NORFOLK COMMUNITY SAFETY PARTNERSHIP

Domestic Homicide Review Elouise Executive Summary

January 2022

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NORFOLK COMMUNITY SAFETY PARTNERSHIP

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Elouise was a young woman in her late teens who was remembered by her family as someone who helped others and stood up for what she believed was right. She was described by college staff as a lovely girl who wanted a good education, had a passion for art and design, and aspired to move away to university. Elouise hoped for a future where she had her own home, meaningful work helping others, and some peace in her life. She carried a strong sense of responsibility for her mother, siblings and father, often trying to protect and care for those around her despite the trauma she had experienced.

Elouise's family believe that she would have wanted her story to be shared, in order to help others in the future.

The Norfolk Community Safety Partnership, the Independent Chair and the panel members extend their deepest condolences to Elouise's family and friends. It is clear to all involved in the review that Elouise touched so many people's hearts, and her absence will be felt by her family, friends and community forever.

EXECUTIVE SUMMARY

1. The Review Process

1.1 This Domestic Homicide Review (DHR) examines agency responses and support given to Elouise, prior to her death in January 2022. Elouise was a White British female in her late teens, and was a resident of Town A, Norfolk.

1.2 On that day, Elouise was taken by her father, Clive, into the local Accident and Emergency Department with serious injuries. Upon arrival at hospital Elouise was pronounced dead.

1.3 Clive was found guilty of Elouise's murder in July 2022, and in September 2022 he was sentenced to eighteen years imprisonment and was also given a lifetime restraining order prohibiting him from contacting Elouise's mother, Rachel, and her three siblings.

1.4 This DHR examines the involvement that organisations had with Elouise, a White British female teenager and Clive, a White British male in his mid-forties; between January 2019 and January 2022.

1.5 The key reasons for conducting a Domestic Homicide Review (DHR) are to:

a) establish what lessons are to be learned from the domestic homicide about the way in which local professionals and organisations work individually and together to safeguard victims.
b) identify clearly what those lessons are both within and between organisations, how and within what timescales will be acted on, and what is expected to change.
c) apply these lessons to service responses including changes to policies and procedures as appropriate; and
d) prevent domestic violence and abuse and improve service responses for all domestic violence and abuse victims and their children, through improved intra and inter-organisation working.
e) contribute to a better understanding of the nature of domestic violence and abuse; and
f) highlight good practice.

1.6 Norfolk Community Safety Partnership (NCSP) were notified of Elouise's death by the police, and a multi-agency Gold Group meeting was convened on 16th February 2022. The Gold group membership contained the appropriate level representation from statutory agencies and senior representation from the voluntary sector specialist domestic abuse services in the county. It was agreed that the criteria for Domestic Homicide Review had been met. That agreement was ratified by the Chair of Norfolk Community Safety Partnership, and the Home Office were informed on 21st February 2022.

1.7 A Mental Health Homicide Review commissioned by NHS England ran concurrently with the DHR and the independent author for that Review joined the DHR Panel.

2. Contributors to the Review

Agency	Nature of contribution
Norfolk Constabulary	IMR Chronology
Integrated Care Board (ICB)[1] on behalf of Primary Care	IMR Chronology
Children Social Care (CSC)	IMR Chronology
Department of Work and Pensions (DWP)	Chronology
Norfolk and Suffolk Foundation Trust (NSFT)	IMR Chronology
Lincolnshire Partnership Foundation Trust (LPFT)	IMR Chronology
Leeway	IMR Chronology
Domestic Abuse Charity A	IMR Chronology
EDAN Lincs	IMR Chronology
Norfolk Community Health and Care	IMR Chronology
Adult Social Care	IMR Chronology
Cambridgeshire Community Services (CCS)	IMR Chronology
East of England Ambulance Service Trust (EEAST)	IMR Chronology
Education Safeguarding Team	IMR Chronology
Hospital A	IMR Chronology
Norfolk and Waveney Mind	IMR Chronology
Housing Association A	Short report
Refuge – Town X	Short report
Change Grow Live (CGL)	Short report
Borough Council A	Short report

[1] An ICB is a statutory NHS organisation which is responsible for developing a plan for meeting the health needs of the population, managing the NHS budget and arranging for the provision of health services in a geographical area.

NORFOLK COMMUNITY SAFETY PARTNERSHIP

3. Review panel members

Name	Agency	Job Title
Liza Thompson	DHR Chair	DHR Author
Amanda Murr	Office of the Police and Crime Commissioner for Norfolk	Assistant Director of Policy and Partnerships
Mary Smith	Niche Consult – on behalf of NHS England	Senior Investigator
Gary Woodward	NHS Norfolk & Waveney Integrated Care Board	Designated Lead Professional for Adult Safeguarding
Lisa Gair	NHS Norfolk & Waveney Integrated Care Board	Deputy Designated nurse safeguarding children
Sara Shorten	NHS Norfolk & Waveney Integrated Care Board	Deputy Designated Lead Professional for Adult Safeguarding
Rachel Holman	NHS Norfolk & Waveney Integrated Care Board	Designated Nurse for Safeguarding Children
Kelly Waters	Children's Services, Norfolk County Council	Senior Safeguarding Advisor
DCI Pippa Hinds DI Louise Wallace	Norfolk Police	Senior Officer for Domestic Abuse Detective Inspector Child Abuse Unit
Charlotte Richardson	Leeway Domestic Violence and Abuse Services	NIDAS Service Manager
Christine Hodby Sharon Rowe	Norfolk and Suffolk NHS Foundation Trust	Associate Director Safeguarding and Patient Safety. Specialist Safeguarding Practitioner
Jessica Howland	Lincolnshire NHS Foundation Trust	Interim Head of Safeguarding
Emma Moore	Norfolk County Council Children Social Care	Team Manager
Sarah Adams	Norfolk County Council Children Social Care	Head of Social Work South and West
Tracy Denny	Hospital A	Lead Professional for Safeguarding Adults and Children
Suzannah Armstrong Cobb	Office of the Police and Crime Commissioner	NCSP Communication Officer

Lucy Parsons	Cambridgeshire Community Services	Named Professional Safeguarding Children
Andy Nederpel	Borough Council A	Community Safety Manager
Tracey Mahoney	Domestic Abuse Charity A	Chief Executive Officer
Sonja Chilvers	Norfolk and Waveney Mind	Chief Operating Officer
Jane Keenlyside	EDAN Lincs	Manager
Anthea Blenkinsop	Norfolk County Council Adult Social Care	Head of Integrated Care
Mark Rowlands	Norfolk Community Health and Care NHS Trust	Deputy for Safeguarding Adults
Matthew Armitage	Change, Grow, Live	Deputy Service Manager
Lisa Barraclough	Department of Work and Pensions	Advanced Customer Senior Leader
Jo Robotham Jen Tan	Housing Association A	Tenancy Manager Housing Operations Manager

4. Author of the Overview Report

4.1. The Independent Chair and Author of the review was Dr Liza Thompson.

4.2. Dr Thompson is an AAFDA accredited Independent Chair, who has extensive experience within the field of domestic abuse, initially as an accredited Independent Domestic Violence Advisor, and later as the Chief Executive of a specialist domestic abuse charity. As well as DHRs, Dr Thompson also chairs and authors Safeguarding Adult Reviews (SARs). She delivers domestic abuse and coercive control training to a variety of statutory, voluntary, and private sector agencies, and is the current Independent Chair for the Rochester Diocese Safeguarding Advisor Panel (DSAP). Her doctoral thesis and subsequent publications examine the experiences of abused mothers within the child protection system.

4.3. Dr Thompson has no connection with the Community Safety Partnership and agencies involved in this review, other than currently being commissioned to undertake Domestic Homicide Reviews in Norfolk.

5. DHR Methodology

5.1 At the commencement of the review fourteen agencies were contacted to establish their contact with Elouise, and/or Clive. Following the commencement of the review, and further information emerging, agencies in Lincolnshire were also approached for information regarding the period Elouise was residing in Lincolnshire.

5.2 The detailed information on which this report is based was provided in Individual Management Report (IMRs) completed by each organisation that had significant involvement with Elouise and/or Clive. An IMR is a written document, including a full chronology of the organisation's involvement, which is submitted on a template.

5.3 The authors of agency IMRs were independent of the case; they had no management responsibilities for the frontline staff who provided services, nor did they have personal contact with Elouise or family members. IMR authors accessed their service records and policies, and where possible interviews with staff involved took place.

5.4 The Norfolk and Waveney Integrated Care Board wrote the IMR on behalf of the GP surgeries, with input from the surgeries.

5.5 Each IMR included a chronology, a genogram and a full analysis of the service provided by the agency submitting it. The IMRs highlighted both good practice, and areas where practice could be improved. Within the IMRs recommendations were made for the individual agencies.

5.6 The collated chronologies and IMRs provided a fuller picture of the various agencies' involvement with Elouise, Clive and the other family members. This allowed overarching learning to be identified, and subsequently whole system recommendations to be developed.

5.7 In addition to IMRs, two agencies who had limited information to contribute provided summary reports to be considered, these included chronologies and a shortened version of the analysis.

5.8 The panel are aware of the length of this report and would like to highlight that this was necessary to tell Elouise's story. Elouise's family were keen for her story to be told in full, to highlight the level of control that Clive had over them; and how he was able to control the narrative inside and outside of the family for many years.

5.9 The analysis of agency involvement has been enhanced by the application of Professor Jane Monckton-Smith's[2] Eight Stages of Homicide, otherwise known as The Homicide Timeline.[3]

5.10 Professor Monckton-Smith is a forensic Criminologist who specialises in homicide, stalking and coercive control. Her teaching at The University of Gloucester focuses on forensic and criminal investigation and addresses issues in public protection.

5.11 The Eight Stages of Homicide framework has been developed from Professor Monckton-Smith's ground-breaking research which has spanned many years. The homicide timeline lays out identifiable stages in which intimate relationships where one partner is coercive, can escalate to murder. The timeline aims to support a better understanding of coercive control and domestic homicide amongst professionals responding to domestic abuse.

5.12 The timeline provided the panel with a framework upon which to build an understanding of Clive's behaviours. When applied to the Eight Stages, and with the benefit of hindsight, his behaviours are clearly identifiable as escalating. Whilst the use of the timeline in this review is not intended as a predictive tool, there is learning to be found within the application of the Eight Stages, which may illuminate the past to make the future safer for victims of domestic abuse and coercive control.

6. Terms of reference for the review

6.1 The full subjects of the DHR were the victim, Elouise and the perpetrator, Clive.

6.2 The review considered whether any agencies identified possible and/or actual domestic abuse that may have been relevant to the death of Elouise. This included domestic abuse perpetrated by Clive towards Elouise's mother within the family home whilst Elouise was a child, as well as abusive behaviour directed at Elouise, by Clive.

6.3 The review considered legislation, including the Domestic Abuse Act 2021, and within it, recognition of children as victims of domestic abuse - in their own right.

6.4 If domestic abuse took place and was not identified by any agencies, the review considered why not, and how such abuse could be identified in future cases.

[2] Jane Monckton-Smith - Staff Profiles
[3] Monckton-Smith J *In Control: Dangerous Relationships and How They End in Murder* (2021)

6.5 The review analysed whether agency's response to domestic abuse were in accordance with their own, and multi-agency policies, protocols, and procedures, which were in existence at the time.

6.6 The review examined the method used to identify risks, and any action plans which were put in place to reduce the risks.

6.7 The following specific issues were considered by the panel and will be included in the DHR analysis:

i. Were practitioners sensitive to the needs of Elouise, and Clive? Were they knowledgeable about potential indicators of domestic abuse and aware of what to do if they had concerns about a victim or perpetrator?

ii. Were Elouise – and her siblings – recognised, and responded to accordingly, as victims of domestic abuse by all agencies, as per Domestic Abuse Act 2021?

iii. Did the agency have policies and procedures for Domestic Abuse, Stalking and Harassment (DASH) risk assessment and risk management for domestic abuse victims or perpetrators, and were those assessments correctly used in the case of Elouise and/or Clive?

iv. Were assessment tools used effectively, and did this include referrals into the MARAC, or other multi-agency fora?

v. What were the keys points of assessment and decision making – were these decisions reached in an informed way?

vi. Did Elouise disclose abuse to any practitioners, and were these disclosures responded to appropriately – including following information sharing protocols?

vii. When, and in what way, were Elouise's wishes and feelings ascertained and considered?

viii. What was known about Clive by services?

ix. Did services use all of the powers available to them, when responding to Clive's abuse within the family home?

x. Agencies were asked to examine how they assessed and responded to members of the family as individuals, particularly around the assessment of risk and needs of individuals but also the family as a collective. How cohesively did the services work together to gain a better understanding of the cumulative risks posed by Clive; along with the holistic, and individual needs of the family?

xi. How did adult and children services interface with one another. In terms of those working with specific members of the family, but also in terms of transitions, when Elouise was moving from children services, into adult services. How were the different systems, assessment and criteria navigated to achieve best outcomes for Elouise?

xii. How did agencies and professionals respond to Elouise in a trauma informed way. Were her Adverse Childhood Experiences (ACEs)[4] considered? Particularly when managing her resistance to engaging and behaviours towards professionals.

xiii. Were services accessible to Elouise, and were they also suitable for Elouise's specific needs as a teenage victim of abuse from her father? What barriers to accessing services can be identified.

xiv. Agencies were asked to analyse how practitioners engaged with family members when there is the presence/potential presence of an abusive family member.

xv. How did Clive's mental health impact in this case and was the appropriate level of mental health care and treatment provided to Clive?

7. Summary chronology

7.1. A full and detailed chronology is presented in the full overview report. The following is a summarised version of the complex and protracted involvement which Elouise and her family had with services.

7.2. In January 2018, Elouise approached staff at her college and disclosed abuse perpetrated by Clive, which she linked to his physical health issues. She said she was worried about her home life, and that she felt anxious and paranoid. The college referred Elouise to Domestic Abuse Charity A and, following further concerns raised by Elouise's boyfriend, referred to Children's Social Care. This was picked up by Early Help.

7.3. In February 2019, Clive threatened Elouise's boyfriend with an axe and reversed his car, nearly hitting Elouise. The college helped Elouise report this to police. Clive was interviewed under caution at his home address. The children and Rachel were spoken to at the home address, and no disclosures were made.

7.4. The Primary School and Secondary school attended by Elouise's siblings were spoken to by the college DSL. They also raised concerns, although they stated that the children had not made any disclosures.

7.5. Following further concerns raised by the college with Children's Services, a strategy discussion was held on 15th February 2019. A joint s.47 investigation was agreed, and a MARAC referral was submitted naming Rachel as the victim, although Rachel had denied abuse and the referral was actioned without her consent.

7.6. Concerns continued to be raised by wider family members, schools and during further visits to the family home by police and Children's Services. In March 2019, Elouise

[4] Highly stressful, and potentially traumatic events or situations that occur during childhood and/or adolescence

told her college that these visits had made Clive more abusive, that he stated he would take his own life, and was blaming Elouise for everything.

7.7. In April 2019, Clive was arrested for Actual Bodily Harm against Rachel and bailed away from the home. Rachel told officers that Clive had assaulted her throughout their 23-year relationship.

7.8. During this time the family were supported by Children's Services on a Child in Need plan.

7.9. Elouise continued to express fear of her father. To get away from the family home, she moved to Lincolnshire on 16th April 2019. She initially stayed with her boyfriend's family, moved to her grandmother's in mid-May 2019, and later rented a single room in a shared house in Lincolnshire.

7.10. Clive returned to the family home during May 2019, after no further action was taken by the CPS due to lack of evidence.

7.11. A further incident occurred in August 2019, which led to Clive's arrest and Rachel moving with the younger children to a refuge in Lincolnshire. She remained there for two weeks, then was asked to leave due to reports from other residents of her meeting up with Clive. Rachel and the children returned to the family home on 30th August 2019.

7.12. In October 2019, the CPS decided to take no further action regarding the assault and coercive and controlling behaviour offences, citing inconsistent evidence.

7.13. On 10th October 2019, records indicate that both Elouise and Clive were back at the family home. From this point, Elouise's behaviour changed from help seeking, to problematic.

7.14. In November 2020, Elouise's younger sister Mia told a friend at school that Clive hits her, their mother and her younger sibling, and that there were cameras in the house so Clive could see what they were doing. This was reported, and a strategy meeting was held on 17th November 2020. It was decided that a Child in Need plan would be made.

7.15. In April 2021, Clive assaulted Rachel and she reported this to police. Rachel moved out of the family home, and Elouise remained there with her father. Clive was arrested, charged and bailed. He was due to appear in court for this incident in June 2022.

7.16. During this time, Elouise was facilitating contact between Clive and the children. It was also widely accepted that Elouise was providing care to her father. Elouise stopped attending college, was treated for alcohol related issues and was self-harming.

7.17. Early Help for the family closed in December 2021.

7.18. In January 2022, Elouise was killed by Clive.

8. Conclusions

8.1. Victim blaming

8.1.1. Victim blaming language was evident throughout agency case notes and IMRs. There was insufficient understanding of the risk Clive posed, the barriers Rachel faced in leaving him, and the degree of control he held over all family members. Rachel described fearing that professionals would judge her as failing to protect her children, and that this could lead to them being removed from her care. This fear contributed to her denying, and hiding, the abuse and staying in a relationship with Clive for longer than she otherwise might have done.

8.1.2. Language such as “minimising”, “arguments” and “discord”, recorded throughout agency files, and IMRs, obscured the reality of domestic abuse and coercive control. Rachel’s responses are better understood as normalising abuse in order to survive, rather than choosing to minimise risk. Likewise, Elouise’s retractions were accepted without sufficient consideration of coercion, despite these retractions coming after she was back in touch with Clive, and he was able to escalate his control over her. Abuse must be named as abuse, and professional records must avoid language which implies mutuality, responsibility or blame on the part of victims.

8.1.3. The review found that professionals too often focused on Rachel’s actions rather than Clive’s behaviour. Abusive fathers and men can be overlooked when services expect the non-abusive parent to manage risk. Elouise’s voice was also not consistently heard by professionals, who appeared to seek further verification before allowing her disclosures to shape protective action. Rachel’s experience in refuge, including being judged and disbelieved, is likely to have further reduced her trust in professionals and contributed to Clive appearing to be the safer or more reliable option at that time.

8.2. Elouise as a Victim of Domestic Abuse

8.2.1. Aside from her college and specialist domestic abuse services, Elouise was not consistently responded to as a victim in her own right. The Domestic Abuse Act 2021 recognises children as victims in their own right, reflecting the long-term harm caused by living with domestic abuse. For Elouise, Clive’s abusive behaviour had been present from birth, making it difficult for services to identify the “before and after” impact normally used to evidence coercive control. However, her withdrawal from college and support, deterioration in wellbeing, problematic behaviour, alcohol-related issues and self-harm were clear indicators of serious harm, and were visible for all to see.

8.2.2. Elouise’s move away from the family home, her approaches to housing teams, and her disclosures about fear of Clive should have prompted stronger safeguarding responses. She was limited by her age, caught between children’s and adults’ systems, and affected by adultification. When she moved to Lincolnshire while still subject to a Child Protection plan, information was not

shared in a way that enabled Lincolnshire services to understand her vulnerability or the risks she faced.

8.2.3. After Rachel moved out and Elouise remained with Clive, there was no continuing professional exploration of domestic abuse despite well documented concerns. Elouise was also not identified as a young carer, even when services were told that Clive's teenage daughter was caring for him. These were missed opportunities to recognise her vulnerability, assess her needs, and offer support. More recent developments, including Health IDVAs in hospital settings and housing-related needs assessment work, show positive learning, although some of these provisions had ended by March 2025, due to funding restrictions.

8.3. Mental Health

8.3.1. The NHS England Mental Health review, into the mental health responses to Clive, identified learning for mental health services which closely aligns with the findings of this DHR. Key themes included lack of professional curiosity, insufficient child safeguarding consideration, long waits for Community Mental Health Team support, limited contact with people on waiting lists, and insufficient multi-agency consideration by the Liaison Team in the acute setting, and the Liaison and Diversion Services, located within police custody.

8.3.2. The NHS England review also identified that Clive's children were not recognised as carers, despite information indicating that Elouise and others were providing support. The recommendations from the NHS England review require NSFT to strengthen professional curiosity, safeguarding escalation, crisis follow-up, contact with people awaiting support, multi-agency risk information sharing, and identification of carers, particularly young carers.

8.3.3. The Norfolk and Waveney Integrated Care Board has responsibility for system oversight of these recommendations and will seek assurance from NSFT that actions are implemented. The DHR panel noted that these findings echo the wider learning from the review, including the lack of mental health representation within the Multi-Agency Safeguarding Hub and the difficulty services reported in contacting or accessing mental health provision for the people they support.

9. Lessons to be Learnt

"When people ask for help, they need to be helped straight away – they may not get another chance to ask." (Rachel)

9.1. Think Family – Risk Assessment and Management

9.1.1. Elouise's family were keen that learning from the DHR highlights that professionals should speak to each family member individually, away from the abuser and other family members, and consider how children present in the abuser's presence. A Think Family approach requires practitioners to understand risks and needs across the whole family, recognising that risk can continue even when people are no longer living together.

9.1.2. Risk assessments and plans must be informed by a clear understanding of coercive control. Clive's behaviour was too often understood as anger, vulnerability or non-engagement, rather than as intentional abuse and control, which affected how risks to Rachel, Elouise and the children were recognised and managed.

9.1.3. Agencies missed opportunities to build a whole-family risk picture from information about weapons, threats, intimidation, home conditions, caring responsibilities and Clive's aggression towards professionals.

9.1.4. Genograms, family conversations and information sharing should be used to identify who is at risk, who is providing care, and who may contribute to safety planning.

9.1.5. Since the scoping period of the review, services have strengthened work around Think Family practice, safeguarding training, domestic abuse awareness and recording historic risk.

9.2. Trauma Informed Professional Curiosity

9.2.1. Trauma informed practice requires professionals to recognise the prevalence and impact of trauma, and to respond in ways that promotes safety, trust, collaboration and empowerment. Elouise and the wider family had lived with long-term trauma caused by Clive's abuse, and this should have shaped professional responses to their presentation, engagement and needs.

9.2.2. Professionals should ask "what happened to you?" rather than interpreting non-engagement, retraction or distress as refusal, unreliability or lack of cooperation. Elouise's disclosures, retractions and deteriorating mental health should have been understood in the context of coercion, trauma and continued exposure to abuse.

9.2.3. Professional curiosity must be respectful, persistent and trauma informed. There was insufficient curiosity about Elouise living with Clive, the impact of Rachel leaving, Clive's behaviour towards Elouise and the children, and the meaning of missed appointments or contact being mediated through others.

9.3. Transitions

9.3.1. During the scoping period, Elouise moved from childhood into adulthood whilst also moving between Norfolk and Lincolnshire services. These overlapping transitions created clear points at which she could fall through gaps between thresholds, service criteria and local systems.

9.3.2. Research and practice learning show that transitions are high risk when young people move from children to adult services, particularly where different eligibility thresholds apply. Elouise was a vulnerable teenager fleeing abuse from her father, and her needs required coordinated cross-boundary support.

9.3.3. Norfolk Children's Social Care did not identify Elouise's move to Lincolnshire as permanent and therefore did not refer her to Lincolnshire Children's Social Care. This was a missed opportunity to alert services in Lincolnshire that a vulnerable young person subject to safeguarding concerns was living in their area, resulting in limited joined up working between LPFT, EDAN Lincs and children's services.

9.3.4. Learning has since been identified for LPFT's Steps2Change service around responding to 16- and 17-year-olds, particularly where there is known Children's Social Care involvement or disengagement.

9.3.5. Norfolk Children's Social Care has also continued work to improve responses to homeless 16- and 17-year-olds, including revised protocols, training and developmental work between adult and children's safeguarding partnerships.

9.4. Collaborative Working

9.4.1. Since the scoping period, there have been more collaborative initiatives, including co-located working and the relaunch of the Resolving Professional Disagreements Policy. The learning from this review illustrates how essential collaboration is when responding to domestic abuse and safeguarding children and young people.

9.4.2. MARAC discussions did not always result in sufficient action, and victim-blaming language such as "minimising" and "refusing to engage" was not consistently challenged. Elouise's voice and Rachel's voice were not always represented strongly enough at the MARAC, while Clive's account sometimes carried disproportionate weight.

9.4.3. There was insufficient challenge at MARAC, Strategy Discussions and Child Protection Conferences. Practitioners who raised concerns did not always see those concerns acted upon, and escalation processes should have been used where risk was not understood or responded to appropriately.

9.4.4. Practitioners also found it difficult to refer into mental health services and access CMHT. Where professionals have concerns, there should be persistent clinician-to-clinician communication and information sharing, including known domestic abuse history, to support risk assessment and professional curiosity.

9.5. Children as Victims

9.5.1. Following the Domestic Abuse Act 2021, agencies must embed the understanding that children are victims of domestic abuse in their own right. Multi-agency training should make clear what this means in practice, including hearing from Mia about her experience of being overlooked by professionals.

9.5.2. Practitioners must understand that domestic abuse and coercion do not end simply because a teenager moves out, or because a non-abusive parent leaves. Older siblings should not be used to facilitate contact with an abusive parent, as this can place them at risk and increase the abuser's control.

9.5.3. Children's health and development should be central to safeguarding responses where domestic abuse is known or suspected. The review identified the need for improved recognition of children's lived experience, stronger recording of the Voice of the Child, better police safeguarding processes for intra-familial domestic abuse, and wider use of DASH and MARAC processes where children and young people are victims in their own right.

9.5.4. Education settings played a pivotal role in recognising and responding to Elouise's abuse. Further enhanced domestic abuse training for education settings, alongside family-focused domestic abuse support through services such as NIDAS, should strengthen future responses.

10. Recommendations

10.1. Norfolk Constabulary

10.1.1. To fully embed 'The Voice of the Child' and use of the ARTHUR mnemonic checklist when recording Domestic Abuse incidents and associated crimes.

10.1.2. A mechanism to be identified that flags new incidents/crimes which are recorded, relating to a victim and associated family members who have previously, or are currently, open to MASH and who remain at high risk.

10.2. NSFT

10.1.3. Elouise experienced gender inequality in multiple NSFT assessment considerations. These aspects of the DHR will be fed into the Trust's Pillar work to drive improvements in culture across the Trust. A 7-minute briefing will be developed, focussing on these aspects.

10.3. Hospital A

10.1.4. A review of the ED electronic EDIS system will be undertaken, to explore if it is possible to add some social/domestic abuse triggers so staff can easily document this information.

10.4. Housing Association A

10.4.1. A policy will be developed to ensure that victims of domestic abuse are safeguarded against ongoing abuse where perpetrators refuse to either remove themselves from tenancies following separation or build up rent areas after the victim has left the shared property.

10.5. Education

10.4.2. Education settings across Norfolk will be encouraged to upskill key staff, within safeguarding and pastoral support teams, into DA Champion roles. Learning from this review will be shared to form part of this Norfolk wide initiative.

10.6. Norfolk Children Social Care

10.4.3. Ongoing training about the accommodation/housing including support we can give young people (16/17 years olds).

10.7. Domestic Abuse Charity A

10.4.4. A Senior Practitioner will be identified within the Domestic Abuse Charity A who will link in with the CSC Team as a single point of access.

10.8. Multi Agency Recommendations

10.4.5. A scoping exercise will be undertaken to identify strong MASH models across England and Wales, to consider possible replications of the model within Norfolk.

10.4.6. Each agency involved in the review will provide assurance that they have trauma informed processes in place, including trauma informed supervision where appropriate, and all key staff have been trained in trauma informed practice.

10.4.7. Each agency involved in the review will provide assurance that their "did not attend/was not brought" policy includes identification of risk where individuals have not been brought to appointments. A template policy statement will be made available for those agencies who did not have this in place.

10.4.8. All professionals involved in Initial and Review Child Protection Conferences should be trained in the use of Signs of Safety risk scaling. The training is available via Norfolk Children's Safeguarding Partnership[5] – and agencies should provide assurance that their key staff members have attended this training.

10.4.9. A case study will be developed to share Elouise's story; to highlight the need to recognise children as victims of abuse, this will be available for use in training within all agencies.

[5] Norfolk LSCP | Signs of Safety: Family Network Approach

10.4.10. A general briefing tool will be developed to share the following learning from this review:

- The resources which are available to support the engagement of fathers will be shared, for all agencies to access when working with families.
- The Norfolk Safeguarding Children's Partnership escalation policy [6], to be used to manage conflict and raise concerns within a multiagency response.
- The scope of the NHCP - particularly where domestic abuse is known or suspected – in order to encourage referrals for families into the NHCP.
- The services available to young carers and a reminder that young people with caring responsibilities should be offered this support.
- Risk assessment and management of the whole family.

[6] Norfolk LSCP | Policies and Procedures