Safer West Sussex Partnership

Domestic Homicide Review relating to the death of Emma

Executive Summary

Independent Chair and Report Author:
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Permission to publish has been granted by the Home Office

Executive Summary Contents

1. The Review Process

1.1 This Executive Summary outlines the process and findings of a Domestic Homicide Review (DHR) undertaken by the Safer West Sussex Partnership into the death of Emma. All the names in this review have been anonymised for the purpose of confidentiality.

1.2 The following pseudonyms have been used in this review to protect the victim, alleged perpetrator and family.

Table 1

Name	Relationship to the victim
Emma	Victim
Ben	Boyfriend of Emma and perpetrator
Sophie	Emma's mother
Fred	Emma's father
Stepmother	Fred's wife and Emma's stepmother
Emma's baby	Emma's baby, adopted in 2017
Great Aunt	Emma's great aunt (Sophie's Aunt)
Liz	Ben's girlfriend
Mary	Ben's girlfriend
Pam	Ben's girlfriend

1.3 Emma was murdered by Ben mid- May 2018 and the police notified Safer West Sussex Partnership (SWSP) about her death. A Domestic Homicide Review Panel was convened, and it was agreed that Emma's death met the criteria for a DHR, and an Independent Chair was commissioned to conduct a DHR. The DHR did not commence for a period of time as there was a lengthy criminal investigation and trial.

1.4 A criminal trial took place mid-2021 and Ben was found guilty of murdering Emma and was sentenced to life imprisonment with a minimum of sixteen years. Ben unsuccessfully appealed against the conviction on two occasions and has now applied to the Criminal Cases Review Commission (CCRC). The CCRC provides the opportunity to individuals who feel they have been wrongly convicted and have previously lost their appeals. The CCRC are the only body who can send a case back to the appeal court.

1.5 A death certificate was issued for Emma following the outcome of the trial.

1.6 All agencies that potentially had contact with Emma, her family and Ben prior to the point of her death were contacted and asked to confirm any involvement with the case and the DHR commenced late 2021.

2. Contributors To The Review

2.1 This DHR has followed the statutory guidance issued following the implementation of Section 9 of the Domestic Violence Crime and Victim Act 2004 as well as the local DHR protocol developed by the Safer West Sussex Partnership.

2.2 The following agencies submitted IMRs detailing their contact with Emma, Ben and Emma's family:

- Sussex Police (the police)
- West Sussex County Council Children's Social Care (WSCC CSC)
- West Sussex County Council Education Dept (WSCC Education)
- Sussex Clinical Commissioning Group (CCG) (from July 2022 became the Integrated Commissioning Board (ICB).

- Sussex Partnership Foundation Trust (SPFT)
- NHS University Hospitals Sussex
- Sussex Community NHS Foundation Trust
- Change Grow Live - Drug and Alcohol Support (CGL)
- Stonepillow (Homelessness Support)
- Arun Council Housing Service

2.3 The IMRs were completed by senior staff who had no direct management involvement with Emma, Ben the family or the incident.

2.4 The Panel gave detailed consideration and professional challenge to the IMRs submitted by these agencies including inviting IMR authors to present their IMRs at a Panel meeting.

2.5 In addition, several organisations were contacted by the Independent Chair to add further information/commentary to the DHR. These included:

- Stonepillow
- West Sussex Children Social Care
- Changing Futures Programme
- Worth Domestic Abuse Service
- West Sussex County Council Community Safety and Wellbeing Community Directorate
- Arun District Housing Department

2.6 Emma's mother and father contributed to the DHR and were supported by the Police Family Liaison Officer (FLO) throughout the process. The Independent Chair and the FLO ensured that the family were provided the support they needed for their own individual requirements. Emma's Great Aunt (maternal) also contributed to the DHR.

3. The Review Panel Members

3.1 Panel Membership

3.2 The Panel consisted of senior representatives from the following agencies:

- Liz Cooper-Borthwick - Independent DHR Chair/Overview Report Author
- Debbie Stitt - Independent DHR Coordinator
- Emma Fawell - West Sussex County Council, Community Safety Lead Officer
- Emma Heater - replaced by Helen Upton-Sussex Police
- Christine Impey - replaced by Sophie Carter-West Sussex County Council Head of Safeguarding
- Jez Prior - replaced by Sally Arbuckle, Head of Safeguarding West Sussex County Council Safeguarding in Education
- Bryan Lynch - Sussex Partnership NHS Foundation Trust, Director of Social Work
- Frank Ungani - University Hospitals Sussex & Worthing and St Richards Hospital, Trust Senior Lead for Safeguarding
- Georgina Colenutt - Named Nurse Safeguarding Children
- Fiona Crimmins - Sussex NHS Commissioners, Designated Nurse Adult Safeguarding
- Jayne Hardy - The You Trust DA Service Regional Manager, DA Services
- Hilary Bartle - Stonepillow, Chief Executive
- Claire Dyke - Arun Housing Services
- Katherine Wadbrook - Change Grow Live, Substance Misuse Services, GL West Sussex Young People & Families Service Manager

3.3 The Review Panel met on five occasions, all virtually, and agency representatives were of the appropriate level of expertise.

4. Chair Of The DHR And Author Of The Overview Report

4.1 The Chair and author of the review is Liz Borthwick, formerly Assistant Chief Executive at Spelthorne Borough Council (Surrey). Liz has a wide range of expertise including Services for Vulnerable Adults and Children, housing and domestic violence. She has conducted partnership Domestic Homicide Reviews for the Home Office and has attended Home Office Independent Chair training for DHRs and further DHR Chair training with Advocacy After Fatal Domestic Abuse (AAFDA). Liz is a member of AAFDA DHR Chairs Network and Liz has also been involved with several Serious Case Reviews. She has no connection with any of the agencies in this case.

4.2 The DHR coordination and support was provided by Debbie Stitt who has worked in the Community Safety field for many years, including for local authorities and Surrey Police where she was a DA mentor. Debbie has been involved in numerous DHRs and joint reviews including DHR/SARs.

5. Terms Of Reference

5.1 Terms of Reference were agreed by the DHR Panel in December 2021 and were regularly reviewed and amended as further details of the incident emerged. The primary aim of the DHR was to examine how effectively the agencies involved with Emma and her family worked together to support them. A full copy of the TOR is attached in Appendix One, but of particular note that has been considered in this DHR:

- Awareness and understanding of professionals and the wider community of the potential presence of coercive control and how this may have impacted on the behaviour of Emma and Ben.
- Consideration of any equality and diversity issues that appear pertinent to Emma and Ben e.g. Femicide, men and women's roles in society, for example Ben did not accept any criticism of his behaviour.
- Whether there were any barriers experienced by Emma or her family / friends in seeking support from professional service providers?
- Whether there were any barriers experienced by professionals / agencies in offering support services to Emma.
- To consider any agencies or wider community groups that had no contact with Emma and her family and whether helpful support could have been provided e.g. specialist domestic abuse services and if so, why this was not accessed? e.g. housing/welfare benefits.
- Identification of any training or awareness-raising requirements to ensure a greater knowledge and understanding of the impact of domestic abuse and availability of support services.
- Impact of drug / alcohol issues on the wellbeing of Emma and Ben.
- Possible impact of trauma and possible neglect in Emma's childhood which may have impacted on her wellbeing and whether professionals/practitioners considered Emma's childhood experiences when assessing Emma's needs and support.
- What support Children's Social Care provided to Emma, post the adoption of her child.
- To consider previous domestic abuse by Ben in his relationships and any interventions by agencies.

- The impact of homelessness and access to welfare benefits for Emma, including the difficulties of CSC and other agencies trying to contact her as she had no fixed address.
- To consider any previous convictions and risk factors for Emma and Ben.

5.2 Emma and her family became involved with agencies when Emma was a young teenager, which included WSCC CSC, WSCC Education, the Police, health and a range of other support services within the community. All the organisations involved with the family were asked to review how their agency responded to the key lines of enquiry.

5.3 The timeframe for this DHR was agreed as follows, for Emma and her family December 2011 up until May 2018; for Ben, November 2007 until May 2018, unless there were any prior significant events for either of them. This was considered proportionate based on the initial scoping carried out by Safer West Sussex Partnership.

6. Summary Chronology

6.1 The DHR Panel received extensive information from the agency IMRs and the DHR panel utilised the SCIE model "Learning Together" to identify the key practice episodes (KPE) in the lives of Emma, her family and Ben.

6.2 KPE One: Emma's arrival in Sussex and involvement with agencies

6.2.1 Emma moved to West Sussex in late 2009 as Sophie (her mother) was unable to support Emma due to her own significant health issues. Emma moved in with Fred (her father) and she became involved with several agencies including WSCC CSC, WSCC Education, and the police. Emma was regularly missing school and legal proceedings were commencing due to her poor attendance. Emma would also go missing from the family home, eventually returning home after a couple of days. WSCC CSC and Emma's school provided support to try to ensure that Emma's school attendance improved and to help her to understand the risks she was putting herself in when she went missing.

6.3 KPE Two: Ben and allegations of domestic abuse with a partner

6.3.1 In 2011, Ben was living in a different county and was in a relationship with Liz. Liz contacted the police concerning domestic abuse, stating that she had been in a relationship with Ben since she was 15 years old and when she finished the relationship, Ben threatened to take his life and was stalking her, turning up at her work. Liz's statement to the police detailed that she was subjected to violent assaults by Ben, and controlling behaviour and harassment when she tried to leave the relationship. Ben was given a police caution for harassment.

6.3.2 Ben moved to Sussex and the details of this incident above were transferred from the previous police force to Sussex Police.

6.4 KPE Three: Deterioration in Emma's wellbeing, including episodes of going missing.

6.4.1 In 2012, Fred reported that to the police that Emma was going missing but that she would normally return after a couple of days. Emma was found at a friend's house who was significantly older than Emma and there were also other males at the house.

6.4.2 Fred was beginning to struggle looking after Emma and her attendance at school was still very poor. WSCC Education Service contacted Fred who said he could no longer cope with Emma and wanted her taken into care. Several professionals within

education started to provide some therapeutic work with Emma and Fred. Also at this time, Sophie moved into Sussex and was living close to Fred and Emma.

6.4.3 In mid-2012, WSCC CSC held an initial assessment meeting for Emma with Emma, Fred and Sophie all attending. Fred told the meeting that Emma was impacting on his own health and that he wanted to give away his parental rights. Emma moved in with her mother and continued to participate in the extra support that was being provided to her.

6.5 KPE Four: Emma's pregnancy

6.5.1 Emma became pregnant in 2012 at the age of 15 years. Emma received some home tuition and was going to undertake her GCSEs. Fred indicated that he was happy for Emma and the baby to live with him, and his wife and that Emma had changed, and their relationship was much better. Emma received some good support around the birth of her baby from her GP, midwifery services and WSCC CSC.

6.6 KPE Five: Further Domestic Abuse by Ben

6.6.1 Late summer 2013, Mary, Ben's girlfriend at that time contacted the police stating that she and Ben had been at a nightclub and Ben was abusive to a male friend. Mary went home and Ben turned up and started shouting that he wanted Mary's car keys and money and pinned her to the bed. Mary bit him and then took him to accident and emergency to have his wounds tended. A Domestic Abuse, Stalking, Harassment and Honour Based Violence Assessment (DASH) was completed by the police and rated standard, and no further action was taken.

6.7 KPE Six: Emma needing increasing welfare support.

6.7.1 Mid 2013, Emma was living with Fred and Emma's stepmother and her baby. Emma ran away from the family home, once on her own and once taking her baby. The baby had a social worker, but Emma did not, despite being a very young mother and the relationship between Emma and Fred breaking down.

6.8 KPE Seven: Domestic Abuse Incident involving Ben

6.8.1 In summer 2013, Pam, Ben's then girlfriend, contacted the police to say she had just told Ben that she wanted to end the relationship and he put a lot of tablets in his mouth which led to her phoning the police. Ben spat out the tablets but later in the day, Pam told the police that Ben had raped her. Ben denied this but the police investigated the allegation and brought charges against Ben. The case was heard by a jury at a Crown Court, and he was found not guilty of the offence in 2014.

6.9 KPE Eight: Emma's baby taken into care and a deterioration in Emma's mental wellbeing.

6.9.1 Late March 2015, Emma was attending support programmes which she had been referred to by WSCC CSC, to help her with parenting her baby, and also help her navigate relationships and welfare support including housing.

6.9.2 Emma's relationship with Fred and her stepmother with whom she was living was breaking down and there were periods of time when Emma went missing yet again. Emma went to Arun District Council Housing department to place herself on the housing register.

6.9.3 In April 2016, WSCC CSC were becoming very concerned about the safety and wellbeing of Emma's baby and it was agreed that pre proceedings should commence.

(Pre-proceeding process is a phase of work aimed at avoiding care proceedings. It is described as a last chance for parents or a parent to make the changes they may need to, otherwise children's services may need to go to court to start care proceedings). In mid-August 2016, attempts were made to deliver pre-care proceeding letters to Emma, but Emma could not be located. Late September 2016, Emma signed a Section 20 of the Children Act 1989 agreement for her baby to be accommodated by WSCC CSC. (Under this provision, social services must provide accommodation to certain children in need in their area. It is used to accommodate children who cannot live with their families). In June 2017, WSCC CSC were granted an Interim Care Order for Emma's baby following a Family Court decision. Emma had no further contact with WSCC CSC although it was recorded that Emma did attend Children Looked After Review meetings.

6.10 KPE Nine: Emma in a known relationship with Ben (family) and ongoing housing issues for Emma.

6.10.1 During 2017, Emma was staying at a hostel and was receiving support for her substance misuse. Emma told the professional who was offering support around her substance misuse that she was in a new relationship, and it was going well. Emma also admitted she took drugs to give her confidence when in male company. At the same time, Emma also introduced Ben to her family.

6.10.2 Early 2018, Emma again made a homelessness application to Arun Housing Services as she had to leave the hostel as she had not been attending appointments around her substance misuse. Emma had been sleeping rough and sofa surfing, but it was felt by housing officers that Emma was a not a priority need and therefore no emergency accommodation was offered.

6.10.3 The housing officer did provide Emma with advice and asked Emma to apply for Job Seekers Allowance and to get some further documents to support her housing register application.

6.11 KPE Ten: Death of Emma

6.11.1 Emma and Ben were camping. An argument was heard between Emma and Ben in the early hours of the morning in May 2018. Neighbouring campers were woken around 6am to the sounds of Ben crying and counting as he 'performed' cardiopulmonary resuscitation (CPR), so the neighbours rushed to help. The neighbouring campers found Ben counting CPR compressions but not actually performing them. Emma was deceased and had blue lips. Paramedics arrived quickly after being called and confirmed that Emma had been dead for at least two hours as rigor mortis had already set in.

6.11.2 After a very lengthy investigation by Sussex Police, the Crown Prosecution Service (CPS) authorised a charge of murder and Ben was convicted in late 2021.

7. Conclusion/ Key Issues Arising From The Review

7.1 The DHR Panel acknowledge that practice and procedure within agencies have significantly developed and improved since Emma was a child and adolescent. Also, the DHR Panel have the benefit of hindsight of Emma's lived experience and a range of detailed information from agencies.

7.2 Emma was a very vulnerable child and a vulnerable young adult. Emma suffered deep childhood trauma, separation, low self-esteem and perhaps she felt this included low attainment in life, all of which impacted on her wellbeing.

7.3 Agencies were involved with Emma from a young age, but this review has identified that's Emma's voice did not seem to be heard. If there had been assessments and Emma's lived experience had been explored, then a holistic approach to her care could have been provided. The DHR identified that Emma as a child and an adolescent was not always given the support she needed by professionals from WSCC CSC, but since this time there has been significant improvements within WSCC CSC and other agencies involved in this DHR, including WSCC Education, health and many of the other agencies.

7.4 Emma was a child when she had her baby, and a young adolescent when her baby was removed, and she was young when she lost her life. When Emma's baby was born, the focus of support moved to the baby and Emma's needs were not always considered, despite her being still a child herself. With Emma having no advocate/support, she would have felt abandoned yet again which appears to have led her into situations which may have impacted on her wellbeing and her safety.

7.5 At the time, following the loss of her baby and difficulties in family relationships, Emma may have seen Ben as someone who could give her a home, support her emotionally and financially. However, he was controlling, had a history of domestic abuse and finally he took her life at a very young age.

7.6 Despite the extensive traumas in Emma's life, she did show great strength. Her parents said she was resourceful and evidence from agencies showed that Emma could engage if she had the continuity of care, and that she had aspirations for the future; she wanted to get into her fitness and she wanted to volunteer. Professionals also highlighted that Emma would engage in programmes provided and she showed great nurturing for her baby in certain settings. Emma should be remembered as a person who liked to care for people, was fun and engaging.

8. Lessons To Be Learnt

8.1 This DHR had identified several lessons to be learnt.

8.2 Lack of support for young people with support needs transitioning from children to adult services

8.2.1 Emma and her family were involved with WSCC CSC and WSCC Education services from the age of 12, when Emma came to live with Fred, as Sophie felt she could not support Emma due to her own personal issues. Emma's attendance at school was very spasmodic resulting in an Education Supervision Order and Emma went missing on several occasions and there was concern she was involved with older males. Emma had her baby when she 15 years old. When the baby was born, a social worker was allocated to the baby, but there was no social worker assigned to Emma. There was a shift by WSCC CSC onto the safety of the baby, despite Emma still being a child herself. Due to concerns about the safety and welfare of the baby, proceedings were taken by WSCC CSC to remove the baby in 2016 and support for Emma appears to have ceased despite her young age. Emma was homeless on several occasions, she was suffering from mental health and substance misuse issues and experiencing the loss of a child.

8.2.2 Transition for a vulnerable young person, who may have multiple disadvantages such as Emma to adult services can be very difficult to navigate and many young people like Emma can be "lost". Emma was literally lost as agencies had multiple addresses for Emma and therefore did not know how to contact her.

8.2.3 The DHR Panel welcome the development of the West Sussex Safeguarding Adults Board and West Sussex Safeguarding Children's Partnership, Safeguarding Young People's 17.5 + Protocol which was implemented in July 2021 and reviewed early in 2022. The Protocol sets out clear procedures for referring a young person and highlights that it should not be assumed that a young person will not meet the eligibility criteria and states that if in doubt, then to check with the safeguarding hub.

8.2.4 A multi-agency response to Emma and her family's needs when she was transitioning into adulthood may have supported her in a holistic way to ensure her basic needs were met and that she could navigate herself away from unhealthy relationships.

8.2.5 What is important is that professionals in the police, health sector, care sector and voluntary sector understand the impact of transition for young people to adulthood and that there is a Safeguarding protocol in place which should provide a more holistic approach to a victim experiencing multi disadvantage including domestic abuse.

8.3 Better Support for mothers involved in their children being taken into care

8.3.1 Emma engaged well with programmes on parenting and professionals highlighted how Emma engaged well with her baby. When Emma's baby was removed from her care, this would have reinforced Emma's view that she was being judged by adults and professionals and could have reinforced the push and pull factors of further exploitation, including by Ben.

8.3.2 Research in 2018 by Ruth Aitken and Vanessa Munro, Domestic Abuse and Suicide identified that children are a protective factor for women, and it may have increased Emma's vulnerability when her baby was taken into care. There was no documentation within the IMRs whether any support was provided to Emma during the removal of the baby and her family indicated that there was none.

8.3.3 WSCC CSC have identified the need to ensure that an appropriate assessment takes place prior to the birth of a child to ensure a multi-agency approach to support both the baby and the young person as a mother.

8.3.4 Although some agencies, who work with multi disadvantaged young mothers feel that there is still a lack of support when a child is removed into care for the mother, in the coastal area of West Sussex, PAUSE is providing a valuable service for women who are presenting pregnant year after year and then their children are taken into care. Vulnerable women and professionals have identified the benefits and value of the service. Although the DHR Panel understand that financial resources will be an issue, it has requested that there should be opportunities to explore whether the service can be expanded to support women who are multi disadvantaged in other areas of West Sussex.

8.3.5 (The DHR Panel welcome the significant support for this recommendation from the West Sussex Children's Safeguarding Partnership).

8.4 Multi agency approach to support people who are multiple disadvantaged

8.4.1 Emma had many disadvantages to overcome in her short life, with attendance at school being limited, Emma living sometimes with Sophie and sometimes with Fred and often with Emma going missing. She seemed not to have a sense of belonging and no secure base.

8.4.2 Emma's needs were significantly high, but interventions were intermittent. Threshold procedures were not activated about strategy meetings / section 47 enquires, where joined up multi agency working would have implemented agreed safety plans and would have reviewed the risk with an appropriate level of intervention. (A section 47 enquiry means that CSC must carry out an investigation when they have reasonable cause to suspect that a child who is found in their area is suffering or likely to suffer significant harm).

8.4.3 West Sussex County Council has placed significant investment both in finances and strategic time to improve its provision to children, young people and their families with the expectation that the new Family Safeguarding Model will support in a more coordinated way. The expectation is that families can stay together, it reduces the risk to children and young people and that health and education outcomes can be improved.

8.4.4 Pan Sussex (East Sussex County Council, West Sussex County Council and Brighton and Hove Council) was successful in a bid to Ministry of Housing, Communities and Local Government (MHCLG) in 2021 to develop a programme to support people with multiple disadvantage or multiple complex needs who are defined by experiencing three or more of the following;

- Homelessness, (Emma)
- Current historical offending
- Domestic abuse (Emma)
- Mental ill health (Emma-never formally diagnosed)
- Substance misuse (Emma)

8.4.5 The programme, called Changing Futures, is about improving the way local systems and services work together to support adults experiencing multiple disadvantage. The programme's aim is to ensure that there is a more joined up approach to support, is more person centred and will make long term change to local systems providing better outcomes for individuals experiencing multiple disadvantage.

8.4.6 Emma would have benefitted from a more joined up approach to her services and one element of the journey mapping process is to review some individual cases when the person died. The DHR Panel would recommend that Emma's journey should be mapped to see how it could be improved and therefore improve learning.

8.5 Importance and understanding by professionals of the housing needs and support for victims of domestic abuse

8.5.1 Emma was homeless several times, resulting in sofa surfing with known and unknown associates which potentially put her at risk of exploitation. Emma did engage with Arun District Council housing services in 2016 as she stated she was homeless. Her housing application was cancelled in September 2017 as her housing register renewal letter was returned, saying the addressee had gone away. Emma presented as homeless again in 2018 but the officer at the time felt that Emma needed emergency accommodation.

8.5.2 If Emma was homeless today and she was identified as experiencing domestic abuse, then the Domestic Abuse Act 2021 would support her. The Domestic Abuse Act 2021 provides duties on local authority housing services to ensure victims of domestic abuse and their children are supported. Housing duties include;

- Proving all eligible homeless victims of domestic abuse to automatically have a priority need for homelessness assistance.
- Ensuring that where a local authority, for reasons connected with domestic abuse, grants a new secure tenancy who had or has a secure lifetime or assured tenancy (other than an assured shorthold tenancy) this must be a secure lifetime tenancy.
- The new duty will cover the provision of support to victims and their children residing in: refuge accommodation; specialist safe accommodation; dispersed accommodation; sanctuary schemes; and move-on or second stage accommodation
- B&B or homeless hostels or other generic temporary accommodation will not be considered 'safe'. Only accommodation dedicated to DA victims can be included in commissioned support.
- All support provided under their duty, must be provided to victims of domestic abuse, or their children, who reside in relevant accommodation as set out above and should meet the MHCLG Quality Standards, Women's Aid National Quality Standards and / or Imkaan Accredited Quality Standards.

8.5.3 It is important that professionals within agencies and the community understand what housing support there is available for victims of domestic abuse. The police, health professionals and other organisations supporting victims of DA should have a basic knowledge of housing support and where to signpost victims in West Sussex and the community should understand what support is available. It is important that awareness is raised within the community as to what housing support is available for victims of domestic abuse.

8.6 Comprehensive Support for victims of domestic abuse by the acute care settings

8.6.1 University Hospitals Sussex NHS Foundation Trust West and St Richards University Hospital Trust did have contacts with Emma and Ben, either in attendance at Accident & Emergency or when Emma was receiving support during her pregnancy with her baby. Health settings, either via the primary care or acute care setting can be the one agency that a domestic abuse victim has a contact with. A lack of routine enquiry by health practitioners is often identified in DHRs.

8.6.2 Both hospitals involved in this review identified the need to develop a domestic abuse strategy, which includes an IDVA navigator, a flagging system, body mapping and clinical photography for preserving evidence.

8.6.3 It has been highlighted in this review that there was an inequality of Independent Domestic Violence Advisors (IDVA's) provision in West Sussex compared to East Sussex and Brighton and Hove. This has been addressed by the CCG/ICB and the hospital trusts to ensure a consistency of support for victims of domestic abuse whether someone lives in East or West Sussex.

8.6.4 The DHR welcome the news that funding has been agreed to provide two IDVA's in the West Sussex Acute settings. In addition, funding has been made available for front line staff for developing a network of domestic abuse champions across the NHS Trust. The NHS Trust will be working with Safe Lives to deliver the training which will allow professionals in the acute health arena to build confidence and essential skills in order to support victims of domestic abuse.

8.7 Professional bias when supporting a victim of domestic abuse and their family

8.7.1 Family evidence would suggest that Emma and her family were judged by agencies. Fred informed the Independent Chair that he had a prison record, Sophie was open about her mental health and substance misuse and the family felt these issues clouded professionals view of the family and created a barrier between the professional and the family. The unconscious bias that professionals may have had when dealing with Emma and her family may have impacted on the support she and the wider family received.

8.7.2 Unconscious bias is triggered by the brain making quick judgements and assessments. It is also influenced by professionals' own personal experiences and societal stereotypes. Unconscious bias can have a significant influence on attitudes and behaviours and how professionals deal with a victim.

8.7.3 If professionals understand unconscious bias, they are in the position to challenge their own assumption about a victim and their family, understand the victim's story (it has been noted that Emma's voice was not heard) and therefore provide the support they need based on evidence and sound decision making.

8.8 Listening to the voice of Emma

8.8.1 Emma faced many challenges in her life and several agencies identified that they did not hear Emma's voice. Professionals in WSCC CSC and WSCC Education did not engage with Emma to listen to what was happening in her life, to fully understand her lived experience. If agencies had spoken with Emma with curiosity, they may have built up a holistic picture of what Emma was experiencing in her own words, her aspirations and her concerns and therefore allowed agencies to develop a more holistic approach in supporting Emma.

8.8.2 The DHR Panel welcomes the finding of the Ofsted monitoring letter October 2022, which states that WS CSC puts the child's voice at the heart of what they do.

8.9 Continuity of Care

8.9.1 Research by Standing Together DHR Case Analysis (Sharp Jeffs and Kelly 2016) has identified that GPs are often the only stakeholder that consistently engages with a victim and perpetrator. Emma was involved with several GP practices whilst in Sussex and the various GP practices were dealing with the problem they saw at the time. If Emma had one or two GP's rather than several there would have been the opportunity to listen to Emma's voice and better understand her transition from vulnerable child to a vulnerable adult. The DHR identified that when Emma did have continuity, for example, the nurses who supported the smoking cessation programme Emma attended, she built up a relationship and described her anxieties.

8.9.2 The DHR Panel endorses the GP recommendations which will address continuity of care as detailed in the agency recommendations.

8.10 Ensuring the practice of a routine enquiry about domestic abuse is embedded in the policy and practice of agencies

8.10.1 This DHR has identified that there were some apparent missed opportunities to make a routine enquiry with Emma about domestic abuse (whether this was about Ben or other males that Emma may have been in a relationship with). A lack of routine enquiry was noted by the CCG IMR author and the DHR Panel requested clarification if

routine enquiry was part of CGL's policy and practice and assurance was provided that routine enquiry is embedded into policy and practice.

8.10.2 Lack of routine enquiry by GP practices is a common thread in many DHRs and GP practices are independent businesses and therefore the ICB cannot enforce a GP practice to make a routine enquiry about domestic abuse. The ICB can reinforce thorough safeguarding training with GP practices, the benefit of a routine enquiry about domestic abuse and how to signpost a victim of domestic abuse in order to provide appropriate support.

9. DHR Recommendations

9.1 Local

9.1.1 Recommendation One

Safer West Sussex Partnership (SWSP) to provide training to a wider cohort of professionals on the Homicide Timeline, which will be in addition to either overarching or individual agencies domestic abuse training on all types of domestic abuse.

Ownership: Safer West Sussex Partnership

9.1.2 Recommendation Two

Review the professional bias training offer for professionals in West Sussex and identify any gaps and ensure training is provided. (A comment, this is also about culture, reflective supervision to challenge decision making).

Ownership: Safer West Sussex Partnership

9.1.3 Recommendation Three

SWSP and district and borough councils in West Sussex raise awareness to the wider community on local housing support for victims of domestic abuse.

Ownership: Safer West Sussex Partnership and district and borough councils

9.1.4 Recommendation Four

SWSP to raise awareness with health /police social care and voluntary sector on the impact of the Domestic Abuse Act 2021 and housing support for victims of domestic abuse.

Ownership: Safer West Sussex Partnership

9.1.5 Recommendation Five

SWSP and Sussex Police to raise awareness of the Domestic Violence Disclosure Scheme (DVDS) also known as Clare's law.

Ownership: Safer West Sussex Partnership

9.1.6 Recommendation Six

Acute health care to develop a domestic abuse strategy for acute care in West Sussex which complements and support the strategic aims of SWSP.

Ownership: Sussex University Hospitals NHS Foundation Trust

9.1.7 Recommendation Seven

CCG (Now Sussex Integrated Commissioning Board) and Sussex University Hospitals NHS Foundation Trust to identify resources to provide an IDVA in the acute health care setting to provide equality of service across Sussex.

Ownership: Sussex University Hospitals NHS Foundation Trust

(To note; IDVA posts have been identified and recruited and these are sited within WORTH services to enable health provision to be effectively integrated).

9.1.8 Recommendation Eight

SWSP to review and monitor the impact of Pan Sussex Housing Strategy Support for domestic abuse victims and seek assurance that the support is being implemented across West Sussex.

Ownership: Safer West Sussex Partnership

9.1.9 Recommendation Nine

Safer West Sussex Partnership will ensure that the multi-disciplinary learning is shared at the West Sussex Domestic and Sexual Violence and Abuse (DSVA) Steering Group.

Ownership: Safer West Sussex Partnership

9.1.10 Recommendation Ten

Safer West Sussex Partnership to request that the West Sussex Safeguarding Children's Partnership (WSSCP) reviews what support is available to mothers following care proceedings/post adoption in recognition of the potential for increased risk and vulnerability and whether this meets current and ongoing needs of this cohort of vulnerable mothers.

Ownership; Safer West Sussex Partnership and West Sussex Safeguarding Children Partnership

9.2 Individual Agency Recommendation/ actions

9.2.1 West Sussex Children Social care

9.2.2 If the threshold for an Initial Child Protection Conference has been met when a young person becomes pregnant and it is evident that they do not have the support of their family or there is evidence that they are vulnerable, at risk of Child Exploitation, substance use etc, an assessment should be completed, ideally prior to the birth so that a multi-agency safeguarding plan will be in place that will support both the young person and the baby.

9.2.3 When it becomes apparent that a first-time parent is unable to meet the needs of their child appropriately or consistently and the Local Authority are of the view that it is not safe for the child to be in the sole care of their parent, a strategy discussion should be convened, in order that multi agency consideration can be given to how best to support the parent and safeguard the child.

9.2.4 When there is evidence that a young person is at risk of exploitation and is frequently going missing, Strategy Meetings are to be held in line with the WSCC CSC processes and partnership safety planning for the young person should commence, which includes a referral to the Youth Homeless Prevention Team for 16-17year-olds at risk of homelessness.

9.2.5 The DHR Panel would also recommend that a copy of the DHR is kept on Emma's baby's care file so that they have the option of reading it when they are older. WSCC CSC to ensure support is provided to during this process, if needed.

9.2.6 West Sussex County Council- Education

9.2.7 West Sussex County Council Education has implemented local practice, including the Keeping Children Safe in Education (KCSiE) 2015 which provides statutory guidance for schools on how they should undertake their safeguarding duties, which includes the introduction of a curriculum which covers relationships and sex education.

9.2.8 West Sussex County Council Education has developed support for Designated Safeguarding leads in schools including training, tool kits and a support network.

9.2.9 General Practice (The IMR ICB author requested that the recommendations be clearly identified as the responsibility of General Practice)

9.2.10 Creation of a short universal safeguarding template for recording safeguarding concerns for general practice notes, which can be utilised by general practice and other agencies. Recording notes with consistency of coding of the entries to appear in the summary and to be updated and highlighted with further episode entries.

9.2.11 Digitalising the GP record. NHS digital are working on digitalising the whole patient record.

9.2.12 Sharing of risk assessments from external agencies with GP practices.

9.2.13 A named clinician to support a family when identified as vulnerable.

9.2.14 The DHR Panel would also recommend that GPs and health professionals working in health settings ensure that routine enquiry about domestic abuse is embedded into policy and practice.

9.2.15 Sussex University Hospitals NHS Foundation Trust

9.2.16 Domestic abuse strategy to be developed which will include an IDVA/navigator, alert flagging system for adults on patients' administrative systems, body mapping, clinical photography for preserving evidence.

9.2.17 An overarching Domestic Abuse Strategy Policy to be formulated and implemented for the Trust. The strategy to reflect the Domestic Abuse Act 2021.

9.2.18 Arun District Council Housing

9.2.19 Where an applicant for the housing register indicates that they are homeless, the case should be referred for a full housing assessment interview to take place.

10. Appendix One

SAFER WEST SUSSEX PARTNERSHIP (SWSP)

DOMESTIC HOMICIDE REVIEW

December 2021

TERMS OF REFERENCE vrs 2 updated 7 Dec 21

1. This Domestic Homicide Review (DHR) is being conducted in accordance with Section 9(3) of the Domestic Violence Crime and Victims Act 2004.
2. This legislation places a statutory responsibility on organisations to securely share confidential information, which will remain confidential until the panel agrees the level of detail required in the final report for publication.
3. The DHR will strictly follow the SWSP DHR protocol, which is based on Home Office DHR guidance.
4. The statutory purpose of the DHR is to:
    a. Establish what lessons can learned from the domestic homicide regarding how the local professionals, agencies and organisations worked individually and together to safeguard the victims of domestic abuse.
    b. Identify clearly what those lessons are, both within and between agencies and organisations, how they will be acted on, and what will change as a result through a detailed Action Plan.
    c. Apply these lessons to service responses including changes to policies and procedures as appropriate.
    d. Prevent domestic homicides where possible in future through improved intra and inter-agency responses for all domestic abuse victims and their children.
5. The agreed timeframe for information to be secured and reviewed is for the period 6 December 2011 - 13 May 2018 (Emma Victim) and 18 November 2007 -13 May 2018 (Ben perpetrator) unless there have been significant events prior to this. Significant events will include engagement due to mental health, other noteworthy medical issues and other wellbeing issues.
6. The DHR will not seek to apportion blame to individuals or agencies from the information it receives. However, it is recognised that other parallel procedures (e.g. SCR, IOPC referral, and internal agency disciplinaries) may use information from the DHR process to support their investigations.
7. The Panel notes that the DHR process may be suspended as necessary to avoid the risk of activities prejudicial to criminal proceedings. (Criminal investigations against Ben concluded in June 2021 when he was convicted of murder).
8. In addition, the following areas will be addressed in the Individual Management Reviews (IMRs) and through wider enquiries:
    a. Awareness and understanding of professionals and the wider community of the potential presence of coercive control and how this may have impacted on the behaviour of Emma and Ben.
    b. Consideration of any equality and diversity issues that appear pertinent to Emma and Ben e.g. Femicide, men and women's roles in society, for example Ben did not accept any criticism of his behaviour

c. Whether there were any barriers experienced by Emma or her family / friends in seeking support from professional service providers?

d. Whether there were any barriers experienced by professionals / agencies in offering support services to Emma?

e. To consider any agencies or wider community groups that had no contact with Emma and her family and whether helpful support could have been provided e.g. specialist domestic abuse services and if so, why this was not accessed? E.g. housing/welfare benefits

f. Identification of any training or awareness-raising requirements required to ensure a greater knowledge and understanding of the impact of domestic abuse and availability of support services.

g. Impact of drug/ alcohol issues on the wellbeing of Emma and Ben?

h. Possible impact of trauma and possible neglect in Emma's childhood which may have impacted on her wellbeing and whether professionals/practitioners considered Emma's childhood experiences when assessing Emma's needs and support?

i. What support Children's social care provided to Emma, post adoption of her child.

j. To consider previous domestic abuse by Ben in his relationships and any interventions by agencies.

k. The impact of homelessness and access to welfare benefits for Emma including the difficulties of CSC and other agencies trying to contact Emma as she had no fixed address.

l. To consider any previous convictions and risk factors for Emma and Ben.

9. The Panel will critically evaluate and approve the Overview Report, Executive Summary and Action Plan produced by the Independent Chair at the end of investigation prior to it being passed to the chair of SWSP, which will own the Report and implementation of the Action Plan.

10. As actions and lessons are identified, the Chair will notify the relevant agencies/ local safeguarding boards so that the implementation, monitoring and review of actions can be commenced as soon as possible.

11. These Terms of Reference may be varied by the DHR Panel as new information emerges.

12. Media: All agencies involved can confirm a review is in progress once the CCB criminal investigation has been completed, but no information to be divulged beyond that.