, housing support staff and a CGL worker. But, given the extent of her mental health history including suicide attempts, self harm, drug and drink related concerns, medication for anxiety - she would have benefitted from specific trauma focussed work with a qualified mental health practitioner. She showed a willingness to engage in some form of support several times, for example saying she would see a non CAMHS psychologist, or would access CBT (cognitive behavioural therapy) but these were not available.

CAMHS reflected how, where Claire remained open to their service, they were not part of wider network meetings (outside of MARAC for example). This contributed to said drift while non-specialist services attempted to fill the gaps as best they could.

During panel discussions Peabody housing stated the funding for their psychologist has ended and they will no longer be offering this provision. Given the vulnerability this provider supports, and the likelihood of engagement challenges their residents may have with mainstream services, this is being highlighted for re-consideration.

4.11 Were suicide prevention plans made with Claire and did these consider the domestic abuse she was experiencing? 3.34

Suicide prevention plans are an essential tool for practitioners working with people where there is a known suicide risk. This risk, aswell as the risk of overdose, was clearly stated and known amongst the multi-agency network. Such risk reduction plans are especially pertinent with those experiencing domestic abuse as emerging research shows those with a history of suicidal ideation / self-harm *and* in an abusive relationship are more likely to end their lives either intentionally or via accidental overdose[80]. Prior to completing a suicide prevention plan, it's vital for practitioners to be aware of domestic abuse so they do not unwittingly recommend the alleged abuser as a source of support. Additionally, recognising the intensity of emotion during a separation or abusive incident is important to ensure suicide prevention plans are as realistic and implementable as possible. This has already been identified as a gap in the Hertfordshire Suicide Prevention Strategy 2020 –

[79] CAMHS targeted team process and offer
[80] Intimate partner violence, suicidality, and self-harm: a probability sample survey of the general population in England - The Lancet Psychiatry

2025[81] which states there is *"A need for additional information and support (or awareness of) for young people during stressful periods in their lives, such as transitions, exams, family separation or family bereavement."* It is a recommendation for the next iteration of this strategy to include learning from this review and consider overdose within their preventative work. Overall, there is limited evidence of suicide prevention plans being conducted directly with Claire (para 3.34 provides more context). These plans are readily available for practitioners to use via dedicated charities such as Papyrus'[82] Suicide-Safety-Plan.

Claire's most recent GP informed this review they had sent her a text with support options if she felt suicidal and had a detailed conversation about suicide risk on her last appointment. They assessed her as low risk of overdose at that time which was partially based on her lack of stated intent to harm herself and her presentation e.g she was proactively attending the GP to get support for her mental health. The GP often has a limited amount of time upon which to assess. To support GPs, 'flags' are visible on their system to alert them to a patient's specific circumstances quickly. In Claire's case she had "Looked After Child", "Child on Child Protection Register" and "Child is cause for safeguarding concern" present. Additionally, she had a marker called "Active Problems" with sub sections of "At risk of domestic violence" (from March 23) and "Suicide attempt" (from July 2022). The clearer the markers for domestic abuse (e.g MARAC markers) and history of suicidal ideation / overdose can be on GP the systems, the more likely it will be for the heightened risk of suicide / overdose to be identified and acknowledged within subsequent actions. There has been learning from this review about the weight placed on the presence of domestic abuse and suicidality when assessing risk which will be reflected within the lessons to be learned section.

When Refuge[83] first spoke to Claire they conducted a risk assessment and asked about suicidal thoughts. She disclosed feeling suicidal *all* the time. There is no evidence that the IDVA explored her suicidal ideation following the disclosure and good practice would have been to have a further conversation about suicidal ideation and create a suicide safety plan with Claire. Refuge's IMR stated, "The IDVA should have logged the risk on the client risk assessment which considers any significant risks that the client may pose to themselves or others such as suicidal thought, self-harm or drug and alcohol misuse." On this occasion the IDVA offered a referral to counselling which can take a long time and would not address immediate suicidal thoughts.

In July 2021 the CAMHS practitioner and Social Worker met with Claire to try and engage her in mental health support. Claire left this appointment and never returned to CAMHS intervention. In her absence a suicide prevention plan / safety plan was made based on information available. This was good practice but whether it was disseminated to agencies, updated and was meaningful to Claire is unknown.

[81] Hertfordshire Suicide Prevention Strategy 2020-25
[82] Suicide safety plan | Papyrus
[83] Refuge, the UK's largest specialist domestic abuse organisation

In summary for this ToR, suicide prevention plans which consider one's available support network and the domestic abuse they are experiencing do not yet appear embedded in multi-agency approaches to risk reduction efforts.

Disrupting perpetration

4.12 Were opportunities to support Claire to apply for legal orders (e.g non-molestation orders[84]) recognised and utilised?

The IDVA spoke to Claire about NMOs (non-molestation orders) and agreed to a referral to We Protect[85] in October 2022 to support an application. We Protect contacted Claire and discussed her situation. She said she'd consider her options and contact again if she wished to proceed with an NMO application. Following this call, We Protect sent an email to Claire with contact details and follow up information but received no further communication. It is their policy to provide an outcome e-mail to the referrer though Refuge have no record of an outcome.

There were often bail conditions in place for Danny not to contact Claire but contact continued regardless. It is not known who the instigator of such contact was, but it is quite likely, based on the information received that both would have begun contact on different occasions. It is of note though, that Danny was always the one with bail conditions such as in April 2024 when he was seen climbing through a window into Claire's flat. It is vital that behaviour such as this is treated robustly. In this circumstance he was already on bail for serious domestic abuse offending and entering Claire's flat via her window should have been seen, at minimum, as harassment aswell as breach of bail. This could have led to a further arrest which in turn could have led to a remand or further charge. Ensuring housing providers of vulnerable people are aware of bail conditions in place to protect their residents are vital. This is a key recommendation and learning outcome.

4.13 Were all opportunities for evidence lead prosecutions utilised?

Evidence lead or 'victimless' prosecution is when the police identify evidence from third parties or utilise CCTV, Body Worn Video etc instead of relying solely on victim statements. This means the onus is not on the victim to provide evidence and attend court which, in a domestic abuse context, can be a difficult and traumatic experience where levels of fear are already high. In this case there is good practice evident with police considering alternative evidence on multiple occasions from agencies, family and body worn video. One example being Claire's housing support who had called the police following her disclosure of abuse from Danny. On this and other occasions the third-party evidence was considered but deemed insufficient to gain a charge and was not pursued. However, the key opportunity from April 24 when Danny was on bail and entering the flat through the window was missed due to a lack of reporting. Third party evidence would have been available from staff at Claire's housing provider. Furthermore, given the history between Danny and Claire, Police agree that coercive control should also have been investigated as

[84] Non-Molestation Orders - Family courts and domestic abuse
[85] WEPROTECT | Legal Support For Domestic Abuse Victims

a crime during Danny's arrest / investigation in April 2024. Had this occurred, evidence from services such as a CGL and / or Peabody may have aided the investigation. They view this as a learning point for officers encountering domestic abuse situations in the future. Police have reviewed the circumstances retrospectively and do not feel there are sufficient grounds to explore a coercive control investigation posthumously.

4.14 Were opportunities to prevent Danny from contacting Claire utilised?

Although visitor bans were given to both Claire and Danny from respective housing providers, they had little impact on reducing contact as both parties continued to see each other. Both Claire and Danny were evicted from their properties for 'allowing the other' into their flat a contributing factor. This approach in a domestic abuse context is important to consider. If one is seen to be "allowing" someone into their flat, this can be very different to seeing the behaviour of the visitor as harassment. This has been highlighted in another recent Hertfordshire DARDR where the adult tenant received warning letters due to her visitor's behaviour. This did not consider the power dynamic or the responsibility of the visitor not to attend. This is due to be highlighted in the forthcoming Home Office ASB strategy to ensure services consider domestic abuse and don't unfairly penalise those at risk of being abused. This is especially pertinent to consider for those housing providers who support some of the most vulnerable in our society.

In April 2024, Danny attended Peabody, Claire's accommodation whilst he was under bail conditions not to do so. Peabody state they were not aware of these conditions and therefore did not initially call the police. They state they contacted the police on the 2nd occasion via the non-emergency number, but no record can be found of this call on police systems. On Peabody's systems it is recorded how police advice was to call back if Danny caused antisocial behaviour. If this is accurate there is clearly a significant issue with information sharing and risk identification which needs to be addressed. This was a significant opportunity to arrest Danny for harassment of Claire and to assist in giving her some space to focus on herself.

There is good practice from police in evidence in December 2022. After arresting Danny for an assault of Claire, a Domestic Violence Prevention Order (DVPO) was applied for by the investigating officer. Had it been successful it would have provided Claire with 28 days of legally enforceable space from him. It may also have contributed to Danny retaining his tenancy had it been enforced. The following excerpt from the Police IMR demonstrates a thorough exploration of this application which was ultimately rejected via a superintendent:

"*A DVPO would be appropriate in this case and has been discussed this with the Detective Inspector. The victim is unsupportive of Police action. There is a pattern of domestic abuse between the couple, starting in March 2022, then June 2022 and November 2022, and now these events. The victim has been unsupportive in all of these incidents and they have been NFA'd. It is clear both parties are vulnerable. Their support workers say that their relationship is very volatile. The victim is also known to police for CSE (with another suspect). The victim has been sitting in the front office waiting for the suspect to be released. Clearly they are going to be back together when he is released and the cycle will*

continue. As such a DVPN should be applied for - it is a valuable tool to enforce the separation of the two and allow the victim's support services to work with her."

The DC (detective constable) applied for the DVPO through the superintendent as per process but they did not authorise it saying: *"I do not believe there are reasonable grounds to believe that the suspect has used or threatened violence against the victim or to believe that a DVPN is needed to prevent future violence to the victim."*

The DC noted they spoke to the Superintendent themselves to challenge this but their rationale for rejecting it remained the same meaning it could not be put in place. Based on the wording provided, this appears to be because the Superintendent did not believe the allegation. The panel considers this to be a missed opportunity and is unfortunate considering the extensive efforts from the DC and DI to try and reduce risk. Whilst it is highly likely the DVPO would have been breached, this would have been Danny's choice to breach it and he would have been accountable as such. Support would also have been required to support Claire not to contact Danny but support services were in place at that time to do just that.

During the scoping period Claire said she wanted services to listen and understand that she wanted to be with Danny. There is an insinuation she was not feeling listened to. This was several days after another police call out for domestic abuse. There is a lack of realism on both her and Danny's parts about the relationship resuming in a healthy way without significant change but there is no evidence of agencies attempting to reframe Claire's expectations about Danny, about his anger or alcohol use and how this alone would not challenge the core beliefs and attitudes underpinning his use of abuse.

This review also heard allegations Danny told Claire to go and kill herself more than once. In October 2023 the UK's online safety act received royal assent with criminal offences introduced by the act coming into effect on 31st January 2024. These covered encouraging or assisting serious self-harm.

As a result of this DARDR, the Police reviewed this allegation and spoke to the Force Crime Registrar[86], a senior police role responsible for 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 are 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.

Upon reflection, Police felt there could be a greater awareness of a) the online safety act amongst staff and b) the ability to seek advice from the force crime registrar when requiring guidance. This will be reflected in their Single Agency Recommendations.

4.15 *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 Danny to these. Were practitioners confident in knowing how to ask these questions?*

[86] Force crime registrar - His Majesty's Inspectorate of Constabulary and Fire & Rescue Services

There was and currently is provision for those using harmful behaviour in relationships within Hertfordshire. This is the Chrysalis Centre whose website states the following:

Interventions are available to anyone who causes harm and is a resident of Beds and Herts irrespective of sex, age, or risk level. We have made the referral process as simple and easy to complete as possible to empower you to take action. It is one single process for everyone.

There were opportunities to speak to Danny about his behaviour and encourage him to engage in such support as the Chrysalis centre provides. This was via Emerging Futures (his accommodation), Criminal Justice Liaison & Diversion Service (L&DS) in custody and his GP. There is no record of Chrysalis or its equivalent being considered or identified as appropriate from any service. On the occasions he was spoken to, he was either seen as the primary victim of abuse or his behaviour was seen through the lens of someone struggling with alcohol use or with anger issue. It is a key learning outcome of this review for services to utilise their opportunities to challenge someone's behaviour in a meaningful, non-judgemental fashion to increase the likelihood of them seeing the need to speak to a service such as Chrysalis.

This ToR should be considered alongside MARAC as Danny's agency network were not aware of him being heard at this forum. Nor was domestic abuse intervention considered for him during MARAC discussions. Embedding consideration of who can safely challenge the primary perpetrator's use of abuse and encourage them to engage in meaningful support should be a standing consideration during MARAC discussions.

Additional:

4.16 *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.*

Within each organisation's Individual Management Review (IMR) they were asked to evaluate this question with their reflections seen in the single agency recommendations in Section 7. In summary, several recommendations have been made to update / review domestic abuse training to include consideration of increased risk of suicidality. As referenced, Refuge have employed a Senior Children's Programme Lead whose work focusses on the support provided to CYP to ensure support for children and young people is embedded into internal training on risk assessments and safety planning. This will be mandatory for all new staff. They are not the only service to recommend mandatory training with social care also recognising their 'ilearning' domestic abuse awareness course should be mandatory for all social care staff. This is something which has been raised before with previous reviews recognising a national recommendation in this regard. The fact it has been identified again highlights the lack of progress.

It is important for this review to be utilised to highlight learning and how practitioners can work together to effectively analyse behaviour, reduce risk and consider suicide / overdose prevention within.

4.17 *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.*

Two of the Peabody properties display both leaflets and notice boards which signpost residents to local and national voluntary sector support services, these include substance misuse services, The Samaritans and Young Minds[87]. There is clear information of how residents can contact staff when there are no staff on site. The review has found no evidence of Chrysalis services being promoted and it is a recommendation for services tasked with challenging the person primarily causing the harm to promote and embed such interventions.

4.18 *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.*

Overall services did largely follow professional standards, policies and procedures. There was good practice evident, for example with joint working (e.g CAMHS and Social Care attending a session with Claire together), referrals to forums such as MARAC and MACE and appropriate safeguarding referrals. But there were also missed opportunities (e.g IDVA service not linking up with housing / social care to meet Claire face to face). These have been noted within the review. Additionally, services reflected as below:

Peabody Housing reflected how their 'Dealing with Threats of Suicide and Self Harm Procedure' was not fully followed in relation to Claire's disclosure of self-harm around Christmas 2023. Had it been followed it may have identified triggers for future self-harm episodes (e.g breakdown of relationships). Support planning and risk assessment paperwork is currently being reviewed to ensure the paperwork fully reflects the voice of the resident and provides a more trauma informed approach to managing support and risk.

Since Claire's death, Peabody, in collaboration with other relevant services have been developing Care and Support Suicide Prevention Guidance. At time of writing, the guidance is in final draft prior to publication. It is recommended this guidance includes risk of overdose which can sometimes fall through the gaps as a consideration due to the ambiguity surrounding intentionality. It should also include the impact of domestic abuse on one's risk of suicide / self-harm. Additionally, as a result of this review, Peabody identified there was no link between the on-call manager system and wider systems at their properties. This gap has now been closed to enable access to additional support in the event of a serious incident.

[87] Dating and relationships advice | Mental health | YoungMinds

CGL have recently simplified their domestic abuse pathway to allow workers to follow this step by step. The pathway has been formulated into a flow chart and displayed in all CGL buildings. The new pathway is incorporated in internal safeguarding training. All new workers are mandated to attend this training, and all workers are expected to attend this bi yearly as refresher training.

Following their IMR, Hertfordshire Community NHS Trust suggested improvements to include joint training, better pre-assessment information, and social worker accompaniment to assessments with children entering the care system. They highlighted a need for a specialist nurse for care leavers due to high caseloads. Additionally, they made a recommendation to consider appointing a chronologist to support pre-assessment record reviews, enhancing understanding and questioning during assessments. During panel meetings the ICB (integrated care board) stated work is underway to develop a domestic abuse risk assessment tool for general practice (GP). Once approved by the ICB and safeguarding GPs, it will be shared with health teams. They are also developing and piloting a new domestic abuse conversation support tool for primary care to increase confidence in having conversations with those using and experiencing harm. They are also reviewing the use of alerts in GP systems to flag safeguarding and domestic abuse.

This year (2025) Refuge have trained their CYP (Child and Young Person) workers in mental health and trauma. Their work with UK Trauma Council and Anna Freud Centre highlighted the intersection between young people's mental health and domestic abuse which has influenced their Working with CYP policy and procedure. In May 2024, the young person's risk assessment was embedded on their case work management system which sadly was post their work with Claire. They have also developed a two-day training session for working with children and young people.

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

Hertfordshire Learning Review into Deaths of Care Leavers 2022

Between 2019 and 2021, 5 care leavers in Hertfordshire died as a result of suicide. As a result, Hertfordshire County Council commissioned a thematic review to identify any learning. Although a small sample size, there are similarities with Claire's situation worth noting for future learning.

- 1 of the 5 YP (young people) reported being raped by their brother. Action was not taken forward by the police at the time, her parents denied this happened.
- All 5 displayed self-harming behaviour.
- 2 out of 5 YP (the only two females) were deemed at risk of child sexual exploitation.
- All experienced numerous placement move's during their time in care.
- 5 out of 5 exited education early.
- Of the 5 young people, 4 entered the care system in their teens, which would have impacted their ability to settle.
- They would have had the added difficultly of trying to regulate having spent prolonged periods in what must have been a stressful environment. The following

diagram highlights a model for supporting someone in a trauma informed way, highlighted here for learning purposes.

Figure 1. Dr Bruce Perry 2018

- Many child psychologists and mental health specialists have produced research regarding the impact on siblings and the feeling of loss when siblings are separated.
- Having a structure such as a place of employment or of study would be of benefit.
- The review recommended the frequent use of chronologies to understand the cumulative impact of ones trauma and experiences.
- There would be a number of benefits to having a mental health worker attached to the leaving care teams following the same model as the Hertfordshire Family Safeguarding service. (Please note – these workers are now in place)

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

The use of hotels to facilitate CSE

Information regarding Child Sexual Exploitation suggested hotels were used to facilitate such actions. There is a legal requirement under the Licensing Act 2003 for hotels to ensure they have suitable control measures in place for the protection of children from harm and should they not meet these requirements action can taken Under Section 116 of the Anti-Social Behaviour, Crime and Policing Act 2014. This enables Police to serve a notice on a hotel owner, operator or manager requiring guest information in connection with child exploitation. The following Guide for Hotel Workers includes a checklist of actions to prevent exploitation such as age verification checks.

One hotel chain was contacted by the chair requesting their stance on this issue. They responded via signposting to the following statement:

Human Trafficking & Child Abuse[88]

The use of hotels for child trafficking and associated criminal activity is a recognised issue throughout the hotel industry. 100% of our colleagues underwent important child trafficking and human rights training in 2025. Police and children's charities tell us that criminal groups often move vulnerable children to locations outside of their local area to minimise the child's ability to access help. This is why all of our hotel teams are regularly trained to national guidelines that are supported by the NSPCC and approved by the National Working Group on child sexual exploitation, South Yorkshire Police and the MET Police.

Further information on work being undertaken locally to prevent child sexual exploitation can be found here: Child sexual and criminal exploitation - Hertfordshire Grid for Learning

Additional good practice

There was good practice identified throughout this review. Of particular note was Claire's arrest and subsequent detention in July 2023. After her initial detention for assaulting Police, careful consideration was given as to whether her continued detention was reasonable and necessary. They summarized their consideration as follows: *"I have carefully considered the necessities regarding detaining the female who is a juvenile. The female is believed to be a victim of domestic abuse by her partner who arrived into the same custody suite a short time before her arrival. The female has become violent towards officers when her partner was being arrested and assaulted a police officer. On arrival to the custody suite she has been calm and engaged in conversation. The main necessity for her arrest was to enable a prompt and effective investigation however due to the time of night it is likely that it will be 10 hours before she is interviewed. I am of the opinion that she should be prioritised as a domestic victim and therefore I have refused her detention. I have explained to her that she will need to be spoken to regarding the assaults and she appeared accepting of this. The female has made no concerning comments regarding her own welfare and she has provided contact details and is prepared to speak to an officer from DAISU (specialist DA unit) in the morning as a victim. The officers have taken the female back to her home address".*

Persistence of practitioners

The IDVA (independent domestic violence advisor) service called Claire 30 times during the period between 30/08/2022 and 06/06/2023 although they only spoke to Claire three times during this time. Though they recognised a lack of linking up with pre-existing support to facilitate engagement, the number of attempts indicates a persistence. CGL met Claire regularly in the community and showed a flexibility of approach. Emerging Futures attended Danny's sister's address to encourage him to return to their premises. There is evidence of practitioners being persistent in their engagement and in their flexibility with how they engaged. Although there were also missed opportunities in this regard this is positive practice to highlight.

[88] *Human Trafficking & Child Abuse - Hotel Statement*

Repairing relationships between Claire and family

As the start of the scoping period indicates, SASH (Specialist Adolescent Service Hertfordshire) were working with the family. Their role is to support young people on the edge of care / family breakdown and identify ways to enable them to return home to a safe environment. Work also occurred with the parents to address ways in which they could safely facilitate this. The legislation used whilst Claire was in care was predominantly Section 20 of the Children Act 1989[89], a voluntary agreement. Had she wanted to return home at any point the local authority could not have stopped her whilst under this legislation. Social care kept the option for Claire to return home open at all times but were met with reluctance either from Claire, her parents or both. Her return home was explored throughout the scoping period with no progress made. Since her death, Hertfordshire have commissioned the Building Bridges Team in the Children Looked After (CLA) Service. It is felt the presence of this team would not have made a tangible difference to this case due to the family dynamics and the similarity to SASH in the work being attempted at the time.

Key Line of Enquiry

An additional line of enquiry was identified as follows:

4.21 *Claire had been a looked after child months prior to her death before officially becoming care leaver. Did the transition from child to adult services impact upon the domestic abuse (DA) support provided and / or the DA awareness of all agencies?*

In answering this question agencies reflected more widely on whether overall support was impacted, not just domestic abuse specific intervention.

The transition to adult services was felt by Claire acutely as, due to turning 18, she was required to move out of her accommodation into a self-contained space. Peabody Housing have reflected on this saying: *"The transition between being a Looked After Child with no responsibility for rent / service charges and an allowance paid, and then moving to accommodation with financial independence with the need to pay rent, service charges and support herself through her benefit claim was particularly challenging for Claire. Peabody have committed to review pre-transition paperwork to ensure that residents are offered increased guidance and support to plan for the financial impact of leaving care and accessing mainstream accommodation options."* This move ultimately meant a change in worker and a hope / expectation Claire would build trusting relationships with another practitioner. This was something she had repeatedly had to do before as the Social Services IMR highlighted she had six social workers during the chosen scoping period of this review.

The HPFT felt internal policies were followed regarding the transfer of care from CAMHS to Adult Mental Health Services, but additional actions have since been identified which, in

[89] Section 20 of the Children Act 1989 places a duty on local authorities to provide accommodation for children in need often via a voluntary agreement where parents consent to the child being "looked after". It requires the local authority to consider the child's wishes and feelings and ensures the child becomes a "looked-after" child, granting specific rights and support, though it's distinct from court-ordered care orders.

future, may assist in addressing barriers faced by looked after children similar to those Claire experienced. HPFT practice guidance states *"transition assessments should take place at the right time for the young person* [8.3]" to *"to ensure the appropriate services, placements or funding are in place by the time they reach 18 years old" [8.4]* The guidance also describes what good transition assessments should include:

- *"Current needs for care and support, and how these impact on the young person's wellbeing*
- *Whether the young person is likely to have needs for care and support after they become 18 years of age*
- *If so, what those needs are likely to be, and which are likely to be eligible needs" [8.7]*

Within Hertfordshire County Council exists a Transitions to Adulthood Panel which aims to coordinate oversight of the transition process for each looked after child. Claire was not heard at this panel. Referrals to this panel are made by the child / young person's social CLA (child looked after) Social Worker. The HPFT have reflected how they could have had a conversation with social care to ensure this referral occurred. The benefit of this would be to ensure a mutual understanding between services of the barriers faced by children in gaining support, such as consistent mental health intervention (e.g alternatives to CAMHS).

A new Transition from CYP to Adult Service policy is currently under review within the HPFT with a proposal to add the following *'If the young person is an HCC (Hertfordshire County Council) child looked after, discuss in the network about whether it would be beneficial to refer to the HCC Transitions to Adulthood Panel for coordinated oversight of the process. The referral to the panel will be made by the CLA social worker."* This review supports this inclusion. It is especially pertinent when considering the gap in Claire's mental health provision.

Also of note, in June and September 2023, two Care Leaver Mental Health Practitioners posts began to further support transition from child to adult services. This was a relatively new post at the time of final referral for Claire, nonetheless there is no evidence of CAMHS making contact with them. This may have been a missed opportunity to seek support with the transition and learning from this review should be shared with this team for reflection and awareness raising purposes.

Section Five

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 via multiple self harm episodes such as one 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[90] highlights 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[91]."

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 arguments and abuse from 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.

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.

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

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

Domestically abusive behaviour is difficult to effectively address without meaningful engagement in specific targeted work such as a domestic abuse perpetrator programme[92] (DAPP - see ToR 4.15). It is often engrained in attitudes, beliefs and patterns of behaviour. Addressing this behaviour effectively is highly 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 (independent domestic violence advisor) 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.

The latter point is especially important. The Home Office kinship care guidance[93] has multiple definitions of what may consitute a private fostering arrangement with the following appearing most relevant for Claire's situation at that time:

[92] Evidence from a study of DAPPs
[93] Kinship care: statutory guidance for local authorities

"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 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. The importrance of analysing age difference was highlighted in the 2025 National Audit on Group-Based Child Sexual Exploitation (also known as the Casey Report[94]), aswell as non-adultification (not viewing children as adults). These were critical recommendations for professionals analysing coercive and controlling relationships.

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)[95] which research indicates increases risk of suicide.
- Overdose of sertraline in adolescence.
- CAMHS involvement as children

[94] The Casey Report - Child Sexual Exploitation and Abuse

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

- Both from large families (Danny 1 of 6, Claire 1 of 5)
- 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[96] 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[97] 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 evictions too (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

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

services supporting the most vulnerable to be aware of this so they can help enforce restrictions and offer support to evidence led prosecutions[98]. 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 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) 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.

[98] Evidence-led prosecution checklist for domestic abuse cases | College of Policing

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.

Section Seven – Recommendations

National recommendation

Recommendation 1 – Home Office / Children's Social Care

Learning (lesson 8) from this review to be shared with the Home Office Department for Education[99] 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. Should the Children's Wellbeing and Schools Bill[100] receive royal assent[101], this recommendation and review have relevance to the proposed reviewing/regulating of kinship carer approvals.

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 – Hertfordshire County Council (Enhanced domestic abuse training)

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[99] Department for Education - GOV.UK
[100] Children's Wellbeing and Schools Bill
[101] Children's Wellbeing and Schools Bill Progress - Parliamentary Bills - UK Parliament – At time of writing (Jan 26), this bill is currently in the report stage within the House of Lords.

The panel acknowledged a lack of enhanced domestic abuse knowledge in this case relating to:

- Domestic abuse in young people's relationships including the importance of motivation interviewing
- Working with those causing harm
- Managing counter allegations[102]

It is a recommendation for the local authority to provide domestic abuse training which encompasses these areas and upskills frontline professionals. In this case, it is especially pertinent to leaving care personal advisors and frontline housing support staff.

Recommendation 4 – Champions Training

For Hertfordshire services to be aware of the J9 Champions network and allocate a member of staff to be their domestic abuse champion.

Recommendation 5 – Hertfordshire County Council

It is a recommendation for the next iteration of the Hertfordshire Suicide Prevention Strategy to include learning from this review and consider risk of overdose, especially where there is known domestic abuse, within their preventative work.

Recommendation 6 – MARAC #1 (Broadening actions to include perpetrator responses)

MARAC to review available actions for chair and panel members to broaden their approach to risk reduction and include perpetrator responses.

Recommendation 7 – MARAC #2 (Ensuring frontline professionals are aware of MARAC and can contribute effectively to enhance risk reduction responses)

Ensure correct representation at MARAC and decisions / actions are disseminated to all relevant parties to avoid missed opportunities and increase knowledge of safety plans.

Recommendation 8 - Criminal Justice Liaison & Diversion Service HPFT / Police (Utilizing the opportunity of custody to signpost and encourage engagement)

For L&DS and the Police 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)

[102] Managing Counter Allegations training was available in 2024. The panel felt this training should continue to be offered and to review which frontline practitioners are attending (e.g housing were significant in this circumstance).

Domestic Homicide Reviews in Hertfordshire: SMART Recommendation and Action Plan Template for the case of Claire 2025

Individual partner agencies are accountable for delivering and implementing the actions they have committed to. Progress is monitored by the Strategic Partnership Team within Hertfordshire County Council, with any unresolved issues escalated to the Risk Management Sub-Group, which is accountable to the Domestic Abuse Partnership Board.

Recommendation (SMART goal)	Scope of recommendation (i.e. local or regional)	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target Date	Date of completion and Outcome
Multi-agency recommendations						
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	National	Learning from this review to be shared with the Home Office for future iterations of their kinship care guidance.	Home Office / Chair of DARDR	Chair of this DARDR / DHR to contact the Home Office and inform them.	Dec 25	

them to reduce the risk of future harm.						
Police to inform housing providers supporting those in care / care leavers when bail conditions are in place preventing someone from attending their premises.	Local	Police to consider the feasibility of ensuring housing providers housing those most vulnerable are informed of relevant bail conditions to enable them to take action.	Hertfordshire Police	Police to review the practicalities of doing this. Should this be possible, to agree a timeline to fully implement this change.	Initial conversation to occur by Jan 26	Domestic Abuse and at the point of disposal / bail the case director should assess this as part of the safeguarding risk and DAISU will reinforce this with their case directors. If the person in housing is a child, then their appropriate adult would be informed as a safety measure and if an adult who is deemed that this would be appropriate for their safety. It becomes trickier if the victim is not in agreement with the bail conditions as there is not a directory of housing for care /care leavers and can only be established if another agency holds this information. If the safeguarding was deemed so serious then local officers would attend the property but equally if this is the case we would likely be

						remanding and if this fails, attending the property to make sure it is safe. If a DVPN is issued, then the victim property must be checked within 28 days and at this point housing support staff made aware.
For staff to have a greater awareness of the online safety act and the ability to seek advice from the force crime registrar when requiring guidance.	Local	Take to Workforce Development Team and the Training and Development Academy to see if this can be included in upcoming learning events.	Herts Police			
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.	Local	Learning to be shared with housing commissioners to encourage providers to review the use of visitor bans in domestic abuse cases. To consider learning from this review to incorporate a domestic abuse response when trying to prevent breaches of	Peabody Housing and Emerging Futures	Housing providers will have reviewed this practice and agreed an appropriate alterative (with guidance / policy / training as appropriate)	Review to occur by Jan 26	

		tenancy / license agreement / eviction.				
The panel acknowledged a lack of enhanced domestic abuse knowledge in this case relating to: - Domestic abuse in young people's relationships - Working with those using abuse - Counter allegations It is a recommendation for the local authority to provide domestic abuse training which encompasses these areas and upskills frontline professionals. In this case, it is especially pertinent to leaving care personal	Local	Training to be provided to frontline professionals, especially leaving care personal advisors and frontline housing support staff increase knowledge and confidence in the identified areas.	Hertfordshire County Council – Learning and Development Department	L & D department to acknowledge learning from this review and identify whether this is feasible within their current training offer.	Jan 26	

advisors and frontline housing support staff.						
For Hertfordshire services to be aware of the J9 Champions network and allocate a member of staff to be their domestic abuse champion.	Local	For Hertfordshire services to be aware of the J9 Champions network and allocate a member of staff to be their domestic abuse champion.		Commissioning officer to provide updates on what is currently being done on the J9 championship.	May 2026	J9 championship work confirmed.
It is a recommendation for the next iteration of the Hertfordshire Suicide Prevention Strategy to include learning from this review and consider risk of overdose, especially where there is known domestic abuse, within their preventative work.	Local	For the Hertfordshire Suicide Prevention Strategy to include risk of overdose within their preventative work.	Suicide Prevention Lead	Suicide Prevention Team to consider learning from this review within their next prevention plan.		Suicide prevention team is aware of this case. Their next strategy review will be in 2030.
MARAC to review available actions to broaden their approach to risk reduction and include perpetrator responses.	Local	The risk management sub group to review actions available to panel members.	Risk Management Sub Group (RMSG)	The RMSG will have discussed learning from this review and how to implement recommendations	Jan 26	RMSG was made aware in December 25 - to be discussed at the next RMSG in January 2026.

For risk reduction responses to be effective, all frontline professionals working with perpetrators and victims must be aware when their allocated individuals are heard at MARAC. In this case, Emerging Futures were unaware and unable to contribute.	Local	The risk management sub group to review which agencies are informed of individuals being heard at MARAC and ensure agencies such as housing providers are aware and able to contribute.	Risk Management Sub Group (RMSG)	The RMSG will have discussed learning from this review and how to implement recommendations	Jan 26	RMSG was made aware in December 25 - to be discussed at the next RMSG in January 2026.
For L&DS and the Police 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)	Local	For the Liaison and Diversionary Service (L&DS) and the Police to implement ways to flag information about perpetrator interventions in custody.	Criminal Justice Liaison & Diversion Service HPFT / Police	The L&DS team have all had training via HCC from Chrysalis and the information for perpetrator support is routinely discussed if there is an identified need on assessment.	Jan 26	Completed. The practitioners in the team screen all detainees and offer assessments however custody staff can also refer for an assessment if they have concerns about a particular individual. Relevant policy states that: 'All detainees in custody during the teams operating hours will be screened by the MH practitioner. This will include screening of HPFT systems for information and the Police computer systems. The practitioner will look at the detained person's risk

						assessment to see what the person has identified as their vulnerabilities when being booked in. ' 'Referrals are received by police and custody staff via case identification. The referral will be made verbally during handover with Custody Sergeant on arrival to custody or electronically via the white board.'
Single-agency recommendations						
Hertfordshire Partnership NHS Foundation Trust						
Transition into ACMHS	Local	Learning from this case to be shared with reviewer of Transition of Care policy for consideration around incorporation of learning	CYPMH Community Services Service Manager, HPFT	Learning shared with policy authors Learning incorporated in Policy review as appropriate	January 2026	Completed January 2026. Policy Authors have reviewed new policy, and appropriate learning is covered. Learning will also be taken to Senior Leadership Team in CYPMHS to support discussion re: robust transitions.
Peabody Housing						
Suicide prevention	Organisational	Publication of Peabody Suicide Prevention Guidance	Peabody	Release of Guidance. Implementation plan	Nov 25	
Suicide prevention	Local	Staff in Herts YPS services to attend multi agency suicide prevention training	Herts Safeguarding Children Partnership	Monitor training records for colleagues	April 26	Ongoing

		provided by Safeguarding Children Partnership				
Domestic violence awareness	Local	Staff in Herts YPS services to undertake training in Domestic Violence	Peabody training programme	Monitor training records for colleagues	April 26	Ongoing
Supporting Transitions	Local	Review and add to current life-skills programme with specifically targeted transition life skills for residents	Peabody	Create materials Pilot materials	April 26	Ongoing
Refuge (IDVA service)						
Training	Local	1.The Hertfordshire IDVA team to receive training on working with young people who are experiencing domestic abuse. 2.The Hertfordshire IDVA team to attend the Tailored Suicide Prevention Course for DVA Specialist Organisations	Refuge	1.Training has been booked for the team in February 2026 2. Two staff members have attended and a 3rd booked. All Herts staff have been sent push notifications through the LMS to book this training and reminded about it in the Jan team meeting. Quarterly reports have also	March 2026 September 2026	Completed- training booked for 26th February 2026 Due to be completed by September 2026 and monitored on a quarterly basis

				been set up to monitor progress.		
Identification	Local	The manager of the Hertfordshire IDVA Service to explore how a flag can be added to the duty log to highlight to IDVAs when a survivor is aged 18 or under to serve as a reminder to consider how to flexibly offer the service.	Refuge		December 2025	Completed January 2026- Flag added to duty log.
Herts Community Trust (HCT)						
Information sharing	Local	Liaise with social care to ensure comprehensive background information on the YP prior to appointments and professional meetings (MARMs, MARACs etc)	CLA leadership team	Ensure CLA health understand the YP lived experience and therefore gauge assessment to meet needs		
Attendance at IHAs (Initial Health Assessment)	Local	Liaise with social care to ensure SWs attend the IHA where possible especially in complex cases where there are concerns	CLA leadership team	Support Information sharing		
Engagement with action plans	Local	Continue 3 month review of records	All CLA team	Providing support earlier in process and minimise risks		

		Be proactive in chasing social care if information not forthcoming Would be good to have a specialist care leavers nurse to focus on the high risk care leavers		Try to be more proactive than reactive.		
Sexual health, domestic abuse, coercive control	Local	Professional curiosity: ask questions about relationships. Update template/documents to reflect the changing nature of risk amongst young people: pornography, strangulation, risk taking behaviours and how to escalate disclosures Prompts to other resources DASH, IDVA, SARC	CLA team	Thinking more broadly about sexual health		

RHA's and 3/12 reviews	Local	Continue to email/phone/contact social worker/carers for updates re action planes but need a safety net to ensure missed actions are highlighted and acted on Ensure RHA's are done in a timely manner, keep a log of due RHAs and chase social care if not submitted	CLA nurses CLA admin	Maximise opportunities to complete action plans and therefore react to health needs Ensure CLA are reviewed in a timely fashion and they understand the process to minimise those declining consent		
GP						
Ensure all admin and reception staff are trained and confident in addressing patient queries, particularly regarding prescriptions and medication availability.	Local (GP Practice level)	Deliver targeted training sessions and introduce a quick-reference guide for handling prescription queries.	GP Practice	Training materials developed; staff training completed; feedback review after implementation.		To be completed – staff demonstrate confidence and patients report improved communication.

Review and update practice policies and procedures to better support vulnerable patients, particularly care leavers.	Local with potential for wider regional learning	Update policies to highlight additional support pathways for care leavers; ensure staff awareness through induction and refresher sessions.	GP Practice (with input from safeguarding)	Policies updated; staff briefed; care leaver flag added to clinical system.		To be completed – monitoring shows improved identification and support for care leavers.
Implement a standard operating procedure (SOP) for confirming prescription status with patients.	Local	Develop and circulate SOP; monitor adherence through audits.	GP Practice	SOP agreed; communicated to staff; first audit completed.		To be completed – reduction in delays for prescriptions confirmed.
Regularly review learning from significant cases and share with the wider safeguarding network.	Local/Regional	Add case review learning to monthly practice meetings; contribute learning summaries to safeguarding forums.	GP Practice in partnership with local safeguarding boards	Standing agenda item added; first learning summary shared.		To be completed – evidence of shared learning and system improvements.
Domestic abuse training must reflect the intersection of domestic abuse risk when victims who are diagnosed with mental health, complex vulnerability and the implications for a DARDR. These should consider wider vulnerabilities of	Local, regional and national	November 2025	HWEICB	Training date and programme planning in progress.	April 2026	To be established

victims, history of trauma, children as victims of domestic abuse and understanding risk from perpetrators.						
Develop robust communication processes to ensure that information is shared between professional when working with vulnerable individuals, to inform risk assessment and care planning.	Local partnership	April 2026	HWEICB	Multi agency working and discussion with DARD board.	April 2026	To be established.
Emerging futures						
Safeguarding not raised for Claire, though she was identified as the perpetrator, focus appeared to be only on Danny.	Regional	Managers to make staff aware of responsibilities around reporting behaviours of residents' associates.	Emerging futures	Reported to Safeguarding Lead of the organisation	01/12/2022	
Missed opportunity to raise safeguarding regarding Claire being under age asking for	Regional	Managers to make staff aware of responsibilities around	Emerging futures	Make teams aware in wider service meetings	13/10/2025	

weed and in possession of alcohol – observed by EF staff on 27/06/2022.		reporting behaviours of residents' associates.		Share concerns with Safeguarding Lead		
Ongoing evidence of Danny allowing Claire to stay over at the property. Staff made aware on a number of occasions without safeguarding raised around her being vulnerable and under 18.	Regional	Reiterate staff responsibility to raise safeguarding concerns for individuals not known to service but who are also deemed vulnerable, perpetrator or not	Emerging futures	Following safeguarding training staff to be reminded of commitment in team meeting	01/12/2025	
Herts Police						
In appropriate cases consideration to be made by police to seek charging advice from CPS without the support of the victim.	Local	ELP Guidance – training already underway for DAISU officers/staff.	Herts Police	Training material already written and due to be delivered to DAISU.	September 2026 – to allow for training/CPD to reach all detectives.	
Consideration to be made by Safeguarding Command Senior Management for mandatory police attendance at ICPC's.	Local	Police attendance at ICPCs is already mandatory but it is specialist Police Staff who attend rather than Police Officers.	Herts Police		Completed	Police attendance at ICPCs is already mandatory but it is specialist Police Staff who attend rather than Police Officers.

		If the Police staff have a query, they will contact the officer beforehand.				If the Police staff have a query, they will contact the officer beforehand.
Safeguarding Referral Hub SOP to be updated as a matter of priority.	Local	Escalation process for Safeguarding referrals: When reviewing referrals or requests for police checks, staff should consider previous referrals. If we have been made aware of a vulnerable person on three or more occasions in the space of 12 months then the member of staff reviewing should write on the Athena enquiry log the previous referrals details and make their line manager aware, who in turn will escalate to the DI for further review. Any decisions made will be entered onto the most recent Athena record with rationale outlining what further action will be taken. If the person has come to light six times or more then this will be raised	Herts Police		April 2026	Escalation process for Safeguarding referrals: When reviewing referrals or requests for police checks, staff should consider previous referrals. If we have been made aware of a vulnerable person on three or more occasions in the space of 12 months then the member of staff reviewing should write on the Athena enquiry log the previous referrals details and make their line manager aware, who in turn will escalate to the DI for further review. Any decisions made will be entered onto the most recent Athena record with rationale outlining what further action will be taken. If the person has come to light six times or more then this will be raised to Detective Chief Inspector level. The number of referrals for LC reached the threshold for the escalation process to Detective Chief Inspector on two occasions during 2021

		to Detective Chief Inspector level. The number of referrals for LC reached the threshold for the escalation process to Detective Chief Inspector on two occasions during 2021 and 2022-3. Having reviewed the relevant crime reports/child protection investigation reports there is no record of above being complied with. All Safeguarding Referral Hub staff need to be reminded of the escalation process. Notwithstanding this all the relevant referrals, and information sharing, were made to partner agencies. The escalation process was amended in 2024 although the SOP is yet to be updated. It was discussed and agreed with CS that cumulative referrals will be escalated on risk, not by				and 2022-3. Having reviewed the relevant crime reports/child protection investigation reports there is no record of above being complied with. All Safeguarding Referral Hub staff need to be reminded of the escalation process. Notwithstanding this all the relevant referrals, and information sharing, were made to partner agencies. The escalation process was amended in 2024 although the SOP is yet to be updated. It was discussed and agreed with CS that cumulative referrals will be escalated on risk, not by a number (volume). The SOP's are currently being updated to reflect this change in working practice.

		a number (volume). The SOP's are currently being updated to reflect this change in working practice.				
All Safeguarding Referral Hub staff to be reminded of the escalation process for Safeguarding Referrals.	Local	Line manager comms/briefing note.			April 2026	
Housing providers supporting those in care / care leavers should be informed by Police when bail conditions are in place preventing someone from attending their premises.	Local	The following wording will be added to the relevant SOP (Standard Operating Procedure) to ensure attempts are made by the police to gain the relevant housing providers details: "Officers should make reasonable efforts to contact housing providers when relevant bail conditions apply and where possible i.e. the housing provider can be identified, especially where the victim is in supported accommodation. This supports housing	Herts Police	This wording will be added to the relevant SOP.	Agreed in Jan 26.	To be implemented Feb 26.

		providers in reporting any concerns regarding breaches.”				

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 led 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?

<u>Appendix B</u> - HPFT (Hertfordshire Partnership Foundation Trust) 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).