NORFOLK COMMUNITY SAFETY PARTNERSHIP

Domestic Homicide Review Elouise Overview Report

January 2022

Author: Dr Liza Thompson

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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 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.



By Elouise aged 6

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Report advisory notice

This report deals with difficult subjects relating to violence, abuse and self-harm. We advise caution for those who may be triggered by reading information which might be distressing and ask that they are helped to read this report in a safe and supported way.

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1. Introduction

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. Confidentiality

2.1. As recommended within the statutory guidance, pseudonyms have been used and precise dates obscured to protect the identities of those involved. Pseudonyms have been provided and agreed by Elouise's mother.

2.2. Details of the deceased and perpetrator:

Name (Pseudonym)	Gender	Age at time of death	Relationship to deceased	Ethnicity
Elouise	Female	Late teens	*Deceased*	White British
Clive	Male	Mid forties	*Father and perpetrator*	White British

2.3. The following individuals/family members were known to the Review Panel and have been given the following pseudonyms to protect their identity:

Pseudonym	Relation to deceased:	Relation to perpetrator:
Rachel	Mother	Wife
Dan	Sibling	Child
Mia	Sibling	Child
Child A	Sibling	Child

3. Timescales

3.1. The Chair was recruited in March 2022; the review process was then paused until the completion of the trial and sentencing.

3.2. The initial panel meeting was held in September 2022, soon after Clive's sentencing. The Terms of Reference were agreed, and agencies requested to complete Independent Management Reports (IMRs). This process was protracted

due to the amount of information gathered and analysed by agencies. IMRs were completed and received in May 2023.

3.3. Following receipt of information from nineteen agencies, it was clear that further individual meetings would be required for the Chair to fully comprehend the complexities of family engagement with agencies. The Independent Chair and NHS England consultant met with individual panel members to discuss agency findings and highlight early learning. Due to the large number of agencies, these meetings were held between June and September 2023.

3.4. The initial report draft was reviewed by the panel in December 2023, and the final version was signed off in July 2025.

3.5. It was not possible to meet the six-month statutory framework for completion of DHRs due to the conclusion of the criminal trial, and the volume and complexities of family engagement with many agencies.

3.6. Although the report was completed in May 2024, there were delays in sharing the report with the family. This was especially important as the level of detail within the report – which had been previously agreed with the family – required informed consent from the family due to the personal nature of the information.

4. Methodology

4.1. 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.

4.2. 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.

4.3. 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.

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

4.5. 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.

4.6. 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.

4.7. 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.

4.8. 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.

4.9. The analysis of agency involvement has been enhanced by the application of Professor Jane Monckton-Smith's[1] Eight Stages of Homicide, otherwise known as The Homicide Timeline.[2]

4.10. 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.

4.11. 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.

4.12. 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

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

illuminate the past to make the future safer for victims of domestic abuse and coercive control.

5. Terms of Reference

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

5.2. 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.

5.3. 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.

5.4. 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.

5.5. 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.

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

5.7. 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)[3] taken into account? 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?

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

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6. Involvement of family members and friends

6.1. The Independent Chair, panel members, and the Norfolk Community Safety Partnership extend their deepest condolences to Elouise's family and friends.

6.2. Elouise's mother (Rachel) was contacted by the NCSP when the DHR commenced. This was facilitated by the Family Liaison Officer (FLO).

6.3. Rachel also had a Victim Support Advocate, who the Independent Chair contacted at the commencement of the review. The advocate supported a meeting between Elouise's mother and the Chair, this took place in November 2022.

6.4. The Chair and the panel are grateful for Rachel's generosity, of her time and of her memories of Elouise.

6.5. Due to Clive's abusive behaviours occurring within the family home, against Rachel and Elouise's siblings, and the obvious effect this would have had on Elouise, the Independent Chair obtained permission from Rachel, and her eldest sibling, to request family members' relevant information, to be shared as part of Elouise's review information.

6.6. The Chair shared the draft report with Rachel, Dan and Mia, in March 2025. There had been some delay in contacting the family about the final report, due to personnel changes at Victim Support and difficulties in contacting Rachel. The panel are very grateful for the support of the DWP panel member who organised a letter to be passed from the Chair to Rachel – who was then able to contact the Chair to arrange a meeting.

6.7. Apart from Child A, all of Elouise's siblings were now adults, they were therefore invited to meet with the Chair and the Head of Norfolk Community Safety, to discuss the report. This took place at the family home in March 2025. The family confirmed their consent for the level of detail within the report to be published, and provided pseudonyms for themselves, Elouise and Clive.

6.8. Rachel and Mia also reflected on some of their experiences, which they had been reminded of by reading the report. These reflections are included throughout the report.

6.9. The family members believe that Elouise would have wanted her story to help others in the future, they said she was always helping people and would stand up for what she believed to be right. Rachel and Mia are both keen to share their experiences of abuse, to also help others - in memory of Elouise.

6.10. The Independent Chair and the panel have been astounded by the strength and tenacity of Elouise's family and are very grateful for their time and for sharing their precious memories of Elouise.

7. Contributing organisations

7.1. Each IMR was written by a member of staff from the organisation to which it relates and signed off by a senior manager of that organisation, before being submitted to the DHR Panel. None of the IMR authors or the senior managers had any involvement with Elouise or Clive during the period covered by the review.

7.2. Each of the following organisations contributed to the review:

Agency	Service description	Nature of contribution	Source of contribution
Norfolk Constabulary	**County Policing Command** - front line officers who are deployed to deal with calls for service from the public **Domestic Abuse Safeguarding Team (DAST)** – sits under the umbrella of the Multi-Agency Safeguarding Hub (MASH). Responsibility of DAST is to secondary safeguard medium to high-risk domestic incidents **Child Abuse Investigation Unit (CAIU)** – responding to public protection and major investigation issues, for example, child abuse and child sexual exploitation. **Multi-Agency Risk Assessment Conference (MARAC**) – a small team that sits within Norfolk police, receiving MARAC referrals from partner agencies and referral to MARAC from police,	IMR Chronology	CIS crime recording system Athena crime and intelligence system COMPACT, the system the Constabulary uses to record missing person cases STORM, used by the Contact and Control Room

	as a result of secondary safeguarding of ongoing incidents.		
Integrated Care Board (ICB)[4] On behalf of Primary Care	Practice A – Elouise and Clive Practice B – Clive	IMR Chronology	Patient care records – including correspondence with external agencies. Both Practices co-operated with the completion of the IMRs.
Children Social Care (CSC)	**Social Work Team –** help to protect vulnerable children from abuse or harm, by creating and coordinating a child protection or child in need plan. **Emergency Duty Team (EDT) –** Out of hours service for urgent emergencies **Multi-Agency Safeguarding Hub (MASH) –** A co-operative arrangement between various organisations. The aim of the MASH is to share information and co-ordinate activities to identify and address risks to children at an early stage. **Child Protection** s.47 Children Act **Child in Need** S.17 Children Act **Early Help**[5] - is about giving information, advice and guidance to families, as soon	IMR Chronology	Social Care Information Management System – Liquid Logic Interviews with social workers.

[4] 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.

[5] Supporting Families: Early Help System guide: GOV.UK

	as difficulties start, to prevent family worries growing into bigger issues.		
Department of Work and Pensions (DWP)	**Universal Credit** - a monthly payment to help people with their living costs if they are on a low income out of work or cannot work. **Personal Independence Payment** – a welfare benefit intended to help working age adults with the extra costs of living with a health condition or disability.	Chronology	Chronology of information shared with internal benefit specialists to comment. Advanced Customer Support Senior Leader also supported with knowledge.
Norfolk and Suffolk Foundation Trust (NSFT)	**Wellbeing Norfolk and Waveney** – a service providing free support for people with common mental health and emotional issues, such as low mood, depression or stress.[6] **Community Mental Health Team** – treatment for people with mental ill health and associated risks.[7]	IMR Chronology	Lorenzo electronic patient record system IAPTUS electronic patient record system Patient Safety Incident Investigation Report Interviews with staff
Lincolnshire Partnership Foundation Trust (LPFT)	**Steps2Change** - provides a range of evidence based talking therapies for problems such as depression, anxiety, post-trauma reaction, panic, phobia, and obsessive-compulsive disorder (OCD). **Children and Adolescent Mental Health Services (CAMHS)** – a broad term for all services that work with children and young people who have difficulties with their emotional or behavioural wellbeing.	IMR Chronology	Electronic clinical records reviewed. Relevant policies and procedures reviewed Interviews undertaken with Service Managers for Steps2Change and CAMHS Crisis Enhanced Treatment Service

[6] Community | Norfolk and Suffolk NHS
[7] Community | Norfolk and Suffolk NHS

	CAMHS Crisis Enhanced Treatment Service (CCET) -a multi-disciplinary team comprised of Social Workers and Nurses, working with the aim of supporting young people in a mental health crisis through assessment and intensive home treatment.		
Leeway	**Independent Domestic Violence Advisor (IDVA)** – supporting high risk victims of domestic abuse until 31st December 2021. **The Norfolk Integrated Domestic Abuse Service (NIDAS)** was launched on 1st January 2022. NIDAS is a Countywide partnership delivered by specialist service providers – Leeway, Daisy Programme and Safe Partnership.[8]	IMR Chronology	Discussion with the allocated IDVA regarding the IDVA case notes Accessed from the Leeway Case Management System
Domestic Abuse Charity A	**Domestic abuse support worker** – one to one support for women affected by domestic abuse.	IMR Chronology	Information gathered from the Domestic Abuse Charity A Case Management System
EDAN Lincs	EDAN Lincs is the commissioned domestic abuse service in Lincolnshire. **Independent Domestic Violence Advisor (IDVA) Service –** providing a specialist service for males and females aged 16, and over, who have been referred into a Multi-Agency Risk Assessment Conference.	IMR Chronology	EDAN Lincs Case Management System

[8] About - NIDAS

	Outreach Service – this service is available for victim/survivors of all risk levels; the service offers emotional and practical support to anyone affected by domestic abuse.		
Norfolk Community Health and Care	**Community Speech and Language Therapy Service (SALT) -** Providing expert assessment and management of communication and swallowing problems associated with ageing, stroke, mental health, and progressive neurological conditions. **Community Palliative Care Service -** The aim of palliative care is to achieve the best quality of life for patients with life-limiting illnesses and to support their families and carers. *complex* **Community Heart Failure Service** - provides assessment of heart failure patients and supports the patient to look after their long-term condition. The service also provides monitoring during the first treatment phase and follow ups by telephone, home or clinic visits. Patients are discharged once stable and on the best treatment.	IMR Chronology	SystmOne case management system accessed
Adult Social Care	**Emergency Duty Team –** runs Out of Hours support for situations that do not require 999 services. **Social Care Community Engagement (SCCE) Team –** a telephone-based service. A	IMR Chronology	Liquid Logic case management system accessed

	generic team that looks at all cases holistically. **Older People/Physical Disability Team** – to use the service a patient will need to be referred by a health professional. Includes the memory clinic. **Norfolk First Support** – providing intensive person-centred home support for a period of up to six weeks, to help people regain as much independence as possible. Once ongoing needs have been identified, alternative provision is facilitated. **Norfolk Assistance Scheme (NAS)** – a support model helping people in financial hardship, who cannot pay their living costs. NAS can provide emergency financial help, such as food vouchers, assistance with fuel or utilities and assistance with rent arrears. **Finance Money Support Team –** help with budgeting **SWIFT Response –** providing practical help to adults with an urgent, unplanned need at home.		
Cambridgeshire Community Services (CCS)	**Norfolk Healthy Child Programme (NHCP)** - an evidenced based early intervention and prevention public health programme – focusing on a universal preventative service for children and families.	IMR Chronology	SystmOne Case management system accessed

	Universal pathway - no additional needs are identified. **Targeted pathway** - a specific intervention is required that can be met by the NHCP service. **Specialist pathway** - needs are more complex, and more than one agency is involved to meet these needs.		
East of England Ambulance Service Trust (EEAST)	Providing 24 hour, 365 days a year accident and emergency services to those in need of emergency medical treatment and transport in Bedfordshire, Hertfordshire, Essex, Norfolk, Suffolk and Cambridgeshire.	IMR Chronology	Computer Aided Dispatch (CAD) checking the system for 999 calls against the family's address Patient Care Records (PCRs) Patient Experience (PE) Single Point of Contact (SPOC)
Education Safeguarding Team	The Education Safeguarding Team completed the IMR on behalf of Child A's school – Primary School A Mia and Dan's school - Secondary School A Elouise's college - College A **Operation Encompass** – police and education early information sharing partnership. This enables schools to offer immediate support to children and young people experiencing domestic abuse. Police inform a child's school following police	IMR Chronology	Safeguarding records requested from the children's education settings. Some supplementary questions posed to the relevant staff at the Primary and Secondary school. Interview was conducted with College Student Welfare Manager

	involvement in a domestic abuse related incident. The Designated Leads within the school are trained to respond to the needs of the child following an incident. **Designated Safeguarding Lead (DSL)** – each school had a DSL who is the person who coordinates and oversees safeguarding procedures and policies in each school.		
Hospital A	**Emergency Department (ED)** – medical treatment facility specialising in emergency medicine, minor illnesses and injury. It provides the acute care of patients who present without prior appointment, or are sent via the 111/GP service, either by their own means or by that of an ambulance.	IMR chronology	Paper clinical records Electronic records – Emergency Department
Norfolk and Waveney Mind	**Psych Liaison Service -** supporting vulnerable people accessing ED, who are first assessed by the Mental Health Liaison Team – support is offered for 2-12 weeks, via face-to-face meetings. **Crisis Community Support –** hospital admission prevention service, supporting individuals and NSFT teams to keep people well in their own homes, and the community rather than admission to hospital.	IMR Chronology	Review of all documentation held on the client management system

Housing Association A	**General housing provision** – all applications for housing are made through Home Choice.[9] **Tenancy Support** – provide a free, non-judgemental service, giving advice on moving, benefits, money management – and specialist advice on domestic abuse, hate crime, hoarding, anti-social behaviour, and home safety	Short report	Open Housing - case management system
Refuge – Town X		Short report	Case management system
Change Grow Live (CGL)	**Alcohol and Drug Behaviour Change Service** – helping people to break free from harmful patterns of behaviour. Offering one to one working, and group sessions. Providing substitute prescribing and medication to prevent relapse.	Short report	CRiiS service user case management system accessed
Borough Council A	**Housing Options Team** – offer a range of services, to reduce risk of homelessness, and to help find a solution to housing problems.	Short report	Housing options data accessed via Home Connections system Environmental Health information accessed via Uniform system

8. Review panel members

8.1. The Review Panel was made up of an Independent Chair and senior representatives of organisations that had relevant contact with Elouise and Clive. It also included a senior member of the Norfolk Community Safety Team.

[9] Choice based letting scheme, which advertises properties on behalf of partner housing associations. People apply to be the register, if they meet the eligibility criteria which includes an annual income and savings less than a third of the average property in the area, and a local connection to the area. Once on the register, applicants are prioritised according to their housing need – with greater priority given to those in the greatest need What is West Norfolk Homechoice | WNKL

8.2. None of the panel members have had direct contact with either Elouise or Clive. The panel met on five occasions during the DHR, and there were numerous individual and small group meetings between the Independent Chair and panel members throughout the process.

8.3. The members of the panel were:

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	Norfolk Community Safety Partnership (NCSP)	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

9. Independent Chair and Author

9.1. The Independent Chair, who is also the Author of this Overview Report, is Dr Liza Thompson.

9.2. 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) and Offensive Weapon Homicide Reviews (OWHRs). 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.

9.3. 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.

10. Other reviews/Investigations

10.1. Following Elouise's death, NSFT conducted an Early Learning Report investigation, followed by a more in-depth Patient Safety Incident Investigation into the incident. The findings are reflected within this DHR report.

10.2. The incident was raised using the Cambridgeshire Community Services (CCS) incident reporting mechanism Datix. Following this, an internal panel meeting was convened, and an internal investigation completed which did identify some learning and actions for CCS. At the time this did not meet the criteria for a Serious Incident, however following the research for this DHR, CCS convened an additional panel meeting to review the case, which resulted in the same outcome of not meeting the threshold for a Serious Incident.

10.3. An independent Care and Treatment Review of Clive's mental health care by NSFT was commissioned by NHS England. The author of the NHSE review also provided independent mental health specialist support to the DHR Panel. [10]

11. Publication and dissemination

11.1. This overview report will be published on the Norfolk Community Safety Partnership website.

11.2. Family members have been provided with hard copy, and electronic copies of the report. Dates to avoid for publication were checked with the family, and Child A's school were updated with plans for publication to ensure they were able to offer support to Child A and her family if required.

11.3 Elouise's story and the learning from this review will be shared across Norfolk multiagency partners, through a learning event. Elouise's family will be invited to attend this event, to share their experiences and reflections on the learning which the review has highlighted.

11.4 Further dissemination will include:

- All services contributing to the DHR and their Chief Officers
- Independent Chair and all members of Norfolk Community Safety Partnership

[10] See appendix two

- Head of Investigations, NHS England (Midlands and East Region)
- The Home Office domestic homicide review team
- The Domestic Abuse Commissioner for England and Wales
- Police and Crime Commissioner for Norfolk
- Chief Constable Norfolk Constabulary
- Chief Executive – NHS Norfolk and Waveney Integrated Care Board
- Chief Officer – Norfolk and Suffolk Foundation Trust
- Chief Executive – Hospital A
- Executive Director – Children's Services, Norfolk County Council
- Executive Director – Adult Social Services, Norfolk County Council
- Members of the Norfolk Safeguarding Adults Board
- Members of the Safeguarding Children's Partnership
- Chief Nurse – Cambridge Community Services
- Norfolk Domestic Abuse Partnership Board

12. Equality and diversity

12.1. The panel considered the nine protected characteristics under the Equality Act 2010, and discounted marriage and civil partnership, pregnancy and maternity, gender reassignment, ethnicity, religion and belief and sexual orientation.

12.2. However, the panel considered that Elouise's life experiences were shaped by her gender and age, along with her father's disabilities.

12.3. Elouise was a female, living with male violence and abuse, which was perpetrated by the person who was expected to care for her. Elouise's mother told the Independent Chair that Clive had been abusive for the entirety of their relationship. They had met as teenagers, and throughout the childhoods of all four children, Clive had been coercively controlling to the whole family. Clive would not allow people to visit, and she stated they remained home as much as possible. Socialising and recreation only occurred altogether as a family. Clive was verbally aggressive and violent. He would have unpredictable outbursts, which he stated were due to his illnesses; this reasoning was also repeated by Rachel and Elouise in agency case notes.

12.4. Very little was known about the family's circumstances. When Clive or Rachels families tried to intervene, they were threatened by Clive and banned from contacting Rachel or the children, this further isolated the family from any outside influences.

12.5. The family unit is shrouded in privacy, Martha Fineman argues that:

> "society has devised special laws to apply to the family…these rules (are) justified by…the family's relational aspects and intimate nature."[11]

12.6. The privacy of the family setting has long been viewed as the primary source of women's oppression.[12] As Catharine Mackinnon argues "(the) ideology of privacy [is] a right of men to be left alone to oppress women one at a time."[13] The setting of the family home is private and therefore potentially untouchable by others; for example, Martha Fineman characterises the family as being "invisible" to those outside of it.[14] This privacy restricts state intrusion, "barring changes in control over….the existing distribution of power and resources within the private sphere."[15]

12.7. Rachel told the Chair that the children had been programmed to deny any abusive issues within the family unit, and they almost certainly would have normalised Clive's behaviours. Clive would not allow the children to go to friends' houses, therefore no other ways of living could be observed by the children. Rachel stated that in essence, the children knew no different while they were growing up.

12.8. Adverse Childhood Experiences (ACEs) are traumatic events occurring in early years; these events include neglect, violence between or perpetrated by parents or caregivers, alcohol or substance misuse within the home, and peer, community, or collective violence. ACEs are associated with the development of health harming behaviours, physical and mental ill health in adulthood.

12.9. The ACEs experienced by Elouise were predominantly caused by male violence, and would have certainly shaped her life, which was tragically also cut short by male violence, perpetrated by one of the people who should have been supporting and protecting her.

12.9. Elouise's gender also shaped her experiences following her parents' separation. Once Rachel had left the home, Elouise felt obligated to care for Clive, stating to one practitioner "if I don't look after him, who will?" She viewed the caring role as hers to take over, from when her mother's role stopped.

12.10. Elouise was a young woman; she was only nineteen when she died – yet she had experienced so much trauma in her short life. Her age would have shaped her experiences of accessing – or trying to access – services. Her young age and naivety led her to expect more than would be available to her – particularly

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[11] Fineman, MA "What Place for Family Privacy" *Geo. Wash. L. Rev* (67) (1998-1999) p.1207
[12] Fineman, M *The Autonomy Myth* (2004) p.152
[13]Mackinnon, C "Roe v. Wade: A Study in Male Ideology" in Garfield, J L and Hennessey, P *Abortion: Moral and Legal Perspective* 45 (1984) p.53
[14] Fineman, above n 6 p.154
[15] Mackinnon, C *Toward a Feminist Theory of the State* (1989) p.193

in terms of housing provision. Yet there appeared to be an underlying expectation by professionals for Elouise to navigate services, cope with the pressures of poverty, and manage her father's illnesses and behaviours. She was never offered a carer's assessment, despite being referenced by Clive and Rachel as Clive's carer following Elouise and Rachel separating.

12.11. Elouise's age also often made her invisible as a victim of abuse. Although the support she received from her college was excellent and considered her wishes and feelings, her fears and concerns regarding her father's behaviour was not taken seriously by Children's Social Care, especially in the earlier part of the scoping period. Elouise's parents' words were believed over hers, and when she retracted her allegations – following a return home when no one could provide her with an accommodation alternative – professionals appeared very ready to accept her retraction with very little consideration for the context of her situation.

12.12. Research over the years has identified the hidden nature of children as victims of domestic abuse.[16] This has led to the Domestic Abuse Act 2021 situating children as victims of domestic abuse 'in their own right'.[17] Children and young people should no longer be viewed as collateral witnesses within a home where an adult is abusive. This change in legislation sends a powerful message about the severity of harm that children suffer when they experience domestic abuse.[18]

12.13. Although Elouise did not have a disability, Clive used his illnesses and disabilities to manipulate the family, including Elouise – this would have certainly shaped her life. It also served to render him largely invisible as a perpetrator of domestic abuse.

12.14. During the earlier part of the scoping period, when Clive remained in the family home, Rachel provided a lot of Clive's care, she made all his calls to professionals, booked and cancelled appointments, and it is recorded that he would often be bed bound. When the relationship between Rachel and Clive ended, Elouise remained with Clive to be his carer. Many children and young people caring for their ill or disabled family members remain hidden or invisible in our communities,[19] and although Clive told healthcare professionals that his

[16] Abrahams, C Hidden Victims: *Children and domestic violence* NCH Action for children (1994); Callaghan, J et al "Beyond 'witnessing': Children's experiences of coercive control in domestic violence and abuse" *Journal of Interpersonal Violence* (2016) 33 (10) pp.1551-1581; Eliffe, R et al "Hiding and Being Hidden: The Marginalisation of Children's Participation in research and Practice Responses to Domestic Violence and Abuse" *Out of the Shadows iii* (2020) (22) 1

[17] Office of the Domestic Abuse Commissioner *Children and Young People Subject to Domestic Abuse: Professionals' Insights Briefing* (2022)

[18] Ho, NG "Children – the Hidden or Direct Victims of Domestic Abuse?" *Journal of Social Welfare and Family Law* (2022) 44 pp.512-528

[19] Warren, J L "Young Carers' Needs and Changing Experiences during an Era of Austerity" *International Journal of Environmental research and Public Health* (2023) 20

seventeen-year-old daughter was his carer, this was taken on face value and recorded in notes – Elouise was never seen, spoken to or offered any support.

12.15. In 2007, Professor Evan Stark introduced the concept of entrapment in the context of coercive control.[20] Since then, the introduction of the offence of Coercive and Controlling Behaviour[21] has promoted a societal understanding of the uses of control by perpetrators, in order to entrap their victims – including children – into a relationship which is uneven in power dynamics.

12.16. Tolmie et al call for a broader conceptualisation of abuse as a form of social and systemic entrapment. They introduced one of their research papers with the following: "how one conceptualises (abuse) influences what is seen when looking at situations involving (abuse). It affects what is considered relevant or irrelevant in making sense of what is happening…"[22]

12.17. Clive used his illnesses to entrap Elouise into a relationship where he presented himself to her and to professionals as vulnerable, and in need of her care. This behaviour rendered Clive largely invisible as a perpetrator by healthcare professionals, whilst also rendering Elouise invisible as both a young carer,[23] and a victim of Clive's coercively controlling behaviours.

12.18. Elouise's age, gender, caring role and her father's illnesses shaped her life. Each element intersected to create a situation where she was largely invisible as a carer for her father, and also invisible as a victim of his abuse.

13. Background information

Family reflections:

13.1. Rachel told the Independent Chair that Clive had been abusive throughout their whole relationship. She explained that throughout the children's lives, he controlled the children, would not allow anyone into the house to visit and the family were isolated from external influences. Rachel recollected that this changed when Elouise turned sixteen and started going out. Elouise saw other people's families and realised that the power dynamics within their family home was "not normal," and she started to be influenced by people other than her father. This led to Clive's abusive behaviour escalating, to keep Elouise controlled.

[20] Stark, E *Coercive Control – How Men Entrap Women in Personal Life* (2007)
[21] Serious Crime Act 2015 S.76
[22] Tolmie, J et al "Social Entrapment: A Realistic Understanding of the Criminal Offending of Primary Victims of Intimate Partner Violence" *New Zealand Law Review* (2018)
[23] Someone under the age of 18, who cares for a friend or family member due to illness, disability, mental health or addiction – where the person they are caring for could not cope without the young persons' support.

13.2. Mia told the Independent Chair that Clive had been jealous of her relationship with Rachel, so had banned her from being with Rachel. She spoke feeling "shy" of speaking to Rachel once Clive was no longer living with them. Mia was not allowed in the kitchen, which is where Rachel always was – because Clive said Rachel and Mia would be talking about him – so Mia had to always stay with him.

13.3. The family spoke about always being together, with Clive always being with them. He would drive them all to school and drive them all back. Rachel was very rarely away from him; however, she recollected that the school were aware of the issues as they allowed her to have a bag packed and kept at the school for emergencies.

13.4. Mia also described how she would take turns with Elouise sitting up at night, listening out for Clive attacking Rachel. If there was an incident, Elouise would jump in and stop it. The family reflected that Elouise always "broke it up", and Rachel reflected that the children were always protecting her from Clive's violence.

13.5. Rachel and Mia described how every Christmas Clive would not wake up until the afternoon and the children were not allowed to open presents until he was out of bed, and they had all eaten Christmas dinner. This was the norm, with Clive controlling every part of their lives. Rachel also reflected that he would keep her awake every night until the early hours of the morning. They would get up to take the children to school, he would drive them there and would then go back to bed for the whole day until school pick up time – in this way, Rachel was isolated from any outside influence as she was not in contact with anyone other than Clive and the children each day.

Information gathered from agency records:

13.6. When speaking to staff at her college, Elouise stated that her father's main problem was that his own father had died when he was young, which led to him having attachment and anger issues. She said Clive was anxious about family members leaving the house as he thought they would not come back, or they would die like his father had. She disclosed that her father was verbally abusive to her siblings, and he would threaten to assault them. Everything in the home had to be the way her father wanted. Her father did not want her to leave the house so she would be late for school. She was bullied by peers, and some teachers were negative towards her.

13.7. Agency records indicated that Clive had not worked since 2009 due to ill health. In April 2012, he requested an urgent Occupational Therapy[24] (OT) assessment, stating he had recently been diagnosed with bone cancer throughout his body. Requests were made for rails throughout the house due to deteriorating mobility. Rachel was recorded as assisting with his care, she declined a carer assessment. At the OT visit to Clive, it is recorded that he had been diagnosed with Myalgic Encephalomyelitis (ME) the year before, had Raynaud's disease,[25] and had stomach problems which had led to a six stone weight loss. He stated that all medical tests had remained inconclusive as to the issues with his stomach. It is recorded that he had been advised that he had a gene which placed him at risk of bone cancer, but this had not been diagnosed. Clive's Housing Association landlords were contacted to improve the heating system, and a referral was made to wheelchair services. After following up with primary care, Clive's OT records were updated to reflect that Clive did not have bone cancer.

13.8. NSFT records indicated that Clive self-referred to the Wellbeing Service in August 2013. A telephone assessment was completed, and he stated he felt hopeless. He disclosed aggressive behaviour, and stated he felt angry due to being in pain. He also disclosed being physically violent two-years previous and had hit someone in a car; he acknowledged that he 'went too far'. There is no further information regarding this incident in the NSFT records. He was advised to return to the pain clinic and was signposted to an Anger Management course before being discharged.

[24] A branch of healthcare that helps people of all ages who have physical, sensory or cognitive problems. Helping them regain independence in all areas of their life.
[25] Where blood stops flowing properly to your fingers or toes. This is a fairly common condition and does not usually cause severe problems.

Diagnosed conditions recorded in Clive's GP records		
Date	Diagnosis	Description
January 2012	Chronic Fatigue Syndrome	Also known as Myalgic Encephalomyelitis – is a long-term condition with a range of symptoms, the most common symptom is extreme tiredness.[26]
August 2012	Gastritis	The lining of the stomach becoming irritated, causing pain, indigestion and feeling sick.[27]
August 2012	Oesophagitis	Also known as heartburn and acid reflux. Where the tube which carries food from the mouth to the stomach becomes inflamed or irritated.[28]
February 2016	Neurological symptom changes	Refers to symptoms that are not constant and may vary overtime, these may include, headache, vision changes, muscle weakness, tremors, seizures
August 2019	Insomnia	Problems with sleep[29]
October 2019	Gastric bleed	A symptom of a disorder in the digestive tract.[30]
November 2019	Haemorrhoid	Swollen veins in the lower part of the rectum and anus that causes bleeding and discomfort. Also known as piles.[31]
September 2020	Inguinal lymphadenitis	The enlargement in one or more lymph nodes, usually due to infection. Swollen glands are usually a sign that the body is fighting an infection[32]
May 2021	Depressed mood	A common mood disorder that affects how people feel, think and act[33]
June 2021	Paraprotein anaemia	An abnormal protein secreted by a clone of plasma cells or lymphocytes. Approximately 65% of patients presenting with paraprotein anaemia do not have demonstrable cancer and 1% will develop a myeloma or low-grade lymphoma.[34]
June 2021	Myotonic dystrophy	A genetic condition that causes progressive muscle weakness, the heart, lungs, gastrointestinal tract, lens of the eye and brain. Affecting muscles of movement. The later in age the conditions start, the milder it will be.[35]
June 2021	Heart failure – left ventricular systolic dysfunction	Heart failure means that the heart is unable to pump blood around the body properly. It usually happens because the heart has become too weak or stiff. [36]
December 2021	Chronic obstructive lung disease (COPD)	COPD is the name for a group of lung conditions that cause breathing difficulties[37]

[26] Myalgic Encephalitis | Chronic Fatigue Syndrome - NHS
[27] Gastritis - NHS
[28] Heartburn and acid reflux - NHS
[29] Insomnia - NHS
[30] Gastrointestinal bleeding: Symptoms, causes, and treatment
[31] Haemorrhoids (Piles): Symptoms and Causes | Bupa UK

13.9. An anonymous Children Social Care (CSC) referral was received in January 2014, stating that Clive's children and wife were being mentally and physically abused by Clive. The youngest child's school confirmed they suspected this to be the case, but there had been no disclosures from the children and no evidence of physical harm. The referral stated very specific assaults on Rachel and the children, and that the children's maternal grandmother had raised similar concerns with the school previously, however this allegation was not on the CSC records. The Clive and Rachel told social workers that the reports were malicious, and no further action was taken. There were missed opportunities at this time to explore the issues further, however consideration should be given to the time which has lapsed since this intervention, and how practices have evolved in relation to services understanding domestic abuse and coercive control.

13.10. In June 2015, the council received a complaint of Anti-Social Behaviour (ASB) between the family and their neighbours.

13.11. During 2015, Clive self-reported as having Crohn's Disease,[38] and there were further requests to OT by Clive to adapt his property. His Housing Association declined the request for an upstairs toilet to be installed, although he did have agreement for a level access shower and was referred into the wheelchair service.

13.12. In January 2016, a carers assessment was arranged for Rachel, who was recorded as providing substantial support to Clive, Rachel was pregnant at this time, and the other children were aged between eight and thirteen years old. Rachel postponed the carer assessment due to the impending birth, and declined the rearranged assessment, stating she was managing well.

13.13. In December 2016, Clive's mother and brother reported concerns for Clive's mental health to police, this also led to a safeguarding alert with CSC. There had been a verbal argument, between Clive, his mother and his brother, which had carried on via texts and calls. Clive's Mother wanted Clive to get help – she alluded to Clive being aggressive towards Rachel and the children. CSC spoke with Rachel's health visitor, who had no concerns. As with the interventions described in paragraph 13.9, this was a missed opportunity to explore the issues, however consideration should be given to how far practices have evolved since the period of this intervention.

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[32] Swollen glands - NHS
[33] Depression - NHS
[34] Non-Hodgkinson lymphoma
[35] Myotonic dystrophy - Overview | Muscular Dystrophy UK
[36] Heart failure - NHS
[37] Chronic obstructive pulmonary disease (COPD) - NHS
[38] Crohn's Disease

13.14. In the summer of 2017, police were alerted to a child being left unattended in Clive's vehicle. Also, Elouise was reported as missing – she was aged fifteen at this time. She was later located by police and returned home. There was no further curiosity by officers, regarding what was happening in the family unit during this time.

13.15. Between March and July 2018, Clive and Rachel were prosecuted for failure to ensure regular attendance of a child at school. This was in relation to Dan and Mia. they were both given a 12-month conditional discharge.

13.16. Elouise had struggled with some aspects of secondary school and her behaviour had been of concern. In September 2018, Elouise enrolled at the local college – she was aged sixteen at this point.

13.17. Once at college, Elouise was described as a lovely girl who wanted to get a good education and aspired to move away to university. Elouise had a passion for art and design. Family appeared to be very important to her and the College Student Welfare Manager described Elouise as having a great sense of responsibility for her mother and siblings but also her father.

13.18. Elouise told her college Designated Safeguarding Lead[39] (DSL) that she aspired to live in her own home, have a job which gave her satisfaction in helping others and find some peace in her life.

13.19. Following successfully finishing her first year at college during 2018-2019 – she was unable to complete her second year 2019-2020. College records state that Elouise was withdrawn from the college register due to lack of engagement. Rachel told the Chair that Elouise could no longer manage college due to the stress associated with her father's actions and behaviours.

14. Chronological overview

14.1. In January 2019, Elouise attended a drop-in session at college to speak about her family life. She stated that her dad was unwell with ME and arthritis. She said Clive was mostly bed bound and had been on medication for the last 10 years, and that he could become very angry, as some days the illnesses can be worse. He accused Rachel of infidelity; Elouise had seen Clive hit the washing machine with a hammer. She disclosed being physically hurt by Clive but stated it was unintentional resulting in a cut to her leg and a bruise to her arm. Elouise stated that she was close to Clive, but that he sometimes turned on her suddenly, and

[39] See table at section 7

blamed her for things. Elouise stated she was worried about her home life, she felt anxious and paranoid. She stated she could speak to Rachel and felt safe at home most of the time – but did think about leaving home when Clive was aggressive. She also disclosed thinking about self-harm but stated she had not recently self-harmed. A further meeting was booked with the college safeguarding team for the following day. Elouise stated she felt better after offloading to the safeguarding team. Elouise agreed to a referral to Domestic Abuse Charity A,[40] and was shown the services available from MIND,[41] and Young Carers.[42]

14.2. The following week Elouise attended a further meeting with the College Safeguarding Team. She said Clive had been worse that week, he had been constantly phoning her, threatening that he would call police if she did not return home, and making references to throwing her out of the family home. She said he had been insisting she help with his bath, had pushed her in the cheek and made a scene when it was bedtime. She said having Children's Social Care (CSC) involved would make matters worse, and stated she felt safe at home. The DSL agreed to follow up on the referral to Domestic Abuse Charity A, they agreed a safety plan, which the DSL wrote up for Elouise.

14.3. A Domestic Abuse Charity A support worker contacted the DSL on 1st February 2019, with concerns about the information on the referral form. She advised she would contact Elouise.

14.4. On 3rd February 2019, Rachel contacted NHS 111 with concerns for Elouise, who had back and chest pain, as well as an unusual vaginal bleed. She was conveyed to Hospital A, where all investigations came back negative. There is no record that Elouise was asked about domestic abuse, her home life, or whether she felt unsafe. Domestic abuse had been well documented to be correlated with a variety of negative physical and mental health outcomes.[43] When victim/survivors of domestic abuse are asked whether they feel unsafe at home, they are far more likely to disclose abuse.[44]

14.5. The next day, Elouise's boyfriend of six months contacted the DSL with concerns that Elouise was not at college. He said that Elouise had been taken to hospital the previous day and had left hospital at 6am. The boyfriend explained the Clive did not allow Elouise out, and just before she was taken to hospital, she had told Clive that she was at work. Clive had called her work, and when he found out she wasn't there, he called police, who called Elouise. He said he had called Elouise

[40] See table at section 7
[41] See table at section 7
[42] Young Carers and Families Support Norfolk | Carers Matter
[43] IRISi - Social enterprise to improve the healthcare response to gender-based violence
[44] Keynejad R et al "Identifying and Responding to Domestic Violence and Abuse in Health Care Settings" *British Medical Journal* (2021)

over the weekend and could hear Clive shouting. The College DSL asked the boyfriend if he thinks Elouise is ever in danger and he said “sometimes”. The College DSL asked if Elouise has ever been physically harmed and he said he didn't think Elouise would want him to answer the questions. Elouise told her boyfriend she wanted to leave the family home with Rachel and her siblings, and that Rachel had hidden packed bags and had tried to leave before. The DSL advised the boyfriend to call police if he ever felt that Elouise was in danger. The DSL discussed concerns with the Domestic Abuse Charity A support worker, and the DSL contacted CSC.

14.6. The following day, the College DSL met with Elouise, who disclosed Clive’s abusive behaviour. The DSL discussed with Elouise about involving CSC, it is recorded that she did not want their involvement as she thought they would “split her family up.” The DSL reassured Elouise that CSC would be there to help and keep Elouise and her siblings safe. Elouise asked that the DSL didn’t call CSC until she said it was ok to do so, however the DSL explained that they would need to make CSC aware. She gave Elouise some time to process this information and arranged for Elouise to join the DSL when she called CSC. A meeting with Domestic Abuse Charity A was set for the following day.

14.7. On 6th February 2019, Elouise met with a support worker from Domestic Abuse Charity A, and discussed her father’s behaviour, describing being threatened with an axe by Clive, which he kept in his car. She spoke about anxiety and explained she had been in hospital over the weekend with chest pains. Elouise remained reluctant to involve CSC.

14.8. On 8th February 2019 the College DSL Team discussed a referral to the Children's Advice and Duty Service. Prior to making a referral the College DSL telephoned the DSL at Secondary School A who reported that Dan was at risk of permanent exclusion due to his behaviour. The Secondary School A DSL had seen bruises on Rachel, but when spoken to Rachel had denied any domestic abuse. The Secondary School DSL said Rachel presented as very shy and quiet, Clive was the opposite and has been into school in his dressing gown telling staff how poorly he was. The College DSL advised she would be referring to CSC.

14.9. On 11th February 2019 Elouise reported to the College DSL that she returned home from her boyfriend’s house, and her dad was waiting for her in the car in the driveway, he had an axe in the car, he was making threats and reversed the car towards her nearly hitting her. He followed her into the house and hit her. He later grabbed her by the throat and kneed her left leg. There were no visible injuries. The College DSL assisted Elouise with reporting this to police. The College DSL contacted CSC and spoke to a Consultant Social Worker who stated there was a lack of evidence that Elouise was telling the truth, and that the parents were clearly struggling to parent their children. The Consultant advised

the College DSL to speak to Rachel about the allegation. Elouise went home that evening.

14.10. The College DSL spoke with the DSL at Primary School A, who advised they also had concerns for Elouise's siblings who attended there; however, no disclosures had made by the children. They planned to see Mia to do wishes and feelings work. The College DSL also contacted Secondary School DSL who advised that they had also referred to CSC and were waiting for an Early Help worker to be allocated.

14.11. The following day the Domestic Abuse Charity A support worker spoke with Elouise, who said she had not been eating and felt scared at home. She viewed her mother as her protector. Elouise stated that her father's behaviour was due to his illnesses.

14.12. On 14th February 2019, an Early Help worker spoke to Rachel who denied the Elouise's allegations. Elouise told the College DSL that when Clive found out about the call from Early Help, he had called Elouise and was very angry at her for speaking to the school. Elouise reported to the College DSL that she was afraid to return home. The DSL also shared their concerns about Elouise with CSC, stating that she had looked exhausted for weeks. CSC referred for a Strategy Discussion.[45] The DSL advised Elouise to leave the house, call police and go to a neighbour if she felt unsafe.

14.13. The Strategy Discussion was held on 15th February 2019, the DSL shared the information disclosed by Elouise, and the school staff who were present shared attendance concerns for Elouise's siblings. Domestic Abuse Charity A had risk assessed Elouise as high risk, however CSC did not revisit this assessment with Elouise, who continued to report being afraid of her father. A decision was made for a joint s.47 investigation,[46] and a social worker was allocated to the family. A MARAC referral was also submitted naming Rachel as the victim, this was completed and submitted without Rachel's consent, or knowledge.

14.14. Clive was interviewed under caution at his home address regarding the alleged offence of common assault. Consideration should have been given to arresting him and this would have provided a window of opportunity to engage Rachel and the other children in a safe environment. Bail conditions were not put in place, which was a missed opportunity to provide respite to Rachel and the family. The children were recorded as being spoken to by the social worker within the home, however

[45] A meeting between a social worker and other agencies when they are worried a child is, or is at risk of, suffering significant harm. The purpose of the meeting is to decide whether the threshold for a child protection investigation has been met, and to plan the investigation.

[46] Child Protection Enquiries - Section 47 Children Act 1989 – a joint investigation is where police and social care work together

officers could have spoken to them away from the home, maybe within their education setting, away from the presence of their parents.

14.15. There were not any house-to-house enquiries made, to assist with the case. Dash Cam, and/or domestic CCTV was not considered, and evidence led approach could have been considered, and for police to take positive action.

14.16. Elouise missed appointments with Domestic Abuse Charity A on 27th February, and 6th March 2019.

14.17. On 24th February 2019 Norfolk Constabulary were contacted regarding Elouise assaulting her younger sibling Mia, and officers attended the home. Elouise told them that Clive often accused her mother of having affairs. The officers recorded they had noticed that Rachel was afraid of Clive. She had denied domestic abuse issues within the home, and did not want any letters sent to her, which concerned the officers as they suspected this was because Clive would open all the mail delivered to the family home. Police case notes included observations that the family were "dysfunctional", and suspicions that Elouise was a victim of abuse from Clive.

14.18. Mia was not spoken to away from the home, best practice would have been to speak to her at school. The Officer in Charge (OIC) recorded that "*there is so much going on with this family*" that he was at a loss as how he could accurately assess the risk to Mia. This statement is of concern, as it indicates that the officer had given up on the family as too problematic to manage. There is evidence that the overall case was supervised but there is no evidence that the officer sought assistance from their supervisor to help them formulate the appropriate risk rating. However, the officer did flag the matter to the MASH for review; and Rachel was referred to MARAC. Rachel was not aware of and had not therefore consented to the MARAC referral.

14.19. The Child Protection Incident was shared as per MASH protocol with CSC. This did not meet the threshold for a S.47 strategy discussion. The assumption being, that Elouise had left the home, so risk was reduced. Presumably situating Elouise as the problem. However, the wider safeguarding of the family was not considered.

14.20. On 1st March 2019, a further domestic abuse investigation against Clive was undertaken. Clive was not arrested and was interviewed at home for the offences. There is no rationale recorded for this decision. Opting to arrest due to the alleged assault on Elouise would have enabled all family members to be spoken to whilst Clive was in custody and opened the possibility of bail conditions to further safeguard the whole family. A more robust intervention could have given the victims confidence in police, and they could have been protected via bail conditions. This may have enabled disclosures longer term from Rachel as well as Elouise.

14.21. Police responses to domestic abuse have improved significantly in recent years, with specialist trained officers and a variety of legislation and initiatives to support their work.[47] However, research indicates that there remains a lack of understanding amongst officers of the impact of domestic abuse on children.[48]

14.22. On 4th March 2019, Mia's school contacted CSC for advice, following a concern raised by the children's maternal grandmother about Clive's behaviour and how the children were afraid of him. The school were also concerned about Mia's attendance, presentation, and development. CSC advised the school to speak to the children and advised that should they raise any concerns or if there is any evidence of risk then a further assessment may need to be considered.

14.23. On 6th March 2019, Leeway received an IDVA referral for Rachel from police, along with the MARAC referral. This referenced the assault on Elouise, and disclosures from Elouise regarding Clive's behaviour. Leeway contacted Rachel, and she agreed to a meeting on 12th March 2019 – held at Mia's school. This meeting was cancelled by Rachel, and a new meeting was booked for 19th March 2019.

14.24. On 7th March 2019, Elouise told the DSL that since the police and social worker had visited, Clive had been more abusive. He was blaming Elouise for the upset and was telling the family he would kill himself. Elouise felt the CSC being involved had made it worse, she had not been told who her social worker was, and all her family were blaming Elouise. She had been offered by her aunt to go and stay there, but Clive had attacked her uncle in the past and she did not want to make matters worse. She stated that she was under too much pressure to engage with Domestic Abuse Charity A support, although there is no record of who she felt this pressure from. The DSL chased the social worker, and advised Domestic Abuse Charity A that Elouise did not feel able to engage at that point, and the Charity closed their case with Elouise.

14.25. The MARAC for Rachel was held on 12th March 2019. Leeway raised concerns for Rachel's safety. CSC stated that Rachel was obviously frightened of Clive, and it was clear that Clive dominated Rachel. There were no actions noted as Rachel was recorded as being supported by advocacy, and as engaging with CSC.

[47] Davies, P et al "The Hard and Complex Work of Implementing New Multi-Agency Risk Assessment Approaches to Policing Domestic Abuse" *Crime Prevention and Community Safety* 25 (2023) pp.148-165

[48] Millar, A et al "Police Officers Do Not Need *More* Training, But *Different* Training. Policing Domestic Violence and Abuse Involving Children: A Rapid Review" *Journal of Family Violence* (2022)

14.26. On 19th March 2019, Rachel met with the IDVA at Mia's school. Rachel stated she was Clive's carer due to ME, they had been together for nearly thirty years, and she did not have a social life as she devoted all her time to her husband and children. She blamed Clive's behaviour on his illnesses. She completed a DASH risk assessment with the IDVA, which came out as standard, however the IDVA recorded that she did not believe Rachel gave accurate answers. Rachel was given Leeway's telephone number to put in her phone under "GP", in case she decided she wanted to speak to them. When the IDVA was leaving the school, the reception staff explained that Clive had been asked not to come to the school because of the rude and threatening way he spoke to female staff.

14.27. There was a social work visit to the family on 27th March 2019, however there is no record of this visit. This is one of a series of visits to the family which were not recorded.

14.28. On 28th March 2019, Clive was assessed by CGL[49] for cocaine use and referred to psychosocial groups.

14.29. On 7th April 2019, Elouise called police to report that her mother had been punched in the face by Clive. Police investigated a report of Actual Bodily Harm (ABH).[50]

14.30. Rachel was spoken to by police and CSC. She described the household regularly walking on eggshells due to Clive's moods. Rachel was seen with bruising and stated Clive had assaulted her throughout their whole relationship. Elouise disclosed that her youngest sibling Child A had been assaulted by Clive.

14.31. On this occasion, Clive was arrested. Police powers under Section 46 of the Children's Act 1989 give the police powers to remove children to a safe location for up to 72hrs to protect them from "significant harm", however there is no evidence on the record to suggest this was considered, the assumption being that this would not have been an appropriate course of action as immediate action was taken in that Clive was arrested.

14.32. Upon attendance at the home, Elouise was spoken to and stated, *"she doesn't feel safe in the property with her dad".* Attending officers risk assessed the case as medium, despite Rachel responding "no" to almost all of the DASH questions. There was good use of body worn cameras. Elouise was tearful throughout further interactions, and this was also captured demonstrating foresight from the attending officer.

14.33. Elouise initially supported a prosecution, Rachel did not provide a statement, Clive answered no comment to all questions. While he was in custody the OIC attended

[49] See Table at section 7
[50] S.47 Offences Against the Person Act 1861

the home, providing Rachel with more time to consider her options. Rachel opened up that in 23 years together Clive had always assaulted her, however she did not consider herself a victim of domestic abuse.

14.34. Clive spent the maximum period, without an extension being sought, in custody. During this time, he was taken to hospital with chest pains. He was bailed with conditions not to go to the family home, and a condition not to contact Rachel or Elouise.

14.35. During the investigation, house to house enquires were undertaken – there was a thorough and well-planned investigation, with clear supervisory records and action plans. Rachel did not want to go to a refuge and was working with Leeway. Information was shared with the EDT via MASH, and a S.47 strategy meeting was held shortly after. The outcome of this was a joint s.17 investigation with work and assessment to be completed with parents and children by CSC.

14.36. Clive was bailed away from the home, with conditions not to contact Rachel or any of the children, until 11th May 2019. The Crown Prosecution Service did not agree to a charge as the evidential threshold had not been reached, and there was a No Further Action decision made.

14.37. On 9th April 2019, Elouise's boyfriends mother contacted police about incidents of harassment and domestic abuse which her son had witnessed at Elouise's family home. Elouise's boyfriend had been intimidated and threatened by one of Clive's friends – this was encouraged by Clive. Rachel tried to intervene and was pulled away by Clive. Once home Elouise's boyfriend told his mother who called police. Police spoke to Clive, who stated he was a victim of Rachel's abuse and that he required a safeguarding referral, as he was a vulnerable adult and a wheelchair user. Police liaised with Adult Social Care (ASC) who confirmed they had not had contact with Clive for 18 months, and ASC confirmed they did not believe he required a safeguarding referral.

14.38. On 12th April 2019 Clive was seen at Hospital A due to chest pains. Investigations were completed and he remained in the observation ward overnight. He was discharged with a follow up to the Acute Ambulatory Care (AEC)[51] on 15th April 2019. He was booked for an electromyography (EMG)[52] as an outpatient due to distal weakness and muscular dystrophy. He was also sent for a review with a neurologist as an outpatient.

[51] A short stay medical unit that provides urgent assessment, investigation and management for patients with new medical problems and ongoing chronic illnesses.
[52] A diagnostic procedure to assess the health of muscles and the nerve cells that control them. the EMG can reveal nerve dysfunction, muscle dysfunction or problems with nerve-to-muscle signal.

14.39. Elouise made a claim to Universal Credit on 12th April 2019, this was closed on 20th May 2019, due to Elouise not attending her initial interview.

14.40. On 14th April 2019, Leeway received referrals for both Rachel and Elouise from police. Initially a MARAC referral had been completed for Rachel only, however, when the case was reviewed by the Police it was identified that Elouise was also a victim of domestic abuse and that she could be at risk of harm. It was therefore decided that Elouise would also be offered IDVA support in her own right. Contact was attempted on the day of referral but not established until the next day. As there was a current case open to CSC, a further referral was not required, and safeguarding procedures were followed to ensure that CSC were aware of the Leeway involvement. Bail conditions remained in place. Police advised that listening devices may be installed in the family home, and Rachel had been seen with bruising. Rachel did not want to move out of the family home and stated she felt safe at home.

14.41. On 15th April 2019 the Leeway IDVA spoke to Elouise who said she was really scared and requested a refuge space, although she only wanted to go to Lincolnshire, so she could commute to college. Elouise had already spoke to Lincolnshire Council and who she had advised her they would help with temporary accommodation, if she is being supported by a domestic abuse agency, however Elouise was too young to apply for housing benefit.

14.42. Also, on 15th April 2019, the Strategy Meeting was held. The threshold was considered for an Initial Child Protection Conference (ICPC), however due to bail conditions being in place and Rachel working with Leeway, it was agreed for the case to continue to be held at Child in Need.[53]

14.43. On 16th April 2019, Leeway recorded that Elouise had moved in with her boyfriend and his mother in Lincolnshire. She was commuting for college, and the boyfriend's mother confirmed to the IDVA that she was supporting Elouise. IDVA advised Elouise to approach the local council for local support services if she was intending to remain in Lincolnshire. Elouise did not answer calls from Leeway for the next two weeks.

14.44. The social work team manager spoke with Clive the same day, who stated that Elouise had been acting strange and suggested she was using drugs. Clive alleged that Elouise had assaulted her siblings and had caused the injuries to Rachel. A plan was made for the social worker to address these allegations with Rachel.

[53] S.17 Children Act 1989

14.45. An appointment was set up for Rachel with the Child Abuse Investigation Unit (CAIU) for 18th April 2019, however Rachel did not attend, and her phone was switched off, as was Elouise's phone.

14.46. On 23rd April 2019. CGL closed for Clive due to non-engagement.

14.47. On 23rd April 2019, a parenting assessment was completed by CSC. Both parents accepted that Clive became angry, but both denied he had ever hurt anyone in the family. Although Rachel was reported to be a carer for Clive, concerns were raised within the assessment that he was using bad health as a distraction. It was assessed that boundaries set at home for Dan were very different to those set for the female siblings. Clive dismissed any concern by the school. The control Clive had over the whole family was assessed as very worrying. A plan was agreed to support Rachel through Leeway, to undertake direct work with the children and to re-refer Elouise to Domestic Abuse Charity A. There was also a plan to support to Clive to address his anger, which is not appropriate where domestic abuse is identified. Perpetrators of domestic abuse do not have issues with anger; they have issues with control.[54]

14.48. On 23rd April 2019, Elouise self-referred to EDAN Lincs. She was seeking support for herself and her boyfriend. At the time she was staying at her boyfriend's parent's house in Lincolnshire. During the initial assessment, Elouise was able to speak of the immediate current situation she was fleeing, who from and what she felt was the types of abuse she had suffered throughout her life. Elouise stated that an incident involving her mother and herself had occurred in Norfolk, where she was awaiting police to take a statement. The details of the offence related to Clive and some of his friends keeping her, and her boyfriend locked in their house for hours. Elouise did express a history of abuse and control by her father in the preceding years, and some weapons used around a year before her contact with EDAN Lincs. Elouise had stipulated that she had reported this to Norfolk police service and that CSC were involved with the family. Elouise provided the triage worker with the social worker's details, but she was not able to provide contact details.

14.49. Elouise had stated at the time of the pre-assessment that her father had been arrested and was on bail to stay away from the house until 10th May 2019. She indicated that she felt he would return to the address after the bail expired. Elouise had alleged at the time of the pre-assessment that Clive used cocaine and weed almost daily. She stated that Clive had anger issues, paranoia and ME. The social worker told the EDAN Lincs worker that Clive was controlling in the family home, and whilst they were aware of verbal abuse, she was unaware of any other abuse at the point.

[54] Standards for domestic abuse perpetrator interventions: GOV.UK

14.50. On 24th April 2019, the College DSL met with Elouise and her boyfriend. They were both scared that Clive would harm them because they had reported him to police. Both understood that if Clive contacted them, they should contact the police. Elouise told the DSL that during the Easter break her father had attacked her mother and the police had been called to the family home. This had been reported to the college via Op Encompass.[55] Elouise was concerned that when Clive realised that she was not living at home, he would "go mad" and might turn up at the college as he had turned up at Elouise's work previously. The DSL assured her that he would not be permitted on college grounds. The DSL provided Elouise with some money and authorised free meals at the college. The DSL agreed to continue to provide funding for the bus to college until her housing situation was resolved.

14.51. Following the meeting, the DSL contacted CSC and gave an overview of the update – highlighting her concerns for the safety of Elouise and her younger siblings. CSC updated the DSL with the situation and explained that there had been a Strategy Meeting. However, the DSL had not been made aware of this meeting. The DSL expressed her disappointment at not being involved in the meeting, as she had a lot of information to share about Elouise and the family.

14.52. On 25th April 2019 the College DSL re-referred Elouise to Domestic Abuse Charity A. On the same day EDAN Lincs contacted Elouise and left a voice mail.

14.53. Also, on 25th April 2019, the family had a social work visit, however aside from a note to that states the younger children were all seen, there is no record of this visit.

14.54. The following day, Elouise called CSC and spoke with an Emergency Duty Team (EDT) worker. Elouise stated she had seen Clive in the street and had reported it to Lincolnshire police. Elouise's boyfriend's mother was concerned for Rachel and the other children and was advised by the EDT to request a welfare check by the police.

14.55. On 28th April 2019, Leeway IDVA spoke to Elouise – she said she was fine and staying at her boyfriend's house, she said she wasn't sure if she needed anything from Leeway and agreed to them calling her again.

14.56. On 29th April 2019, the social worker called Elouise's boyfriend's mother following the call with EDT. She expressed concerns about Clive similar to those discussed in the strategy discussion. Elouise reported being fearful of bumping into Clive or one of his friends. this was reported to the Police. There was a request to police to complete a welfare check on Elouise's mother and siblings. There is no record of whether these checks were undertaken.

[55] A police initiative, where a child's school is informed when there has been an incident of domestic abuse within the home Home: Operation Encompass

14.57. During this time, Clive self-referred to NSFT talking therapies and declined treatment when they returned his call.

14.58. On 30th April 2019, the Leeway IDVA called Elouise. She said she was still fine and was engaging with EDAN Lincs, who were helping her with housing, Elouise agreed to her Leeway case being closed. On the same day Elouise spoke to the College DSL, stating she had not heard back from CSC. She was concerned that her grandmother had said that Rachel's car was not at the house and the children had not been at school. Elouise returned to the College DSL again later and discussed having suicidal thoughts, saying she had been feeling that way for two weeks. She disclosed previous suicide attempts around July 2018, through cutting her wrists and also that she had attempted jumping off a bridge, but the water had not been deep enough. The College DSL gave Elouise a crisis card, and Elouise agreed to call 111 if she was suicidal. Elouise agreed to see the College counsellor to discuss her anxiety.

14.59. On 2nd May 2019, Domestic Abuse Charity A staff confirmed that they would support Elouise and would contact her. The same day, the College DSL contacted the social worker, who stated that they had been investigating and would be holding a strategy meeting. The social worker stated there were some inconsistencies in what Elouise has said, and she had also heard the suggestion that Elouise wanted to be housed with her boyfriend. The social worker said she would look into mental health support for Elouise, but that she could return home as Clive was bailed not to be there.

14.60. On 3rd May 2019, Elouise raised a concern with CSC as she had not been in contact with Rachel for some time and she had concerns about her. The social worker was concerned that the children were not in school. The social worker contacted Primary School A who attempted to contact Rachel.

14.61. The Child Abuse Investigation Unit (CAIU) had received an email from Elouise stating she was concerned that Clive may be staying with Rachel and the three children somewhere. Several checks were carried out, and on 6th May 2019 Rachel returned home. Police spoke with Rachel who stated she had not seen Clive since the night he assaulted her, and she had taken the children away for a few days as it was all getting too much, she agreed that she should have let someone know her whereabouts.

14.62. Elouise saw the college counsellor on 7th May 2019, and spoke about her anxieties, including that if her boyfriend went quiet, she was worried he was about to hit her, like her father used to.

14.63. On 8th May 2019, Elouise spoke with EDAN Lincs. She described an incident from 8th April 2019, when Clive had locked her and her boyfriend in the house, and Clive encouraged one of his friends to pin Elouise down and stated that the police were

investigating the incident. She was staying temporarily with her boyfriend, and CSC were involved with her siblings. Elouise gave social worker's details and EDAN Lincs' support worker spoke to them. CSC were aware of the incident and advised that a Child in Need (CiN) meeting was taking place. They confirmed Clive was controlling. The Social Worker also stated that Elouise and her boyfriend were looking to obtain a house.

14.64. The CiN meeting was held the same day, Rachel in attendance, Clive was not present. Concerns raised about domestic abuse, professionals agreed that threshold for Child Protection had been met, strategy discussion planned, and an Initial Child Protection Conference was arranged. Rachel remained adamant that she was not returning to Clive, and the Primary School stated they had been concerned about domestic abuse for some time. There were discussions about a plan for Clive to attend "anger management", although it was not clear from the notes whether this plan was shared with Clive.

14.65. On 10th May 2019, Elouise was taken to the CSC offices by her boyfriend's mother, stating she could no longer stay at their home. On this day EDAN Lincs and Leeway both spoke to Elouise about her housing situation. She required support with accessing a refuge. Elouise was not accepted by any refuges as she was under eighteen and was not entitled to housing benefit. It was agreed that Elouise would move to her Maternal Grandmother's house.

14.66. On 13th May 2019, Elouise met with Domestic Abuse Charity A staff, she raised that she did not feel supported by the family's social worker and stated that previously having been accepted at a Foyer[56] she had lost her space as the social worker did not provide a signature in time. Elouise believed that the social worker had been brainwashed by Clive, and that her mother had been in Clive's company for the past week, although Rachel was telling CSC she was staying away from Clive.

14.67. The following day, the social worker advised the college DSL that there would be no further police action and Clive's bail conditions had ended. Clive had returned home. Elouise remained staying with her grandmother.

14.68. On 15th May 2019, Rachel told her IDVA that Clive had returned home, and she did not need any help. Leeway had not been aware of the bail conditions ending. There was a lack of professional curiosity used by the IDVA, and there was no further exploration with Rachel about the situation. The alarm which was due to be fitted was cancelled and the IDVA updated the social worker two days later. Since the scoping period of this review, the IDVA team now have access to Athena and can check matters such as bail conditions when they are working co-located with police teams.

[56] This is a staffed hostel for young people

14.69. In May 2019, Elouise reported her father for crimes involving firearms, or imitation firearms, with intent. This related to incidents spanning January 2017, to December 2017. Elouise was seventeen at the time and was contacted by a Detective specialising in child abuse within the MASH.

14.70. The National Firearms Licensing Management System was checked by the MASH officer as part of the safeguarding protocol.

14.71. Following this disclosure, information sharing occurred in a timely manner, and a S.47 strategy discussion was convened. This focused on the whole family and assessment. An evidence-led approach could have been considered in respect of this reported offence, and police could have taken positive action irrespective of Elouise wishes.

14.72. On 15th May 2019, police attended the family home, with a warrant to search due to a disclosure made by Elouise to the EDAN Lincs IDVA that there were weapons in the home. The weapons found were old, not in use, or replicas. No items were seized.

14.73. By leaving the items in the home, they are available to Clive to continue to use when making threats towards the children. They would not know that the items were replicas, or no longer in use. These items could have been seized as part of evidence of an offence, or if it was suspected they would continue to be used by Clive as threatening objects, however officers were not investigating regarding coercive and controlling behaviour, and no other offences were identified, so the items were left with Clive.

14.74. A CiN meeting was held on 17th May 2019, it was shared that Elouise was still afraid of Clive and would not be returning home. Child A had also told the SW about Elouise being assaulted and shouted at. SW was aware of the weapons being found at the home, “two legal air rifles with no ammunition found”. It was decided that no ICPC would be necessary, although it was acknowledged that Clive was controlling and verbally abusive. It was agreed that the s.17 planning would continue. Plans for Dan’s views would be sought, and SW would meet with both parents, to consider a wider family network to facilitate Elouise’s return to the family home. A decision was made to reconvene a strategy discussion if further safeguarding concerns emerged.

14.75. The planned Strategy meeting went ahead on 17th May 2019. The police advised that no further action was taken as Rachel was unwilling to give a statement, however an active investigation was underway regarding threats to Elouise’s boyfriend. Plans were made to encourage Clive to the next CiN meeting. During discussions - which were recorded in individual agency notes - Primary School A raised a concern that something serious would happen, before action was taken,

and Secondary School A also raised similar concerns. However, all agencies agreed that the threshold for an Initial Child Protection Conference was not met, and the minutes of the strategy discussion did not reflect the concerns raised by the schools, which were recorded in their own meeting notes.

14.76. Elouise returning to the family home appeared to be driver for some time after this Strategy Meeting. Part of the team manager's analysis in the Strategy Meeting notes on 17th May 2019 stated that "*it was agreed that further work is to be undertaken with the family by Children's Services…. including a frank and open discussion to be had with the parents around professional's concerns…consideration for wider family network meeting to facilitate Elouise's return home…"* This reference to Elouise returning home was then re-referenced by social workers, and within other agency case notes for weeks to come. The team manager also noted the need for a safety plan, there is no record of one being completed either with Elouise, or for her.

14.77. On 20th May 2019, CSC received a call from District Council A Housing Team, Elouise was with them and refusing to return to her grandmother's house. The Housing Worker was concerned about the abuse Elouise was disclosing. Elouise was advised to return and remain at her grandmothers with a safety plan in place. Through the research carried out for this review, no safety plan could be located. Referencing a safety plan, when there is nothing written and robust in place, is potentially dangerous practice as it provides a false sense of security to other agencies and is confusing for the victim(s).

14.78. On 21st May 2019, Elouise reported to have seen Clive whilst out walking. He was in the car with the family. Elouise stated Clive initially was nice to her, but then became angry. He stated he was "king" and would pay someone to burn her boyfriend's house down. This was reported to police, CSC was made aware, and Elouise spoke to the DSL at her college and Domestic Abuse Charity A about the incident. Elouise stated that no one was listening to her, and no one was taking her seriously. She stated she didn't feel safe at her grandmothers, as it wasn't far from the family home, where her father was living. Elouise told the College DSL that she spoke with the social worker about moving to the Foyer, she was told there was no funding for this, and that Elouise could return to the family home, but that Clive would not be permitted to speak to her. Although this is a third-party report from Elouise to the DSL, if the social worker was encouraging Elouise home, with unrealistic expectations of Clive not to speak to Elouise within the home, this indicates a worrying lack of understanding of coercive control. Elouise also raised a concern about a mark on Rachel's eye she had seen while in the car with the family. It was documented by police that this injury would need to be dealt with by way of a welfare check to Rachel; however, there is no clear evidence that this was completed.

14.79. Elouise called EDAN Lincs, and they had found her a refuge in Birmingham, but Elouise was worried this was too far away, as she wanted to finish her college course. EDAN Lincs updated the social worker that Elouise had become upset when told the EDAN Lincs case being closed, and that Elouise had not been aware of the safety plan which CSC had put in place. The social worker stated that Elouise was partly driven by her wish to be near her boyfriend in Lincolnshire. However, it is now clear, as mentioned above, that there was not a safety plan in place, therefore Elouise's confusion is understandable.

14.80. She disclosed further information about Clive using drugs when the children were around and giving Elouise and Dan drugs. Elouise also told the College DSL that during the period of bail, Clive had been with Rachel and the younger children on holiday away from Norfolk. She repeated that no one believed her as there was no evidence. The DSL emailed the social worker with this information.

14.81. The social worker spoke with Elouise at college; it is recorded that Elouise was "challenged" about why she did not contact the police straight after the incident as per the safety plan they had put in place. Elouise was placed by housing in a B&B overnight.

14.82. As mentioned previously, there was no formal written safety plan, although it is referenced regularly by social workers and also across other agency records. There was a preoccupation with Elouise's housing situation, and this overrode any real exploration or understanding of the risks Clive posed, or the effects of his behaviours on Elouise.

14.83. The following day, the social worker spoke with Rachel and concluded in their notes that Elouise was making *"assiduous effort to convince everyone she is homeless". Rachel* shared that Elouise had been to the family home, which it is thought "*contradicted what Elouise said about feeling frightened to go home*". The SW advised Rachel to tell Elouise she could stay at her grandmother's if she continued to refuse to return home.

14.84. On 24th May 2019, two social workers attempted a home visit, there was no answer, and all blinds were closed. Elouise again contacted CSC stating she could not go home and was homeless. She was advised to call police if she felt unsafe.

14.85. In the absence of a robust and written safety plan it is not clear whether social workers involved Elouise's grandmother in any of the plans. A lack of risk assessment, and safety planning would have failed to provide assurance to Elouise that she would be safe at her grandmother's house.

14.86. On 28th May 2019, Elouise attending the CSC office stating she could not stay at her grandmothers due to safety. Clive had made threats towards her and her boyfriend. Elouise was told by the social worker that she could stay at her

boyfriends or her grandmothers, the social worker also advised she would be speaking to Elouise's parents. The Bed and Breakfast accommodation provided by Lincolnshire housing remained available to Elouise until 31st May 2019.

14.87. Also, on 28th May 2019, Clive attended Practice B and saw the nurse, he was complaining of night sweats and weight loss. There is a record that the GP spoke with Rachel and advised that Clive should see his own GP. He had a blood test; however, Clive did not return as requested for the blood results.

14.88. On 30th May 2019, Elouise spoke to Leeway, she disclosed non-fatal strangulation by Clive in the past, and stated he had told her to return home, or he would chop her up into little bits. Elouise stated she was petrified, he knew where her grandmother lives and Elouise stated he used cocaine, had terminal cancer, and was volatile and unpredictable. The social worker was updated. It is recorded that the Leeway IDVA had closed Elouise because she was engaging with Domestic Abuse Charity A and lots of other services, she was therefore closed to Leeway IDVA. The same day, Elouise spoke again to the College DSL and was distressed that no one was helping her. The DSL spoke to the new Social Worker who stated that Elouise had access to a bed and breakfast in Lincolnshire until 31st May 2019. The social worker reiterated that Elouise could return to the family home, or to her grandmothers. The College DSL and Domestic Abuse Charity A spoke with Elouise, who stated she had lied the week before, and that she had been with her father, as she felt she had to check on the younger children. She stated that Clive drank and drove and took the children with him when he collected drugs. The Domestic Abuse Charity A worker planned to complete a DASH, but Elouise had an exam to go to. Elouise confirmed she was leaving the bed and breakfast and returning to her grandmothers that day, which was near to the family home.

14.89. Within the DASH completed with Elouise, she made clear disclosures on family life, including Clive regularly slapping and punching, and calling all family members names. She referred to him slicing carpets with an axe and destroying the washing machine/fridge. Elouise referenced to breaking her shoulder when she fell rushing to get home on time, and Clive had refused to take her to hospital for three hours. This information correlates with information held by Hospital A from July 2018 where Elouise had an oblique shaft fracture of her right clavicle, sustained at 8pm when she is said to have fallen off her bike.

14.90. The DASH completed with Elouise also stated that Elouise would frequently access the college student support, telling them she is frightened of Clive, and would cry, curled up in a chair and plead for help to get away from him, and to keep her family safe.

14.91. The information gathered in this DASH should have led to a strategy discussion and consideration of s.47. Following the DASH completion, the College DSL made a MARAC referral for Elouise.

14.92. On 2nd June the Leeway IDVA spoke to Elouise, who stated she was currently feeling ok staying at her grandmothers, and she had an alarm. The IDVA called the new social worker, who explained that due to family members being able to take Elouise in, and because she was too young to receive housing benefit, CSC were unable to provide Elouise with accommodation.

14.93. Clive was seen at Practice B on 6th June 2019; he had a painful groin swelling and continued to complain of night sweats. He was treated with antibiotics.

14.94. The MARAC referral was received on 6th June 2019. A temporary social worker attended the MARAC due to the allocated worker being on annual leave. Domestic Abuse Charity A spoke to the temporary social worker on 10th June 2019, who stated that she had visited the family, had no concerns, Clive could be "short" at times, but he was happy for Elouise to be living with her grandmother. The social worker had not been aware of the MARAC referral. At the MARAC meeting, the MARAC Chair recommended that a Strategy Meeting be held – this was not actioned, and no further action was taken by CSC.

14.95. The social worker saw the children at their respective schools. The Domestic Abuse Charity A worker was concerned about the disclosures made by Elouise when she completed the DASH, which included incidents involving the children who remained at the home with Clive. The case remained under CiN following a review meeting on 12th June 2019. Concerns were raised that parts of the plan which involved Clive were not shared with him, including a requirement for him to seek support for anger management.

14.96. On 13th June 2019 the Leeway IDVA spoke to the social worker who advised that Elouise was staying with her maternal grandmother, an alarm had been fitted at her grandmother's house, and Elouise was engaging well with Domestic Abuse Charity A. It was agreed that IDVA would close the case as Elouise was being supported by Domestic Abuse Charity A and the social worker would also continue support.

14.97. The social worker met with Rachel, who clarified that all of the incidents described by Elouise on the DASH had occurred. The social worker tried to arrange a follow up meeting, but Rachel then cancelled these meetings twice, stating the Clive did not want the social worker at the house.

14.98. Following Rachel's confirmation of Elouise's disclosure of Clive's ongoing abusive behaviours, further action should have been taken to protect the children who remained in the home.

14.99. On 16th June 2019, Clive self-referred to NSFT for talking therapies, however dropped out of the service after it started.

14.100. On 20th June 2019, Clive was seen at Practice B with ongoing lymph nodes and with a fever. He was referred urgently to haematology[57] but did not attend the appointment he was sent.

14.101. On 25th June 2019, Elouise had a meeting with the DSL and was happy that she had achieved a merit in her last exam, meaning she could progress onto the next year. She stated that she was living between her maternal and paternal grandparents' and had reconnected with an uncle who was very supportive.

14.102. A further MARAC referral was received by Leeway for Elouise on 26th June 2019. The case was reduced from high to medium risk at the MARAC. The IDVA contacted Elouise through her boyfriend and organised a safety phone for Elouise at the local police station. Elouise did not collect this phone. There was no further contact with Elouise, and the case was closed to the Leeway IDVA service on 25th July 2019.

14.103. On 28th June 2019, Police arrested Clive for drug driving. Police updated CSC regarding this arrest and also discussed the alleged threats to kill Elouise and her boyfriend. Police also updated CSC regarding Clive telling the children that he had cancer, and that they had caused it. This is emotional abuse and did not appear to be recognised as such. Following this police involvement and further allegations, a Strategy Meeting should have been held to share the ongoing and increasing risk.

14.104. A MARAC referral was made to Norfolk MARAC by police, following disclosures made by Elouise to EDAN Lincs and passed to Norfolk police, whilst she was residing in Lincolnshire. Elouise had stated Clive had chased her with a firearm and with an axe, one or two years previously.

14.105. Mia was seen at school on 1st July 2019 and was recorded as being happy.

14.106. The MARAC for Elouise was held on 3rd July 2019. During the meeting, the information Elouise told EDAN Lincs regarding disclosures of the threats with offensive weapons, was shared by Leeway. It was noted in the MARAC minutes that Elouise had made previous suicide attempts. There is no indication that Elouise's mental health was discussed at the MARARC. The information shared at the MARAC, and the ongoing risk of harm posed by Clive should have led to a Strategy Meeting.

14.107. Leeway called Elouise via her boyfriend on 3rd July 2019, she was at her grandmothers but didn't feel safe there, she was offered a safety phone as she no longer had her own phone, she accepted this offer but did not arrive to collect it.

[57] Investigation, treatment and advice to patients on a management of blood conditions.

14.108. On 12th July 2019, an incident was reported which was alleged to have occurred on 17th June 2019. The allegation was that Elouise had grabbed Mia by the neck and had tried to push her down the stairs. Police attended the home and recorded that body language suggested Rachel was submissive, and Clive was possibly manipulative. Officers commented that there was so much going on in the family they were at a loss to accurately risk assess.

14.109. Clive was seen at Hospital A for a swollen cheek and an abscess, for which he was prescribed anti-biotics and discharged home for an abstraction by his dentist.

14.110. On 16th July 2019, Elouise made a claim to Universal Credit. attended her initial appointment, after which a note was added to her claim confirming that she had been "removed from her parents' house by CSC due to her abusive father." Elouise applied for an advance[58] which was approved, and her first payment of UC credited was on 22nd August 2019. Although Elouise did discuss experiencing domestic abuse, apart from this first contact, she did not provide a name for the person subjecting her to domestic abuse – and neither was she asked about this. This was a missed opportunity to gain further information of the abuse.

14.111. The CiN review took place on 23rd July 2019, the CiN plan was to continue. It is recorded that progress on the plan was questionable. Clive had not been spoken to about his anger and was not attending any CiN meetings. Clive had been referred to Change Live Grow (CGL), as part of the CiN plan, but he discontinued this after one appointment, citing disability discrimination. There does not appear to have been any follow up with him about this by CSC. There was no sense of progress for Rachel working with Leeway. Mia was seen at school, and they were recorded as being happy.

14.112. Leeway closed their case with Rachel on 23rd July 2019.

14.113. The Domestic Abuse Charity A support worker met with Elouise on 30th July 2019. Elouise had not been able to get in contact with the Social Worker and was upset about her father's ongoing controlling behaviour. Domestic Abuse Charity A chased up the Social Worker and did not get a response. The next day Elouise attended the CSC offices and saw the Social Worker, Elouise shared that she was worried about Rachel and her siblings.

14.114. On 2nd August 2019, Elouise called 111 with back and chest pain, which she stated she had been suffering with for a week. There is a record of social stressors, and that she was living with her grandmother. All investigations were normal, and the impression was anxiety related symptoms.

[58] An interest free loan from the DWP, which is paid back from the monthly Universal Credit payments

14.115. On 6th August 2019, Elouise met with Domestic Abuse Charity A, she was excited about finding somewhere to live but just needed to find the deposit. Elouise told the Domestic Abuse Charity A support worker that her mother had started to open up to the family's social worker.

14.116. On 19th August 2019, the social worker visited the family home. Clive interrupted the social worker constantly whilst she was talking to Dan. Clive believed that Elouise was being "held hostage" and used by her Grandparents. He considered Elouise to be his princess. He talked about his Post Traumatic Stress Disorder (PTSD)[59] and other problems. There were no concerns recorded about any of the children's presentation. The social worker planned to speak to her manager about closing the case.

14.117. On 20th August 2019, police were called by Rachel. Clive had threatened to set her alight and burn the house down. Rachel opened up to police, stating Clive had been violent over the years. Clive was arrested at the home for common assault and battery; Rachel and the younger three children went to a refuge in Lincolnshire.

14.118. Following the arrest, an officer from the MASH took safeguarding measures, and provided regular support to Rachel for the following six weeks.

14.119. At refuge, Rachel was very nervous and very open about not wanting to be in the refuge. She stated her social worker had told her if she returned home the children would be made subject of Child Protection. Rachel was petrified of having the children removed. The social worker visited Rachel in refuge on 22nd August 2019.

14.120. On 22nd August 2019, Clive self-referred to NSFT Talking Therapies, citing drugs and alcohol concerns. He was signposted to CGL. Clive also attended Practice B, spoke to his GP and admitted to kicking his wife during an "argument" two days previously. He also admitted drug and alcohol use. He had moved from the family home and was having trouble sleeping, for which he was provided with sedatives. These disclosures did not trigger any professional curiosity, or safeguarding referrals for the children.

14.121. On 23rd August 2019, Rachel spoke with the refuge support worker, she was concerned that Dan felt uncomfortable in the refuge. The refuge staff looked for a self-contained flat for the family, one was found in another county. Rachel stated this was too far, staff agreed to check the availability of self-contained flats each day, over the next week. The Social Worker was updated.

[59] A mental health condition that develops following a traumatic event characterised by intrusive thoughts about the incident, recurrent distress/anxiety, flashbacks and avoidance.

14.122. On 27th August 2019, another resident raised a concern that Rachel and the children did not get up until the afternoon, and that Rachel had been going out every day and not getting back until around midnight. They had also heard Rachel on the phone to a male, asking where they should meet him. The other residents believed that Rachel was meeting up with Clive. Rachel denied this, stating she had been meeting up with Elouise.

14.123. Following her review of this report, Rachel spoke about the family's time in refuge. She again clarified that she had not been meeting up with Clive. However, she had been meeting up with Elouise, and Rachel recognises now that Clive was controlling Elouise during this time – and in turn, Elouise was controlling Rachel. She described this to the Independent Chair as "a three-way control situation." Elouise was encouraging Rachel to return home to Clive. Rachel described feeling very uneasy in the refuge, unable to relax, and she knew "he would never let them be free" – she had a doubt in her mind that Elouise may have told Clive about their whereabouts, so they did not really feel safe to stay there.

14.124. On 27th August 2019, Clive was seen at the Practice by a GP who was not his usual GP. Clive was requesting sleeping tablets for PTSD, which he stated was due to a bereavement which was never addressed. He stated he was separated from his daughter due to CSC and Police involvement. He stated he was having nightmares and had lost weight. He was provided with sedatives; his bloods were requested – which came back as normal – and he was advised to follow up with his own GP.

14.125. The following day another resident informed refuge staff that Rachel was using two mobile phones. Rachel had showed the refuge staff all of the calls and messages on one of the phones. The resident also stated that when Rachel came into refuge, she made it clear that she was still with her husband and was still in contact. The refuge asked Rachel to leave, she moved to a hotel in another town in Norfolk, and CSC were updated. Clive was the subject of a Norfolk MARAC on 28th August 2019. There was a strategy meeting held on 29th August 2019. The refuge joined the meeting to update on the situation.

14.126. Also, on 29th August 2019, ASC contacted Clive to ask if he had somewhere to stay that night, as he was bailed to stay away from the family home. ASC offered an assessment for support, and Clive hung up, ASC were unable to get back hold of Clive for the rest of the day and the following day. ASC case closed due to non-engagement.

14.127. Rachel and the children returned to the family home on 30th August 2019.

14.128. Elouise was referred into LPFT CAMHS by her GP on 30th August 2019. It is noted that Elouise was privately renting in Lincolnshire, and she had been experiencing suicidal ideation. Telephone triage was undertaken with Elouise, and

she disclosed physical and mental abuse from Clive. She stated she had a job which she enjoyed and was returning to college the following week. The assessment found that she did not require CAMHS at that time and was signposted to Steps2Change. She was given advice on how to contact LPFT CAMHS Crisis and Enhanced Home Treatment Service's (CCETT)[60] Out of Hours if she needed them in the future.

14.129. Elouise self-referred to Steps2Change on 2nd September 2019, she described her needs as "anger problems and depression". A telephone assessment letter was sent to Elouise for an assessment on 19th September 2019.

14.130. On 3rd September 2019, Elouise told her college DSL that she was struggling to cope emotionally. She was renting a room in Lincolnshire, was struggling financially, and having suicidal thoughts. She was feeling to blame that her mother and siblings had to leave their home and go to a refuge. The DSL referred Elouise to the college counsellor and signposted for benefits entitlement and student finance support.

14.131. Elouise saw the college counsellor the following day, and on 5th September the Student Services contacted Elouise to support with alternative housing options, including the Foyer which had been discounted by CSC earlier in the year.

14.132. Clive saw his own GP on 5th September 2019, stated he was not happy with the way he was being treated by CSC and CGL. He said he had an appointment with the NSFT Wellbeing Service at the end of the month. He stated he missed his family and wanted to return to them. He was prescribed antidepressants and provided with more nightly sedation.

14.133. As Clive had shared some of his behaviours within the family home, the GP could have addressed these with him and signposted Clive to the Respect Helpline.[61] Training for GPs now includes this information.

14.134. The next day, Elouise contacted 111 stating she was going to assault the next person she saw and was suicidal. NHS111 called Lincolnshire police, she was located and returned to her home address. She was supported with speaking to the Lincolnshire CAMHS Crisis Team, a face-to-face meeting was arranged for the following day. At this meeting Elouise voices her struggles with managing her emotions, and suicidal ideation, although denied any plans of intent on acting on the ideation. She disclosed feeling alone, with no support network. She agreed to contact Steps2Change to commence psychological interventions. Elouise was discharged from Lincolnshire CAMHS.

[60] See table at section 7

[61] Respect Phone Line this is a phone line for people who suspect they are perpetrators of abuse, to refer themselves for help in changing their behaviour.

14.135. Elouise had registered with a GP in Lincolnshire, and Lincolnshire CAMHS updated the Lincolnshire GP regarding the contact.

14.136. Around this time, it was suspected that Clive was back in the family home with Rachel and the younger children.

14.137. Domestic Abuse Charity A spoke with Elouise on 9th September 2019, Elouise stated she had not been able to get hold of the social worker. Domestic Abuse Charity A called the Social Worker and was advised of an ICPC booked for 19th September 2019. The Social Worker described Clive as a very scary person.

14.138. CGL updated CSC on 10th September 2019, regarding Clive. He had been seen by the service on 5th September 2019, and had become angry and aggressive, accusing them of discrimination due to his disability. Clive had not returned since this visit.

14.139. Domestic Abuse Charity A spoke with the college DSL on 11th September, stating that Elouise had missed a number of appointments, and they would be closing her case with them.

14.140. CSC tried to undertake a risk assessment with the family, who were all now back in the family home – however Clive would not engage. Rachel stated she had not heard from Leeway, there are records to indicate Leeway had tried to contact Rachel.

14.141. On 13th September 2019, Elouise saw her Lincolnshire GP in person. Elouise described herself as feeling more relaxed and was now on new medication of Fluoxetine. No concerns were raised, and an appointment was made for a review in one week.

14.142. On 19th September 2019, an ICPC was held. The CSC report prepared for the ICPC stated that Clive was banned from the school due to his aggressive behaviour, and that a restraining order had been put in place prohibiting Clive from contacting Elouise – this information is incorrect as there was no restraining order in place at this time. A Family Group Conference was arranged for the paternal family, which no-one attended. The children were made subject of a Child Protection Plan. When asked at the conference why she needed a child protection plan, Elouise stated “because I don’t feel safe with my dad, and I don’t want to know him.” Conference agreed the need for Child Protection Plans under the category of neglect.

14.143. Throughout this period Clive continued to refer to Elouise as his carer. However, there were no referrals for Elouise to Young Carers, or any attempts to speak to Elouise, establish whether she was able to care for Elouise, and/or to assess her wellbeing.

14.144. Also on 19th September 2019, LPFT Steps2Change contacted Elouise for an assessment. She stated she was unable to speak due to being in a Child Protection meeting. She agreed to call back, however LPFT had no further contact from Elouise, and her case was closed.

14.145. The Social Worker spoke with the Social Housing landlords on 19th September 2019, Clive had his bail extended to 15th October 2019, although there had been reports of him being at the family home. Rachel was now back at the property and did not want to move. Clive had stated he wanted to return to the property, and that Rachel was his carer. The landlord advised that Rachel could apply for a property transfer and move without Clive on a new tenancy.

14.146. On 20th September 2019, Elouise saw her Lincolnshire GP face to face. She stated she still had low days, but the medication had improved this. She told the GP she had no support from her parents, and that she believed the relationship with her father was abusive, although she stated she was not in touch with him anymore. There is no follow up recorded – considering Elouise was aged seventeen at this point and has described being estranged from her family, and abusive behaviours from her father, a safeguarding referral could have been actioned by the GP.

14.147. A MARAC meeting was held on 26th September 2019.

14.148. Elouise's Lincolnshire GP sent a referral for Elouise to Steps2Change on 26th September 2019. Elouise was sent an appointment letter for 4th October 2019.

14.149. On 30th September 2019, Clive saw his GP, as he was not getting on with the antidepressants, his medication was changed to another antidepressant.

14.150. Elouise met with the college DSL and shared that she was worried about Clive being back at the family home. The Social Worker was updated about this. Elouise was referred to Domestic Abuse Charity A Project.

14.151. The Social Worker visited Rachel on 2nd October 2019. Rachel stated she had no contact with Clive. Rachel said she wanted Clive risk assessed before he came back home. No record of a risk assessment being completed. Note to visit Rachel every ten days.

14.152. The DSL met with Elouise and the Social Worker on 3rd October 2019. Elouise was still living at the shared house in Lincolnshire; she had not seen Clive but had seen Rachel and her siblings. Elouise is spoken to, about her behaviour towards her now ex-boyfriend, it is understood she had been using social media to bully him. She agreed to stop and understood that if it continued, it would be a disciplinary matter.

14.153. The Steps2Change telephone assessment was conducted on 4th October 2019. Elouise described flashbacks of the abuse from her father. She stated feeling that bad things would happen and said she could not relax. She stated she was jumpy and was always looking out for Clive's car. She was recommended for Cognitive Behavioural Therapy[62] (CBT) and was placed on the waiting list for this.

14.154. On 7th October 2019, Elouise was seen at Hospital A ED due to being a passenger in a car accident., she had bruising to her neck from the seatbelt. No acute injuries were identified; Elouise requested a CT scan[63] for her head.

14.155. On 8th October 2019, CPS decided to take no further action on the assault, and the Coercive and Controlling Behaviour offences, citing inconsistent evidence.

14.156. On 10th October 2019, it is recorded that Elouise and Clive were both back at the family home. Bail conditions had been lifted, Rachel retracted all the allegations around domestic abuse, and Elouise told the social worker that she had made up all of the allegations against Clive. She said that her ex-boyfriend had told her to make up the allegations, and now everyone was back together, and things were back to normal. A plan was made for a risk assessment of Clive to be completed by 25th October 2019, and a home visit was attempted by the Social Worker, but there was no answer.

14.157. From this point, Elouise's behaviour changed from help seeking, to problematic.

14.158. On 11th October 20019, Social Worker tried to make an unannounced home visit, no one was at home. There are also concerns raised about Dan, who stated that he protected his mother and younger siblings when Clive was not at home. Dan appeared flat in mood and did not name any worries when prompted. The social worker was concerned that the children were not being honest about home life. Mia was seen in school, she appeared nervous but said she was enjoying school and happy to have Clive back, said he was better he didn't shout anymore or call them stupid.

14.159. A home visit was conducted on 14th October 2019; the Assistant Practitioner and the Health Visitor were careful with what they said in case Clive was listening. No concerns were raised.

[62] A short-term form of behavioural treatment, which helps people to problem solve, and reveals the relationship between beliefs, thoughts and feelings – and the behaviours that follow.
[63] A computerised tomography scan, which can show soft tissues, blood vessels and bones.

14.160. On 18th October 2019, Dan and Mia were seen by the Social Worker at school. They do not disclose anything; however, the Social Worker is concerned they are hiding something about home. On the same day Leeway is closed for Rachel, she states she is back with Clive, and everything was really good.

14.161. On 26th October 2019, Clive attended a walk-in clinic out of area. He had abdominal pain and coffee ground vomit. He was transferred to ED due to a gastric bleed.

14.162. On 27th October 2019 CSC prepared a report for the Review Child Protection Conference. Concerns were raised about "disguised compliance." The children are recorded as thinking before they speak and being very guarded with their responses to questions. The Manager recommended a step down to CiN. The risk assessment on Clive had not been completed, a plan for this to be completed was extended to 13th December 2019.

14.163. The Social Worker was at the home for a visit on 31st October 2019, and the family arrived home in the car. Rachel said they had been shopping, and they picked Elouise up from college. Clive said he had not been well which was why he hadn't contacted CGL. Social worker recorded no concerns.

14.164. On 4th November 2019 a Core Group was held, concerns were raised that services had stopped due to the relationship resuming, and also due to non-engagement. Risks seem to have increased since the ICPC, with Clive moving back to the family home. He would not attend Core Groups and did not agree with the plan. There was little sense of contingency planning beyond calling police. Also on 4th November 2019, Clive was seen at a neurology clinic appointment at Hospital A, for possible facioscapulohumeral muscular dystrophy[64] and was booked for genetic testing.

14.165. On 7th November 2019, Clive was seen by a GP at Practice B, for a re-referral of a colorectal surgery[65] as he had not attended an appointment for an operation to treat piles in June 2019. It is recorded that Clive was diagnosed with Myalgic Encephalitis.[66]

14.166. On 20th November 2019, the Housing Benefit was reinstated. This had been suspended when there was had been a query about who was living at the family home. All arrears were covered off by the benefits.

[64] A muscle wasting condition caused by a genetic mutation that affects the facial, shoulder and upper arm muscles.
[65] This is a blanket term used to describe a number of surgeries that fix problems with the lower gut.
[66] Also known as Chronic Fatigue Syndrome, it causes extreme fatigue, and affects multiple body systems, including the nervous system, the immune system and the body's production of energy.

14.167. On 21st November 2019, there was an email received from the college DSL to the social worker.

14.168. On 25th November 2019, Elouise was seen in college by the social worker and the college DSL. There had been concerns over Elouise's attendance and behaviour. Elouise told the social worker, "My dad will meet you in court and he is going to report you to the police for threatening and intimidating behaviour for threatening to remove their children and my dad said don't ever come to our house again." The next day there was a report to police by Elouise's ex-boyfriend as Elouise and her friends had been shouting at him at a bus stop, college were informed.

14.169. On 2nd December 2019, there is a Core Group, neither parent attended. CSC recommended a closure to Child Protection, following the Review conference. The Social Worker stated a period of Child in Need would be more appropriate, but they do not believe the family would engage meaningfully. All family members stated that family life was the best it has been. No risk assessment of Clive had been completed due to him not engaging with social workers.

14.170. The Review child protection conference was held on 13th December 2019. Child A's nursery attended and raised a concern about her attendance. Leeway and Domestic Abuse Charity A had closed their cases due to Clive returning home. CGL had discharged Clive due to his poor health and continued use of illegal substances. It is recorded that Clive had stated he'd had a wakeup call" although there was no recorded discussion of Clive's mental health. There was the unanimous decision for the children to be removed from Child Protection, and to be supported under Section 17, Child in Need. The rationale or this being that the children had not disclosed any concerns, they were observed as being happy, progressing in line with their peers at school, and Rachel had not stated any further concerns.

14.171. Rachel missed CSC home visits on 16th and 20th December 2019. Due to Child in Need being a voluntary process, the lack of engagement by the family led to the CSC case being closed in January 2020.

14.172. During January 2020, Elouise was reported to police for sending abusive messages to her current boyfriend's ex-girlfriend. Elouise was dealt with by police for Anti-Social Behaviour, she was also recorded as fighting in town and verbally threatening another student in the street. There were issues with Elouise making fake calls to the emergency services, and acting in a threatening manner, which continued into February 2020. Also, Mia spoke to staff at her school about self-harm, stating she had not done it for a couple of months.

14.173. On 24th February 2020, Clive underwent a colonoscopy which was normal and did not identify any issues.

14.174. Elouise's first CBT session on 26th February 2020 did not go ahead as Elouise did not answer her phone. A voicemail was left. A further appointment was sent for 11th March 2020; this call also went unanswered. Steps2Change was closed.

14.175. On 16th March 2020, Clive registered with GP Practice A. He is noted as having a carer on his new registration. Clive was seen the same day by the neurology team at Hospital A, for slurred speech. He underwent genetic testing which came back as normal. A follow up was made for July 2020, but Clive did not attend.

14.176. On 23rd March 2020, the National Covid-19 restrictions began, and schools were closed. During this time the schools offered telephone support and sent workbooks home as the family did not have internet connection. They received free school meal packed lunches.

14.177. On 22nd April 2020, NCHC received a Speech and Language Therapy (SALT) referral for Clive, for slurred speech and swallowing difficulties. He was placed on the waiting list. On 28th April SALT called Clive to discuss his problems. He stated he was coughing fluids, had frequent chest infections, and struggled with word finding. He was given an appointment for 30th July 2020.

14.178. On 29th April 2020, Elouise withdrew from her college place.

14.179. Mia's school unsuccessfully attempted to visit and drop off work for Mia, on 1st May 2020, and visited successfully on 6th May 2020.

14.180. Elouise was seen at Hospital A ED for sunburn on 29th June 2020, and 4th July 2020.

14.181. Clive attended Hospital A for a haemorrhoidectomy on 1st July 2020.

14.182. Elouise registered with Practice A in July 2020.

14.183. On 30th July 2020 Clive failed to attend his SALT appointment. When called, Rachel answered and stated Clive had been to emergency dentist due to tooth pain. A letter was sent to request contact if he still wanted to engage with SALT.

14.184. Clive attended Hospital A for a haemorrhoidectomy on 17thAugust 2020.

14.185. On 2nd September 2020, Clive was seen at Practice A with Rachel due to lump on his groin which he stated had been there for one week. This was identified as a pea sized lymph node, and he was treated with antibiotics.

14.186. Elouise started back at college in the new term. On 11th September 2020 a tutor raised a concern that Elouise said she had not eaten all day and had no money for food.

14.187. On 14th September 2020, Elouise completed an online consultation with the GP regarding lower abdominal pain, she was advised to attend the genitourinary medical clinic for screening and to complete a pregnancy test. There were no further notes regarding this.

14.188. On 22nd September 2020, Rachel left a message with SALT team asking for a new appointment for Clive. They attempted to call back, and Clive asked them to call Rachel as he had a poor memory. A new appointment was made for 5th October 2020.

14.189. On 25th September 2020, Elouise's tutor raised a concern that Elouise had left a class halfway through, but she had been doing really well. The college DSL attempted to call Elouise, and DSL managed to speak with her on 28th September 2020 Elouise stated she was not in a good place and was living with a friend. She agreed to speak to the DSL if she had concerns.

14.190. Clive failed to join the online SALT appointment on 5th October 2020, a new appointment was given for 13th October 2020, which he also failed to join. All attempts to call Clive were unsuccessful. A letter was sent to Clive with a food record for completion.

14.191. On 26th October 2020, Clive attended Hospital A with shoulder pain, he denied any trauma. No injury was identified, and he was sent home, however the records for this attendance indicate steroid abuse from August 2020 to May 2021. There is no record of this in Clive's GP notes.

14.192. On 26th October 2020 Clive contacted NHS 111, due to crushing chest pain, upper arm pain, and rectal bleeding. He was seen in ED and given pain relief for shoulder pain. Rachel called Practice A for Clive on 29th October 2020, due to ongoing shoulder pain. She was advised to take Clive back to ED. The following day the GP spoke to Clive, ED had excluded any cardiac cause for the pain, the GP prescribed Morphine Sulphate and a sedative.

14.193. On 1st November 2020, police received a referral from NSPCC, as Mia had told a friend at school that Clive hits her, her mother and Child A, and that there were cameras in all the rooms watching what they were doing. She had been seen with recent bruising to her back and shoulder. A strategy meeting was booked for 17th November 2020.

14.194. Police were involved; however, a DASH was not completed for this incident. Force Policy states one should be completed following all domestic reports and the

closure meant this was never brought to the attention of the DAST MASH Safeguarding Team. Another consequence was that police never spoke to Rachel about any potential violence aimed at her by Clive.

14.195. On 4th November 2020, Clive was discharged from SALT, as no contact had been received from Clive.

14.196. On 5th November 2020, Clive requested further pain relief for his shoulder, and was issued with further prescription of Morphine Sulphate, advised to use sparingly.

14.197. Clive missed a neurology appointment on 6th November 2020.

14.198. On 17th November 2020, the strategy meeting was held following allegations of violence on Mia, Child A and Rachel. In addition to the initial information from NSPCC, there was an update that cameras were in every room. Mia's school's DSL attended the meeting, sharing that Mia had 94% attendance, had good behaviour but recently had a few wobbles. Neither of the other schools were in attendance. It is stated that the family were well known to CSC and police for similar concerns. A further strategy meeting was booked for the following day, to allow time for Mia to be spoken to. When she was spoken to, she disclosed no injuries or assaults on her. Child A was spoken to and stated that Clive smacked her and shouted at her, and the Primary school staff, who had taught all four children, stated it was the most open any of the children had been. Child A's attendance was at 81% with the majority of the absences being unauthorised. It was agreed the Child A would have wishes and feelings sessions with the school. The strategy discussion concluded single agency s.17 – Child in Need - with no active role for police deemed necessary; the family were allocated a new Social Worker. In the context of the wider concerns and reporting to police and other services, the view is this was a missed opportunity for a joint investigation. The voluntary nature of the Child in Need process also requires the engagement of parents, in order to have an impact, and at this point professionals should have been very aware of the power dynamics in the family which rendered Rachel and Elouise controlled by Clive – therefore expecting engagement from them appears naïve.

14.199. Following the s.17 Child in Need decision, a joint visit was completed with a Health Visitor, all children were seen, and parents stated that the concerns were malicious.

14.200. On 18th November 2020 Clive's prescribed Pregabalin was increased to help with nerve pain, this was following a medication review.

14.201. On 19th November 2020, Child A had a session with a Parent Support Advisor (PSA), using conversation cubes. She stated Clive hurts and fights Rachel and

smacked Child A. She had a further session the next day and stated she "curls into a ball" when she gets angry because Clive shouts at her.

14.202. The next day, police are informed of children throwing stones at traffic on a main road, Mia is reported to be involved. The Social Worker updated Mia's school, following a visit to the family. The parents stated the NSPCC referral was malicious and untrue, and in front of her parents, Mia was stating it was not true.

14.203. Child A had sessions with the PSA during November 2020. During one of these sessions, she stated Clive had told her to say to the PSA that daddy wasn't too bad. During the next unannounced visit, Clive states he is unhappy about Child A seeing the PSA and plans to challenge this. Clive had also threatened to sue the Social Worker if he shared information with the children's schools.

14.204. On 24th November 2020, Practice A's Pharmacist spoke with Rachel and explained that no further Morphine would be prescribed for the shoulder pain. Clive was offered physiotherapy but declined this. Clive re-registered with Practice B the following week.

14.205. On 8th December 2020, Elouise's tutor raised a concern that she had a bottle of whiskey at college and appeared under the influence of drugs. She had been living at her boyfriend's house, but they had argued, and he had told her to move out – she stated she has returned home. The college start a disciplinary due to the incident that day. Elouise does not remain at home and is soon back at her boyfriend's house.

14.206. On 9th December 2020, the college DSL emailed Elouise's GP requesting that Elouise be seen as she was struggling with mental health and was drinking alcohol at college. Elouise was also concerned that she had a heart problem. The same day a GP consultation was made with Elouise. During this phone consultation Elouise reported low mood, she was offered a face-to-face meeting for the next day – however she did not attend this.

14.207. On 1st January 2021, there was a second National school closure due to covid 19. Mia's school offered her a school place during the closure, but this was declined due to Clive's illnesses. The Secondary School DSL informed the Social Worker of this, who stated that he was not concerned about Mia being at home during the lockdown period as he was in the process of closing the case.

14.208. The CSC case was closed in January 2021.

14.209. Elouise called her GP practice on 2nd February 2021, reporting an episode of feeling dizzy. Bloods were requested.

14.210. Clive missed a neurology appointment on 12th February 2021.

14.211. On 3rd March 2021, Mia's school raised a referral to CSC, this is following a third-party concern from another family member. The referral stated ongoing domestic abuse to family members and to animals by Clive. No further action taken. Given the history of concerns, this referral should have been progressed. There is no recorded reason why it was not progressed.

14.212. On 8th March 2021, the schools reopened, and the next day Child A had a wishes and feeling sessions at school. She stated she was unhappy because, *"daddy keeps shouting at me when I am naughty and when I am trying to be good...daddy shouts at mummy and she didn't do anything wrong...I wish I could go to Elouise's boyfriends."*

14.213. On 10th March 2021, Elouise attended the practice for insertion of an intrauterine coil[67]for contraception, and on the 16th of March 2021, she contacted the GP requesting a medical termination[68] of a pregnancy. This was facilitated the following day.

14.214. On 19th March 2021, in a further wishes and feelings session, Child A stated that on her birthday everyone is happy, but she really wanted to be at school on her birthday. Elouise had not come to her birthday, and Child A stated Clive does not like Elouise coming to the house.

14.215. On 1st April 2021, Rachel moved to her mother's house following a serious assault on her by Clive. Clive was arrested for GBH and Coercive and Controlling Behaviour. There is limited detail on police records regarding arrest attempts of Clive, however he was arrested four days after the report to police. Attending officers at the scene provided a good quality initial response, capturing injuries and obtaining a statement.

14.216. Norfolk Constabulary Domestic Abuse Policy dictates that high-risk incidents will be reviewed within 24 hours or as soon as possible. The case was assessed as medium and therefore was not reviewed until Clive came into custody. The investigation appears to have been completed in a timely manner.

14.217. CCTV cameras were found in four of the rooms, police had noted that following any assaults on the family Clive would reportedly run upstairs and delete the footage from the CCTV cameras. The upstairs windows were screwed shut to prevent "men coming into the house".

14.218. When Rachel moved out of the family home and in with her mother, Elouise remained at the family home with her father. Elouise told police that her father's

[67] A small device made from plastic and copper which sits inside the womb. It is a form of contraception that prevents pregnancy.
[68] This is a medicine, in tablet form, which terminates a pregnancy.

controlling behaviour towards her had escalated since her mother had left the family home. She stated Clive was controlling her, forcing her to call Rachel at least 20 times per day. She was being kept off college to care for Clive, and when she spent the day with her mother, Clive took an overdose of 43 tablets to signify Rachel's 43rd birthday.

14.219. CSC records state that Elouise decided to stay with her father, although from previous disclosures, and what was well known at this point about Clive, there could have been an exploration of these behaviours with Elouise. There continued to be a lack of insight by social workers, into Clive's coercive behaviours, and Elouise's ability to "choose" in this situation appears to be taken on face value.

14.220. A MARAC and Leeway referral was made by police for Rachel on 6th April 2021. The referral stated that Elouise was "taking Clive's side" and had been calling Rachel to force her to return home.

14.221. Clive was seen in police custody by the NSFT Liaison and Diversion Team. He had been arrested for Coercive and Controlling Behaviour,[69] Actual Bodily Harm and Possession of illegal substances. He told police he had anxiety and Post Traumatic Stress Disorder, and no history with mental health services. He refused to speak to a Liaison and Diversion practitioner.

14.222. Following his arrest, Clive was bailed and eventually charged at court. Over the following weeks, officers were made aware of repeated breaches of bail, for which officers obtained statements. The repeated breaches did not give rise to consideration for Stalking Protection Orders[70] which could have provided an additional layer of safeguarding to Rachel and the family.

14.223. Records show approximately 11 weeks between the breaches of bail and the charge, and this could have undermined victim confidence. Rachel did remain engaged, and safeguards were in place, but as highlighted this could have been further considered. The case was submitted in line with processes in Norfolk. A case reviewer completed their task, and the action plan was promptly completed. Similarly, the supervisor completed their submission in a timely manner. The Crown Prosecution Service reviewed the case and charged Clive for the breaches of bail, 41 days after it was submitted. A service standard of 28 days is agreed, and this falls outside of that. Charges were laid and a court process followed.

14.224. Elouise contacted her GP on 8th April 2021 due to pain following the medical termination, and she was treated with antibiotics. She later contacted NHS 111 stating ongoing abdominal pain, she cited her father as not being well enough to drive her to ED. She stated her mum had "run off" and she had no friends to take

[69] S.76 Serious Crime Act
[70] Stalking Protection Act 2019

her to ED. Elouise was seen again in Hospital A on 12th April 2021, due to ongoing effects of the termination.

14.225. Following Clive's arrest, he was interviewed on 9th April 2021. He stated he suffered from Multiple Sclerosis,[71] which caused him so much pain that he could not walk without a walking stick, and often used a wheelchair. It is recorded that on 1st April 2021, during the arrest of Clive, he had climbed over two 6ft fences, this was captured on body worn video.

14.226. Police had made a CSC referral, a Children and Families assessment was completed, and the family were supported via a Child in Need plan. The new social worker visited Rachel at her mother's house on 9th April 2021. During this time, support was given around housing and work to help relationships within the home. Bail conditions were in place for Clive not to contact Rachel.

14.227. Elouise facilitated contact between Clive and the younger children. CSC were aware of this, and there did not appear to be any concerns raised about the safety of this arrangement. There is no recorded exploration regarding safe contact, with either Clive or Elouise herself. At this point the risk of harm linked to Clive's behaviours appears to have been side-lined, as he no longer lived at the family home. This highlights a lack of understanding of the pervasive and ongoing nature of coercive control, especially following separation.

14.228. Over the next few days Rachel updated both Mia and Child A schools about her circumstances. DSL's and Safeguarding Leads from both schools all prepared for change in children's behaviours. Plans were also made to drop off and pick up Child A at different times, so Clive could not approach them at school.

14.229. On 13th April 2021 Adult Social Care contacted Rachel following a referral made by police due to the incident on 1st April 2021. Rachel reported feeling safe, does not require ASC input, and did not have any care and support needs.

14.230. Clive contacted Practice B on 13th April 2021, to advise that the day before he has collapsed and blacked out for ten minutes, no one had witnessed this. He was advised to attend ED.

14.231. Child A had a wishes and feelings session with the school on 14th April 2021, she stated she was now living with her grandmother, and that she was happy.

14.232. On 19th April 2021, Elouise's boyfriend raised a concern with the college DSL. He stated she had been pregnant and had a termination which led to some health issues. She was currently caring for Clive who was violent and abusive. He was worried that Elouise was taking cocaine with Clive. The DSL met with Elouise the

[71] A disease that affects the central nervous system.

following day, to discuss these concerns. She denied that she was at risk from Clive and stated she was safe at home. Bruising was observed on her face. Elouise declined a referral to domestic abuse services. The same day, Rachel reported to police that Elouise had been assaulted by her father.

14.233. The following day, Clive made a call to police, making allegations against Rachel. He stated she was coercively controlling, and violent towards him. It is recorded that this was malicious and intended to provide him with a defence for his upcoming case.

14.234. On 24th April 2021, the College DSL updated CSC regarding concerns of Clive assaulting Elouise. There was also information shared that Clive would often lie on the floor, pretending he had fallen, and Elouise would have to help him up. He is recorded as manipulating her to remain at home to care for him, and this was affecting her college attendance.

14.235. Also, on 24 February 2021, Elouise wrote on her DWP journal that she needed help with her overpayment as she was struggling with money. Elouise was advised to contact DWP Debt Management to discuss if the repayment amount could be reduced. These requests should have prompted further exploration with Elouise.

14.236. On 28th April, Clive was taken into Hospital A by Elouise, following an overdose of Pregabalin.[72] He was seen by the Mental Health Liaison Team. He was oriented to time and place, and there was no evidence of mental illness. He described himself as feeling lost since his wife had left, as she was his main carer. He disclosed anger issues and a recent arrest. He was referred to Mind for support and bereavement counselling, as he had lost his father when he was seventeen.

14.237. Clive returned home, and Mind text Clive to organise a follow up call. They spoke with him on 30th April 2021, he stated he would like phone support, as he was struggling. He stated he would like anger management. He agreed to speak to his GP about his medication. He stated his daughter was supportive. A plan was made to call again the following week.

14.238. Clive contacted his GP the same day, he requested Meptazinol[73] for pain relief, as he had received this in ED. He stated the overdose from the day before was due to acute distress, secondary to chronic pain and a fall out with his wife. He stated his 19-year-old daughter was caring for him. This did not raise additional questions from the GP regarding Elouise's suitability to care for Clive, her welfare as a young adult caring for her father, or any suggestion of a carer's assessment. He had taken the overdose as he felt like no one was helping. He raised that Elouise had alleged that Rachel was taking his benefits and giving him out of date medication – which the GP advised to take up with ASC. He was given two weeks

[72] A medication to ease the symptoms of epilepsy, neuropathic pain or anxiety
[73] An opioid painkiller

of Meptazinol, and Pregabalin was removed from his medication list. He was signposted to NSFT Wellbeing Service and sent for a follow up with a Healthcare Assistant for an ECG and a Blood Pressure monitor to investigate the collapse.

14.239. ASC had attempted to call Clive several times following a referral from police after the incident on 1st April 2021. Contact had been attempted via Elouise's phone. Hospital A confirmed with ASC that Clive had attended ED on 29th April 2021, had been seen by MHLT who confirmed he was experiencing depression. No further action to be taken, ASC sent an email to Clive to advise of the case being closed. Clive responded to the email, stating he had been collapsing after blacking out, struggling with speech, and finding his words, and stated he had a GP referral for a brain scan to aid diagnosis. He stated his daughter was currently helping him to bed, and with the shower and toileting.

14.240. Following the email response, ASC attempted to contact Elouise. When this was not successful, ASC emailed Clive, requesting a contact number for him, or confirmation of whether he needed care or support.

14.241. On 5th May 2021, Mind called Clive, he stated things were going ok. He had missed the GP appointment due to being unwell. He stated again that Elouise was helping him. He disclosed anger issues but not suicidal ideation. Clive is recorded as having a GP telephone consultation, discussing pain relief, he stated he had pain all over. Awaiting blood results.

14.242. The following day Elouise called NHS 111 complaining of a headache, the ambulance attended, and Elouise approached the crew explaining that she had previously had blackouts. Paramedics asked Elouise if there was any other reason she felt she needed to go to hospital, Elouise stated she was safe at home and did not need a safeguarding referral. She was signposted to social prescribing[74] for financial difficulties. Whilst at the house, Clive was also seen, and told paramedics about the separation from Rachel, he said "'she (partner) gave me a black eye, and I gave her a fat lip, ya know". Due to this information the crew put in a Vulnerable Adult Referral for Elouise, which was good practice, and showed strong professional curiosity from paramedics.

14.243. The Social Worker visited the younger children at school on 6th May 2021.

14.244. Mind called the Housing Association on behalf of Clive, asking about heating being repaired. Clive continued to tell Mind that Rachel had been violent towards him, and the assault on her was self-defence.

[74] This is an approach that connects people to activities, groups and services in their community, to meet the practical, social and emotional needs that affect their health and wellbeing.

14.245. The following day Elouise called NHS 111 with a severe headache. She stated she was unable to attend ED as she was needed at home to care for father. She stated they had no money, no electricity and were waiting to be evicted. She described them both as vulnerable adults. A call back was attempted but there was no answer.

14.246. Mind attempted to call Clive on 10th May 2021; there was no answer.

14.247. On 11th May 2021, Clive met a Mind worker in the community, for his appointment. He pulled up with Elouise in the car, when the worker arrived, Clive stated he had nearly run him over further up the road, at first Clive shouted and was angry, Elouise calmed him down, and then Clive apologised for this. They sat on a bench and had a chat. Clive minimised the incident where the police had recently been involved, stating this was an argument which had got physical on both sides. He said Rachel was lying about the incident, and that he was no risk to any of them. He spoke about his physical illness, having ME, losing lots of weight. The Mind worker agreed to call the GP to discuss medication. He spoke about the cameras in the house, stating they were there due to having expensive items, not to control the family. He was asked what support he would like from Mind – he stated housing and medication. An appointment was made for the following week.

14.248. On 13th May 2021, Mind called Clive's GP to request a call to Clive. Clive spoke to the GP the following day, asking to re-commence antidepressants. He was started on Citalopram; there was no record of exploration of context of request for antidepressants.

14.249. On 17th May 2021, Elouise was referred by the GP to Social Prescribing. The Social Prescriber attempted to contact Elouise by text, phone and letter and Elouise was discharged following unsuccessful engagement.

14.250. On 21st May 2021, the college DSL called CSC with concerns that Elouise has not been seen or spoken to all week. The social worker advised that Elouise had moved out of her fathers and into her boyfriend's house.

14.251. Also, on 21st May 2021, Clive's blood results returned abnormal, and he was referred via suspected cancer pathway to haematologist. Prescribed further antidepressants and sedatives.

14.252. Mind attempted to call Clive on 24th May 2021.

14.253. The victim contract[75] with Rachel set out contact every fourteen days. For the first month, this was complied with. There is then a noted 3-week delay between contact with Rachel in May 2021 and 4 weeks in June 2021. Contact with Rachel

[75] Support for victims and witnesses of crime | Norfolk Constabulary

resumed in line with the contract thereafter. This is a well-managed and documented contact log however these two exceptions are highlighted. There is limited documentation that the voice of the children was heard and recorded appropriately, the emphasis being on the domestic element between Rachel and Clive.

14.254. On 25th May 2021, the college DSL met with Elouise, who states she is now living with her boyfriend. However, she stated that she felt responsible for her dad who was refusing support from carers.

14.255. On 25th May 2021, Clive had self-referred to the NSFT Wellbeing Service, upon speaking with him they were concerned that he was suffering with psychotic depression and referred him to the NSFT Early Intervention Service (EIS).[76]

14.256. Clive was discussed at the EIS team meeting the following morning. There was no evidence of psychosis, he had low mood, and his relationship had ended due to Clive assaulting his wife. He had reported one incident of self-harm, Clive passed back to the Community Mental Health Team (CMHT) to undertake an assessment and re-refer if psychosis was suspected. This assessment was booked for 10th June 2021.

14.257. Mind attempt to call Clive on 26th and 28th May, with no answer on either occasion. On 2nd June 2021, there was a text exchange between Mind and Elouise, she agreed to ask Clive to call them, Mind advised that if they did not hear from Clive the following day he would be discharged from their service. Clive called the following day, stating he had been ill due to cancer cells in his blood, and he needed treatment. He updated her on the current situation.

14.258. On 1st June 2021, Clive attended the haematology outpatient clinic following a suspected cancer referral from his GP.

14.259. On 3rd June 2021, the s.17 assessment was completed, it was decided that the family would be on CiN due to Clive no longer residing with the family.

14.260. On 4th June 2021, a referral was made by NSFT Wellbeing Service, to the NSFT Youth Team for Elouise. The referral cited trauma history. Elouise had threatened to jump off a bridge or jump in front of a car. Trigger for these events are reported to be stress with her father, who she reports is physically, mentally and emotionally abusive. The referral was triaged, which included speaking with the Early Help worker allocated to the family at the time. The Early Help worker stated Elouise's issues were related to her domestic situation rather than mental illness. She was therefore discharged. It was subsequently discussed that as the family were then allocated a social worker with a CiN plan, the Youth Team would

[76] Service details | Norfolk and Suffolk NHS (nsft.nhs.uk)

not need to be involved as CSC would be addressing the issues from a social context around Elouise's father a re-referral could be made once the primary problems were addressed.

14.261. Clive called NHS 111 on 7th June 2021 due to abdominal pain, stated he was awaiting a scan for cancer. An ambulance was not sent, he was advised to self-present at hospital. That day he was admitted to a ward at Hospital A with suspected lymphoma, following abdominal and chest pains.

14.262. The following day, he underwent an Echocardiogram,[77] and cardiac failure[78] was identified, with a severe left ventricular dysfunction.[79] emphysemas lungs,[80] and he was started on anti-heart failure medication. That day Clive contacted Mind to cancel his appointment, stating he was in hospital as a scan found cancer protein in his blood. He advised the previous day he had been taken into hospital by ambulance.

14.263. Over 9th to 11th June 2021, Mind followed up by text and was advised Clive was still in hospital.

14.264. On 10th June 2021, CMHT undertook a virtual assessment. Clive was in Hospital A, due to investigations for cancer. He requested an alternative appointment, this was agreed. He stated no concerns re self-harm. He stated feeling more positive, hopeful his relationship would rekindle, as his wife wanted him to go to anger management classes. There were no further questions asked of Clive, indicating a lack of professional curiosity, and ward staff confirmed no concerns.

14.265. A CiN meeting was held on 11th June 2021. There was positive feedback from the schools, college informed the meeting that Elouise had a big weight on her shoulders as a carer and was now living with her boyfriend. Elouise was having to manage contact between the children and Clive. Whenever the social worker tried to agree suitable contact times with Clive, he was not in agreement with them. Clive's family had been in contact with Rachel to say she should be caring for him as he had cancer. Rachel stated she wanted to stay in the immediate area and would remain at her mother's house in the meantime. CSC book next meeting for July 2021, with a possibility if closing if all continues to go well.

14.266. Mind contacted Clive on 14th June 2021, he stated he was in hospital and that he now had a heart condition. He was advised that Mind support would end whilst

[77] A type of ultrasound scan to look at the heart and nearby blood vessels.
[78] Where the heart is unable to pump blood around the body properly.
[79] This can worsen without treatment; however, many people manage the condition with lifestyle changes and medications.
[80] A lung disease that results from damage to the walls of the tiny air sacs at the end of the tiny air tubes (alveoli) in the lungs.

he was in hospital. The Mind worker updated the MHLT, requesting a new referral upon discharge from hospital. The same day CMHT contacted Clive who stated that he was awaiting a transfer to another hospital for cardiac surgery. Although there is no record of Clive moving to another hospital. He stated no self-harm or suicidal ideation. The CMHT team discussed a face-to-face appointment offer once Clive surgery completed.

14.267. The social worker visited the family on 17th June 2021, Rachel reported ongoing breaches of bail by Clive. There is no recorded evidence that this was fed back to through the Multi-Agency Safeguarding Hub as would be expected. The same day Elouise contacted the college DSL, she hadn't been seen for a while. She was back at home, although Clive was still in hospital, she didn't want to be there when he returned. Elouise made an application for Universal Credit, however the housing costs element of Universal Credit was rejected because she was not liable for the rent, as she was only an occupant.

14.268. On 18th June 2021, Mia told her form tutor she was having chest pains, she did not know what this was, but it felt like cramps and sharp pain.

14.269. Around this time Elouise was working with the housing team at the local council and requested a move to a three-bedroom house. She was advised she would be entitled to a room in a shared house. [81]

14.270. Clive called Mind on 21st June 2021, stating he was out of hospital and wanted care and support, along with help with housing. The line was unclear, so Mind worker called back the next day. No answer. The worker sent over a referral to the Mind Hub.

14.271. On 22nd June 2021, a friend of Dan's made an allegation of false imprisonment against Clive. However, on 25th June 2021, she stated this was a false allegation which she had made up following being away from home for a few days.

14.272. During a wishes and feelings session with Child A she stated she sometimes stayed at Clive's house.

14.273. On 25th June 2021, police attended Clive's home to arrest him, due to allegations made by Dan's girlfriend regarding false imprisonment and assault. During Clive's arrest, Elouise assaulted an officer. Elouise was seen in Hospital A ED, whilst in custody, the notes stated she had caught her foot on a ceramic plate, causing an incision to her ankle. Clive was also taken into Hospital A whilst in custody, stating left sided chest pain and insomnia, after investigations musculoskeletal chest pain and insomnia was attributed to stress, and he was discharged back into police custody.

[81] Most single private renters under aged 35 would be entitled to a shared accommodation rate of Local Housing Allowance.

14.274. On 29th June 2021, Clive called Mind, he stated he had been in hospital again. He was advised that a Hub referral had been made for him.

14.275. The next day Clive attended a gastroenterology[82] appointment at Hospital A.

14.276. The Mind Hub attempted to call Clive on 8th July 2021. Elouise answered and said Clive was in bed.

14.277. Clive failed to attend a Heart Failure Optimisation Clinic appointment on 9th and 12th July 2021.

14.278. On 12th July 2021, the school DSL visited Mia at home as she was not in school. The grandmother asked the DSL to come in and see the overcrowded conditions they are living in and all family possessions in lounge as they have nowhere else to store them. Mia looked tired but was happy to go into school with the DSL. The DSL emailed the social worker for a housing update and concerns about the conditions the family are living in.

14.279. On 14th July 2021, Mind tried to call Clive and also sent a text message. Mind were able to speak with Clive on 19th July 2021, he was advised of the four to five week waiting list.

14.280. Clive failed to attend a neurology appointment at Hospital A on 22nd July 2021.

14.281. On 23rd July 2021, the Social Housing Landlord attempted to call Clive regarding his rent arrears. No payment of rent had been made since the Universal Credit claim had been moved to Clive. Rachel was also called about this but confirmed she had moved out in April due to domestic abuse. She requested taking her name off the tenancy, so she could move from her mother's one-bedroom house. She was currently a priority banding but could not move whilst she remained on the tenancy.

14.282. On 27th July 2021, CMHT informed Clive's GP that he had missed two offered appointments, and not responded to phone calls. They would offer one more appointment and close to CMHT.

14.283. Clive called the landlord on 3rd August 2021, stating he had been in hospital and had not been contactable. He had requested payments for his rent via Universal Credit and was advised that this would be from his next pay on 11th August 2021. They advised he had a Notice of Seeking Possession, and he was required to attend a meeting on 10th August 2021. Rachels social worker was supporting her regarding half of the rental debt which Rachel was liable for.

[82] The diagnosis, treatment and work to prevent gastrointestinal and hepatological diseases.

14.284. Clive had a phone appointment with Housing Association A on 10th August 2021, he stated he had been in hospital due to heart failure and had been told he had five years to live. He stated he was living at the property with Elouise. He arranged to pay £100 per month for the bedroom tax, for the empty bedrooms in the house, and to decrease his debt. He stated he was trying to get an overnight carer and was due to return to hospital for further tests. He stated his wife, and children were planning to move back in after the court hearing, when the bail would end. He advised that Mind were assisting with paperwork, as his wife used to do the paperwork before.

14.285. The MIND support worker visited Clive on 12th August 2021. Clive told the support worker that he had been given five years to live due to blood cancer and heart problems. Clive said he had lots of problems organising his appointments and being well enough to get to them. The support worker helped by writing the appointments all down, and advised he would take Clive to as many appointments as possible.

14.286. On 13th August 2021, the Mind support worker organised with the heart specialist nurse to obtain Clive's discharge letter, for evidence of his serious health problems, which he could use for the court case which was coming up.

14.287. On 14th August 2021, the Mind support worker picked up Clive to take him to have a blood test at his GP surgery. Clive had Child A with him as it was the school holidays. The Mind support worker stayed with Child A in the car while Clive went in for his appointment. The following day, the Mind worker drive Clive to the hospital for an MRI of his heart. He had Child A with him again, and the worker sat with her in the car for 1.5 hours while he went in for his appointment. Clive mentioned he did not have much food indoors, so the support worker bought him some shopping. The following day, the support worker picked up Clive for his court hearing, Child A was with him again. Clive met with his solicitor, and the Mind support worker sat in the car again with Child A. Clive pled not guilty to the assault on Rachel and possession of cannabis. The hearing was moved to the Crown Court for the following month. On the drive home, Clive became upset as he had been told he could get a prison sentence of 2.5 years, and he stated he only had five years to live. The support worker took Clive to the food bank and collected him a parcel. The following day, the Mind support worker turned up at the house to collect Clive for his Covid vaccination as planned, there was no answer at the door, and Clive was not answering his phone. Clive texted the Mind worker back later that day, apologised that he had lost his phone since the day before and now had a new number.

14.288. On 24th August 2021, Clive was conveyed to Hospital A by ambulance, with chest pains and complaining of multiple collapses during that day. He was admitted

for further investigations. He had low grade myeloma[83] and was referred to a colorectal surgeon due to bleeding and weight loss. Clive was admitted as an inpatient 24th to 26th August 2021 and readmitted on 27th August 2021 after leaving the hospital without being discharged the day before. He was complaining of chest pain, and Elouise explained to the doctor at Hospital A she had heard a crash upstairs and found her father in the foetal position. Clive disclosed steroid abuse, which he stated was injected weekly by Rachel from August 2020 to May 2021, purchased from the internet.

14.289. Elouise was also seen at Hospital A on 27th August 2021, stating she had neck pain from a car accident 2 years before. She stated she had right arm tingling and feeling weak. She was discharged, and was not happy with this, as she stated her father was in the hospital and she was estranged from her mother. It is noted that Elouise booked herself back into ED ten minutes after being discharged. She was seen in ED with a tight chest, neck pain, tingling and dizzy spells, her bloods were taken and did not show any concerns. Notes are clear about her father's behaviour, and her vulnerabilities. She is recorded as having no money or transport. She is recorded as previously being subject to child protection plan. Her boyfriend collected her. There is no evidence of safeguarding concerns being raised, despite Elouise being under eighteen, and all of the above information being known to staff.

14.290. The Mind appointment for 28th August 2021 was cancelled as Clive was in hospital.

14.291. On 30th August 2021, a police officer was assaulted by Elouise, whilst Elouise was being arrested for drunk and disorderly behaviour.[84] Elouise was seen in custody by the NSFT Liaison and Diversion Team, who made a referral to the NSFT Youth Team for consideration of support re mental health within the community. Elouise pled guilty the following day at Magistrates court.

14.292. On 1st September 2021, Clive called for an ambulance due to chest pain. No ambulance was sent, and Clive was referred to his GP. Later that evening Clive called NHS 111 complaining of chest, back, neck and arm pain after a head injury two days previously. He stated he was feeling suicidal. An ambulance conveyed him to Hospital A. Whilst in Hospital A he was reviewed by a cardiologist, dietetics, and heart failure nurse. He also spoke with the MHLT. He had an ultrasound of his left arm. No issues found. The heart failure nurse discussed the importance of no illicit drugs or alcohol, Clive agreed to self-refer to CGL in the community.

14.293. Also, on 1st September 2021, Elouise called NHS 111 with chest pains, neck pain and headache, she stated her face felt funny and she often had tingly feelings in her legs, which had been going on for nearly a week. She stated that her parents

[83] Occurs in people with a low level of M protein, meaning there are small amounts of abnormal plasma cells, but no other evidence of myeloma.
[84] Criminal Justice Act 1967 s.91

had recently separated, and she could not cope. The ambulance was stood down and a referral was made to her GP. Later that evening, Elouise made four 999 calls, between 10.30pm and 11.30pm, she stated again that she had chest pain, and a numb face and legs, the ambulance arrived, and she disclosed suffering a head injury two days before and had recently suffered seizures. Elouise reported drinking a bottle of vodka, and stated she was suicidal. She was conveyed to hospital at 2.45am, upon arrival Elouise told staff she lived with her father who was currently on admission in another ward at the hospital. An X-ray showed a fracture of her wrist, which she stated had happened during her arrest on 30th August 2021. There is no evidence that she raised this injury as a concern at the time, or whilst in custody. Elouise reported as feeling scared during the examination and also became angry. Her GP was updated, and fracture clinic appointment was made.

14.294. As with Elouise's ED attendance three days before, there was a lack of safeguarding of Elouise, despite staff being made aware of her social situation. It is not clear who she was sent home with, as her father was known to be in another part of the hospital.

14.295. NCHC Heart Failure Nurse received a referral for Clive on 7th September 2021. He was placed on the waiting list.

14.296. Practice A contacted Elouise on 7th September 2021, following the letter from ED for Elouise's attendance on 20th August 2021, asking the GP to review Elouise's hearing.

14.297. A CiN meeting was held on 8th September 2021. A property had been found for Rachel, however Clive had to agree for Rachel to come off of the tenancy of the family home, before she could accept this property. His being in hospital was cited as holding this up. Rachel stated that Mia and Child A went to stay with Clive during the holidays, Child A had stayed for ten days and returned having worn the same clothes the whole time. Mia came home after one day. During the time that Child A was there, Rachel could not get hold of Clive. The police suggested unaccompanied contact with Clive was not recommended, as it was known that Clive used cocaine in the home.

14.298. Mind worker attended Clive's home on 9th September 2021, as Clive had an appointment. Clive stated he had a fall and had been in hospital for two weeks. However, he was taken good care of and had been eating much better whilst in hospital. Elouise was back at the home with him. The Mind worker drove Clive to his CMHT appointment. Clive spoke about the mental health issues he had been experiencing since his wife had left. NSFT made referral to ASC for a care needs assessment. He told CMHT that he felt suicidal every day but was not making plans. He stated he heard voices which told him lies about his wife, and he had poor concentration. CMHT requested GP to undertake ECG and bloods. The Mind worker then helped Clive with making phone calls, to his solicitor to discuss the

court case, and ASC to arrange a care needs assessment. They called the local council to advise that Elouise was back in the home, and the Mind worker tried to get Clive a bus pass. The worker then took Clive to the food bank and picked up a parcel for him, as he stated he had not eaten for a day or so.

14.299. ASC contacted Mind regarding the referral the following day. The Mind worker updated that Clive had depression and would be supported by the CMHT in the coming weeks. ASC then called Clive, who confirmed he lived in a three-bedroom house, with his 19-year-old daughter. He stated he had ME, Myotonic Dystrophy, Cystic Fibrosis and COPD. He stated he had heart failure and had been told nothing could be done and he had five years to live. He stated he used a walking stick and wheelchair for further distances. He stated he was very shaky, drop things, forgets things in the oven, and struggled to cook and clean. The assessment concluded that he would require support with personal care and breakfast in the morning, and support with meals in the evening. The next day, following the SWIFT welfare check, ASC contacted Elouise. She advised that Clive did not speak on the phone, she advised Clive needed carers support for meal preparation, personal care, and cleaning, and that ready meals were not suited as they contained too much salt. They followed up with a text message, reminding Clive that he could re-refer back into NFS.

14.300. On 12th September 2021, Child A was visiting Clive and was due to be dropped home at 8.30pm, when she was not returned home, Rachel called Elouise and was told that Child A was finishing her dessert and would be dropped home. Elouise had called Rachel to ask if she would come to meet them, but Rachel said no, just bring her home. Rachel then received calls and photos from Clive harming himself, stating he did not want to live if she was not with him. Child A was present throughout and witnessed Clive harming himself. Elouise messaged Rachel asking her to come and help. Rachel refused and told Elouise to call an ambulance. Upon arrival of the ambulance crew Clive stated the call had been made maliciously by Rachel, no cuts were seen, and Clive was left at home.

14.301. Elouise was discharged from the fracture clinic as she had not attended any out-patient appointments.

14.302. On 14th September 2021, the care provider attended Clive's home, and Elouise met them at the door. She advised that Clive required a different service. He required a full prepared meal, with meat and vegetables and a dessert, as he did not eat microwave meals. ASC called Clive later that afternoon, he stated he was not happy with the level of service during the evening, and he was advised that the personal care could be completed in the morning. He stated he was not happy with microwavable meals. He stated due to his illness he needed healthy home cooked meals. He was advised that domestic tasks were not part of the service. Clive reported as being very stressed as he had a court hearing the following week, and he said there was a possibility of being sentenced to two years,

he stated his rent debt was causing him distress and he was suicidal. He asked the care provider for a few days to consider if he wanted the package of care.

14.303. Later that day, Clive called Housing Association A to request the direct debit for the bedroom tax and rent debt to be cancelled as it would bounce. He was insistent that he had already paid for August. Later that evening, Clive called for an ambulance complaining of chest pain, he stated he had collapsed earlier that morning. He was conveyed to Hospital A and admitted for investigations. A clinical examination was found to be normal; Clive described numbness in both hands. He was discharged home, and booked for an MRI, 24-hour tape[85] and nerve conduction studies as an outpatient.[86]

14.304. The landlord made a tenancy support referral for Clive, and a home visit was booked for the following week.

14.305. ASC called Clive on 15th September 2021, they left an answerphone message to state that if they did not hear from Clive that day, the care package would be stood down. No contact from Clive so care package cancelled.

14.306. The Mind worker drove Clive to court on 16th September 2021. Clive pled not guilty, and a trial date was booked for June 2022.

14.307. On 16th September 2021, the NSFT Youth Team met to discuss the referral from the Liaison and Diversion Team for Elouise. The referral was declined as Elouise did not meet the criteria. There is insufficient information on the decision making to identify which criteria was not reached. Elouise was sent a letter advising of the referral being declined and signposting her to the NSFT Wellbeing Service and CGL – due to mention of alcohol misuse in the referral made by the Liaison and Diversion Team.

14.308. ASC again attempted to call Clive on 17th September 2021. There was a concern about him, and SWIFTS[87] were asked to check on him. When they arrived at the property, the blinds were closed and there was no answer. SWIFTS updated ASC. Whilst still at the property, Elouise arrived home, she stated her father was in bed and he needed carers who could provide proper cooked meals, as he had to manage his salt intake. Elouise stated that Clive did not answer his phone due to his mental health, she stated she assisted her father when she was home but attended college and worked.

[85] A specialist cardiovascular investigation allows for a patient's electrical heart activity, such as rate and rhythm, to be monitored for a prolonged period while the patient is completing normal activities including resting and sleeping.
[86] Used to detect problems with nerve signals.
[87] A 24-hour service that provides practical help to adults with an urgent, unplanned need at home. It is a free service. Norfolk Swift Response: Help from Home

14.309. On 18th September 2021, police received a call from a female stating she had been assaulted by Elouise whilst out with friends, she had bruising and scratches to her face.

14.310. On 18th September 2021, Clive asked if he could have Child A and Rachel refused, due to what happened the week before. Clive could not understand why she would not permit Child A to visit. Clive then sent further photos of self-harm and filling a glass with blood from a self-harm wound. He also wrote on the walls in his blood that he loved Rachel and sent photos of this to the children. Rachel called an ambulance; upon arrival Clive told the crew that he was alone in the house and was trying to kill himself. He was not actively bleeding at this point. Clive spoke about the separation with his wife, and that he was involved in court proceedings for contact with his children. He stated his self-harm was to stop his wife's action against him. He stated that he had no further intention of self-harm. The crew contacted the Hospital a Mental Health Team and was advised it was safe to leave Clive at home. Dan then arrived and was advised by the crew to keep an eye on Clive that evening. Dan was in his teens at this time, and it is of concern that he had been left with a suicidal adult, with the instruction of keeping an eye on him.

14.311. The next day, Clive asked again to see Child A, Rachel agreed for Child A to visit but to be back by teatime as it was Mia's birthday. Clive did not return her until 8.30pm when it was too late for Mia's cake. Rachel had a meeting at the school with the Social Worker on 22nd September 2022. The social worker did not attend, so Rachel updated the school and said she intended to call the Social Worker and update them that day.

14.312. On 27th September 2021, at the CiN review it was agreed that the support would be stepped down to Early Help. This was a very premature step down, as it was not known at this time whether there was sustained change in the family dynamics. There continues to be harm to the children in the form of emotional abuse from Clive self-harming in the presence of the younger children, which Rachel told the Independent Chair of the DHR that the social workers were aware of.

14.313. On 30th September 2021, Clive cancelled his planned meeting with Mind, as he was in bed due to being unwell.

14.314. Clive contacted the landlords on 1st October 2021, stating he had been ill and had missed a payment. He was warned about missing payments as there was a Notice of Seeking Possession in place. He also asked for another appointment for Tenancy Support as he had missed them coming around as he was asleep. Tenancy Support team called Clive on 5th October 2021 to make another appointment, he did not answer, voicemail left asking for him to call back. Also, on 5th October Mind Support Worker picked up Clive, and took him for his heart failure

appointment. Clive had not been taking his medication and had not collected his prescription so the tests could not be carried out. The Heart Failure team organised for his prescription to be available, and the Mind worker took Clive to collect it, and the Heart Failure team made Clive a new appointment. He was advised that this was his last appointment with Mind as he had already received more sessions than the original plan.

14.315. On 5th October 2021, Elouise attended Practice A with Rachel. The purpose of the consultation was flu/throat/chest. Rachel mentioned to the nurse about Clive's mental health issues and ask if Elouise could be referred for a mental health assessment. They were advised by the nurse to book this in with the GP to discuss further, but there is no record of this happening.

14.316. Mia's school DSL visited Rachel on 6th October 2021, as they had not been able to get hold of her. There was no answer, so the DSL followed up with three calls, a text and left a note through the door.

14.317. Housing Association A's Tenancy Support team attempted to call Clive again, no answer and voicemail left for a call back.

14.318. The Heart Failure assessment took place on 7th October 2021, Clive stated he was struggling with his mental health and told them he was having support from a Mind Support Worker. Clive's heart failure was recorded as stable.

14.319. On 8th October 2021, Elouise was arrested for being drunken and disorderly, whilst in custody she was seen by the Liaison and Diversion Team. She disclosed multiple issues with her own anger, anxiety, her education, lack of opportunities, and her own relationships. She also spoke of the impact of her father's behaviour on the family. She stated that the main problem was her father had lost his father at a young age and had developed attachment and anger issues which he refused to seek help for. Because of the assault on Rachel by Clive, she lived with her father and didn't see her mother as much. Her father continued to be abusive to her, but she felt an obligation to care for him. The assessor concluded: "I feel like her father has been taking advantage of her and the rest of the family for years." She denied substance or alcohol use. She described previous injuries, poor sleep, poor childhood experiences, controlling and coercive treatment from the father on all of the family – which is recorded by the practitioner as extreme. Elouise was re-referred to NSFT Youth Team. Also, at this point an Adult Social Care referral may have been appropriate for Elouise, and also specialist domestic abuse support referrals could have been made,

14.320. On 7th October 2021, Clive was seen by NCHC community heart failure specialist nurse for a review of heart failure. He reported dizziness, fatigue and breathlessness. Noted to have scarring from self-harm. He stated he needed support at home from carers to help with meal planning. He was referred for

smoking cessation advice, Integrated Palliative Care for the heart failure. Recorded as having Myotonic Dystrophy and depression.

14.321. On 8th October 2021, Elouise did not attend a Neurophysiology appointment at Hospital A, and a further appointment was sent.

14.322. On 10th October 2021, Rachel reported to police that her front tyre had been stabbed and there was a scratch down one side of her car.

14.323. On 12th October 2021, Mia's school's DSL received a call from Rachel. she explained she does not answer unknown numbers due to domestic abuse. And stated Mia was unwell and would not be in school. The DSL suggested Mia come into school and if she was unwell, she could return home.

14.324. The same day, Elouise explained to her college DSL that she had been suffering with a chest infection and this was why she had not attended college. She explained all that had happened over the past few months, and stated she was now staying with her boyfriend again, because her dad made her feel guilty. The GP called Elouise the same day to discuss the mental health services referral made by the Liaison and Diversion Assessor. Elouise did not answer, GP tried again the next day but still no response.

14.325. On 13th October 2021, the Palliative Care Community Nurse held a telephone call triage assessment. He stated he had a "messy divorce" with his wife, they were still in contact as she was his only next of kin, and they shared custody of their five-year-old child. Stated he lived alone, managed daily activities independently, but did not leave the house due to fatigue, breathlessness and transport needs. He stated his illness had been devastating, he had never felt so low and had suicidal ideations. He stated he was finding input from the NSFT Wellbeing Service helpful.

14.326. The same day, Clive called Housing Association A, he stated he was paying the monthly amount that day for September, and there was a Direct Debit set up for 25th October to pay for October amount. He stated he now had an overnight carer who used the spare room, and Elouise used the other, and he had informed the Universal Credit about this, and his full rent was now paid on the property.

14.327. Also on the same day, Mia spoke with her DSL, and told her about Clive self-harming, and sending photos. She said she was worried about her mum. And that Clive had slit her mum's tyres that week. She was looking forward to moving to a place with more space, but was worried about changing schools, and having to make new friends. The DSL contacted Rachel and left a message. The DSL noted that the social worker assessment was complete, and CSC involvement was closed, without any of the schools' knowledge, and no paperwork had been received for this. She contacted CSC to find out what mental health provision has been put in place for the individual family members.

14.328. Also, on 13th October 2021 Elouise did not attend a General Medicine Clinic appointment at Hospital A.

14.329. Clive called an ambulance on 14th October 2021 at around 3pm due to breathing problems, he also stated he had blood cancer and heart problems and had been trying to get help from MIND and his GP for three weeks; the crew arrived in just under two hours. Clive called his housing association at around 3.30pm. He stated he had been rushed to hospital and was still there, he had not paid the monthly amount as promised and asked for longer to pay, this was agreed. Ambulance came to the scene around 5pm, he stated he had help from his GP and from MIND. He had been self-harming by inserting needles and bleeding out. He was conveyed to Hospital A.

14.330. On 14th October 2021, Hospital A acute medicine attempted to call Elouise for a review, they were unable to reach her.

14.331. On 15th October 2021, while he was in Hospital A, Clive was seen by MHLT. A risk assessment was completed which found a low risk of harm from himself, but also the possibility of more serious harm from misadventure. He told MHLT that he was waiting to be allocated a CMHT worker and had not been informed of a timescale for this. There was a discussion with Clive around emotional dysregulation, which happened when he spent time thinking about his circumstances, especially at the end of the day. Clive identified himself as the victim of abuse in his relationship with Rachel. He stated that he had a three-year history of low mood due to his wife's behaviours, but also poor resolution of grief when his father passed many years before. Child A told staff that he had cut a vein and had filled two glasses with blood – he did not mention that his children were present at the time. Clive also told staff he had five years to live, although this is not recorded as official anywhere in his medical notes. A plan was made for MHLT to refer into MIND for support whilst CMHT allocated Clive a worker. A medication review was requested with the GP, and the contact details for CRHT, First Response Service and Samaritans were given to Clive. Considering his detailed description of financial and emotional abuse from his wife, there were no referrals made for him to specialist domestic abuse services.

14.332. On 15th October 2021, Clive had a phone consultation with the Local Information Support Team (LIST) and told them he had been admitted to Hospital A due to chest pains and self-harm to his arms. He stated he did not feel he needed any help with housing exchange as it had to be done online, and his 19-year-old daughter would help him. Whilst admitted, he was seen by the MHLT and referred to MIND. He was discharged the following day; he was noted as being anxious about going home. Mind organised a case co-ordinator, and the hospital organised a taxi and a snack box for him.

14.333. On 20th October 2021, Clive spoke to the Community Heart Failure Nurse, and also the Community Specialist Palliative Care Service. On both calls he was very distressed, and reporting only one week left of medication and he was struggling to pick this up from the surgery. He stated he had been in hospital a few days previous, with chest pain and suicidal ideation, he reported that his heart rate was only 40BPM but there is no documentation to support this. He reported living alone in a flat with no heating or food. He came across as very low in mood and extremely anxious talking about ex-wife and daughter, he did not express that he wanted to self-harm or take his own life.

14.334. The Community Heart Failure Nurse prioritised Clive's mental health issues and spent twenty-five minutes on a call trying to get through to the NSFT first response team. There were also attempts to speak with Clive's GP, again without success. A SystmOne Task was subsequently sent to the surgery GP to share concerns. No action was taken by the Nurse regarding Clive's social issues, however the following day they contacted the Community Specialist Palliative Nurse, who indicated they had referred Clive to ASC for his care and support needs.

14.335. Practice B called Clive on 22nd October 2021. It was noted that Clive stopped antidepressant two weeks previously and wished to now try a different anti-depressant. He reported to be under the care of the CMHT. He was prescribed Fluoxetine.

14.336. On 24th October 2021, Clive called ASC due to no food or electricity. He stated he had just come out of hospital and was given the contact details for duty social workers. Clive also called NSFT First Response Service (FRS)[88] reporting feeling suicidal, not eating, and having no money. He stated his wife had left him and was turning his children against him. He stated she had changed her mind about rekindling the relationship. He believes she has cheated on him, and had the divorce papers written up in preparation, when they first got married in 2011. He stated he had five years to live, denied substance misuse, and was able to engage well, was calm and laughed at jokes. He was given advice about accessing a food parcel. A safeguarding referral was made by FRS for self-neglect, a request was submitted for care and support needs assessment and CMHT were informed of the call.

14.337. In the early hours of the morning, Clive rang the duty team and informed them that he had been discharged from hospital on 17th October. They called him back and asked why he was calling at 2am for a food bank referral. His call was passed to the daytime duty team. When they called back, a suggestion was made to ask Elouise for support. He was due to receive Universal Credit the following day, and PIP on 29th October 2021. He was advised that a NAS referral was made for him,

[88] NSFT First Response

but he still needed to send them his bank statements. The locality team called him back, he stated his neighbour was assisting with meals and he did not want a food box due to dietary needs.

14.338. Later on, 25th October 2021, CMHT attempted to call Clive on four occasions following the information FRS. They discussed Clive with the Crisis Response and Home Treatment Team (CRHT), who also made a cold call to Clive's property, with no answer. CRHT contacted Elouise on 26th October 2021, who stated she would contact him and come back to them. Elouise called CRHT the following morning and stated Clive had been sleeping the previous evening. CRHT called again, no answer.

14.339. Tenancy support again tried to contact Clive on 26th October 2021. They made a note to keep open for two weeks, then to close if no contact from Clive.

14.340. Following a further call by CRHT in the morning of 27th October 2021, Clive returned the call, and a face-to-face appointment was made for the same day. They also arranged a food parcel for Clive. The CRHT attended the home as planned on two occasions that day, he was not home on either occasion, contact details were left.

14.341. Also on 27th October 2021, Clive was offered support from the Money Support Service (MSS), with debt and money management advice. MSS called and provided an appointment for 19th November 2021, Clive stated that he was working that day and would not be available until the afternoon, a new appointment was booked for 2.30pm that day. MSS called as planned, and Clive stated he was sick in bed, appointment rearranged for 14th December 2021.

14.342. A further phone call was made by CRHT on 28th October 2021, and Clive answered, stating he had been asleep the day before due to his ME illness. An appointment was made for the next day. CRHT made a successful visit to Clive on 29th October 2021, the house was dirty, untidy, and cold. His children were present, he discussed cutting himself over the past four weeks. His fourteen- and four-year-olds confirmed this, as they had been present. He denied drug use, and admitted hitting Rachel, which had led to the divorce. He stated he could not afford heating, food, bills. Superficial scratches were seen on his arm, he described having ME, COPD, and having five years to live. He was assessed as a low risk of suicide, moderate risk of self-harm and self-neglect. No further need for CRHT, referred to CMHT. Mind were recorded as still supporting. A referral was made to CSC, who declined the referral.

14.343. On 29th October 2021, Clive's claim from NAS Finance was refused as he had not provided bank statements. He was signposted to a food bank.

14.344. The MHLT made a referral into Mind on 2nd November 2021, this was not picked up as he had already received his allocated 24 weeks of support.

14.345. Clive was seen by Practice B on 2nd November 2021, regarding a lump on his groin. He was noted to be walking with a stick due to hip pain. He was referred for an x-ray of his pelvis and prescribed Codeine[89] for the pain.

14.346. CMHT called Clive on 8th November 2021, as he was on the waiting list. He stated stressors remained the same, he was now also behind with rent, benefits were being used to cover arrears, and he was living on food parcels.

14.347. Clive was seen on 8th November 2021, for day therapy for breathlessness, with the Palliative Care Team's Occupational Therapist. He reported feeling frustrated, upset and a burden due to his breathlessness. He was given two further appointments. However, he did not attend and was discharged from the service on 6th December 2021.

14.348. On 9th November 2021, a case conference was held between the DWP Work Coach Team Leader and a Decision Maker[90] where it was determined Elouise's case was "sanctionable" due to non-attendance at appointments with her Work-Coach. A low-level sanction[91] was applied to her claim. DWP staff do not ask about domestic abuse as routine enquiry, however where there has been reference to domestic abuse, they should be asking about safety and risk. Because staff were aware of Elouise's "historic" issues with abuse from her father, they asked her broadly if there was a reason for missing the appointments, Elouise did not disclose issues with domestic abuse, or violence within the home as the reason.

14.349. On 16th November 2021, Elouise's college started the process of removing her from her course, as she had not attended or engaged with the support on offer. It is recorded that she was supported by the Youth Offending Team[92] and Mental Health Team.

14.350. On 22nd November 2021, Elouise did not attend for a recently booked MRI or 24-hour tape. Unable to contact Elouise by phone, and she was discharged from acute medicine back to her GP.

14.351. On 23rd November 2021, Elouise attended the college to request evidence that she was enrolled in the college, to support a meeting with the local council. Elouise was advised that this was not possible as she had not attended since early

[89] A painkiller which is part of a group of medicines called opiates.
[90] Assessed the claim and issues a decision on it.
[91] A low-level sanction will be applied if a claimant does not do tasks within their claimant commitment.
[92] This was incorrect as the Youth Offending Service have no record of Elouise

September 2021, and she had been withdrawn from the course. Elouise was angry and made a scene.

14.352. On 25th November 2021, Mia's school attendance officer reported that Mia had been absent all week. Rachel confirmed she was catching the bus for school. She had been receiving absence calls but had assumed these were for Elouise.

14.353. On 30th November 2021, and Attendance Support Meeting was held at Mia's school. Rachel attended and was advised her attendance was at 56% A plan was made for Mia and Rachel to follow.

14.354. On 30th November 2021, Elouise was assessed by Liaison and Diversion practitioner whilst in custody. She is recorded as suffering from post-traumatic stress disorder due to abuse form her father. She has also a diagnosis of anxiety and depression. Risk assessed as low, no risk to harm herself or others. Elouise was referred to the CMHT, and given crisis support contact details.

14.355. On 1st December 2021, Clive's pre-operation assessment was cancelled, and Hospital A staff called Clive's mother to advise. She stated he was currently unwell and his whereabouts were unknown.

14.356. On 2nd December 2021, Clive did not attend his Community Heart Failure appointment. When called, he stated he had been burgled, his house was a mess, and the letters had gone missing. He reported only getting two hours sleep per night, being tired and breathless, but this was not evident on the phone. He reported support from his mother, who was elderly and could not help too much. He was advised to call the CMHT for support with low mood. He spoke with CMHT, who completed a recovery plan. Clive stated he has cystic fibrosis, ME, Myoclonic Dystrophy, cardiac problems and blood cancer. He stated he wanted to move to a smaller house with no stairs. He was given information about the local Mens Shed scheme.[93] He stated his house had been burgled and the presents he had bought his children had been stolen. No evidence or thoughts of self-harm.

14.357. Also, on 2nd December 2021, Clive spoke to the Palliative Care Team Community Nurse, he stated only having two hours sleep, and only having support from his mother as none of his family visited him. He was advised to call the CMHT.

14.358. On 8th December 2021, Elouise is officially withdrawn from the college.

14.359. Also, on 8th December 2021, Clive attended the pre-operation assessment clinic for EUA and haemorrhoidectomy. Following the assessment, the operation was cancelled due to progressive weakness with likely myotonic dystrophy and cardiac failure. Clive was therefore deemed unfit for surgery. He was noted to be

[93] Community spaces for men to connect, converse and create.

low mood, stating this was due a breakdown of his marriage and court battles. He gave Rachel as his next of kin.

14.360. Elouise did not attend her Neurophysiology appointment and was discharged from the service.

14.361. The Bowel Clinic attempt to call Clive on 13th December 2021, no answer, appointment booked for three weeks' time, for a review within the clinic.

14.362. On 14th December 2021, Mia school was updated that the Early Help was being closed. Leeway had also closed, and Domestic Abuse Charity A would open a case for the family in the new year. A house had been found for Rachel and the other children, within the area, and Rachel had been removed from the previous tenancy.

14.363. On 14th December 2021, MSS called and spoke with Clive who stated that he may only have three weeks to live. He was struggling to come to terms with this, not in wanting to engage with this service but would contact them when he was ready.

14.364. On 17th December 2021, Early Help was closed, with an ongoing safety plan which included Elouise facilitating contact between Child A and Clive. This is dangerous practice and does not consider the dynamics within the family. It places Elouise as a young person in a position where she must protect her younger siblings, whilst appeasing her father, who by this point is recognised by professionals as abusive, manipulative and controlling.

14.365. Clive called the CRHT on 21st December 2021, he was feeling low due to Christmas period and not being with his family. Clive stated he had anger issues, a split personality, anxiety, depression, PTSD "walking problems" and chronic fatigue. He stated no intent to harm himself.

14.366. Clive spoke to a GP at Practice B on 30th December 2021, he reported feeling depressed and that he had stopped taking his antidepressants several weeks previously, as they made him feel angrier. He requested a further anti-depressant, and Oral Morphine[94] for his leg pain. He was prescribed Mirtazapine, and a higher strength co-codamol.[95]

14.367. Clive also called FRS on 30th December 2021, he was feeling tearful and alone. He had no plans to self-harm. He denied alcohol or substances. He was given advice about the Steam Café,[96] his GP and CMHT were advised of the call.

[94] An opioid treatment, used to treat pain when other pain medicines do not work well enough
[95] A pain killer combining paracetamol and codeine
[96] Purpose designed mental health crisis cafes – Steam House Cafes

14.368. On 6th January 2022, Clive was seen in Heart Failure clinic. His assessment was completed, and he is recorded as having poor mental health, he stated he had been in touch with NSFT Community Mental Health Team during the Christmas period and had been given advice on how to manage his mental health. He was not happy as the emphasis was on him to arrange support, and he stated due to his ME diagnosis he used to have carers' help as he gets "mind fog". Clive got irate and stated he had not had transport or a phone for some time. Clive requested a letter for his solicitor to evidence that he only had four years to live, as this is what he states he was told. The Nurse was unable to write this letter, as this was not an accurate prognosis. The nurse updated the GP that Clive had reported to be overusing his antidepressants.

14.369. On 7th January 2022, Housing Association A attempted to call Clive as his Direct Debit for the monthly payment had not been successful.

14.370. The Heart Failure team called Clive on 10th January 2022, as they had some advice about financial support. Clive returned the call on 13th January 2022; he stated his breathing was getting worse. He reported problems with his phone and car, which was making it hard to cope, he was advised to approach his GP. A referral was made to the Community Matron for more support. Clive's GP tried to call him but there was no answer.

14.371. On 14th January 2022, Elouise had been found by police on a bypass late at night, in her pyjamas. Her boyfriend had assaulted her causing bruising. Elouise was not supporting a police investigation. She was referred to NSFT MHLT but had left Hospital A before they could speak to her. A call was made to Rachel who knew that Elouise needed help but stated that Elouise would not accept any. FRS numbers given to Rachel for Elouise.

14.372. Also on 14th January 2022, CMHT called Clive to arrange an appointment, he was provided with a food parcel. Also, on 14th January 2021, Clive was seen by his GP, he had ongoing symptoms of depression and was not sleeping well. He had ongoing symptoms of COPD and muscle weakness. A letter was sent to neurology for a follow up, and a letter to CMHT for a review. There was also a request made to the respiratory nurse.

14.373. On 15th Jan 2022, Elouise's Work Coach had a discussion with a Decision Maker as Elouise continued to miss her appointments. It was decided that no further action was required as "Elouise was unaware of the appointment due to phone problems and due to mental health issues could be considered vulnerable." Her payments were still sanctioned from previously. The same day, Elouise left a distressed journal message mentioning suicidal thoughts. Subsequently, several attempts were made to call Elouise without success. Contact was then made with Rachel, who agreed to pass on the message that DWP had called to offer support.

14.374. On 17th January 2022, Mia's school have recorded that she had told her support worker that she felt tired and drained in lessons. She believes she may have bi-polar and felt like she had been angry forever. She had an ECG, but nothing had been found, but she was still having chest pains. Any time there is shouting or raised voices it gave her flash backs of Clive. Rachel was contacted and confirmed that Mia had not been accessing Norfolk CAMHS or any other mental health support, although CSC and Early Help had been in place on and off for some time – mental health support for Mia had not been suggested. The family's move to another property had been on hold as Clive was still refusing to sign her off the old tenancy, which now had arrears as he had not made the correct benefit claims. Rachel stated it was a battle to get Mia into school. She gave consent for a Norfolk CAMHS referral.

14.375. Clive spoke again to the landlords; he had run out of electricity and was having trouble budgeting. He had not paid off any of the rent arrears since Rachel left the property in April 2021.

14.376. On 18th January 2022, Elouise's GP received a letter from the police Mental Health Coordinator, detailing the abuse within the family and subsequent mental health issues for Elouise. The letter requested that the GP contact Elouise by letter as she didn't have a mobile phone.

14.377. On 20th January 2022, Elouise was taken to Hospital A ED by her mother following an incident of self-harm. Elouise refused to speak, and Rachel spoke for her. She was passed the details of the crisis team, and the GP was contacted to consider medication. Elouise also sent an online consultation request for help with mental health issues. She stated she could not eat or sleep properly and didn't know what else to do. She stated, *"I suffer from visions and thought about what has happened in the past and what I may do to myself."* As she had no phone, Rachel was contacted and advised GP that Elouise was "prone to impulsive acts" and was advised to hide sharp objects. She was signposted to the Steam Café; she is noted as engaging with Mind and Wellbeing Service. And was commenced on anti-depressants.

14.378. On 20th January 2022, Elouise was seen by MHLT whilst in ED having attended with cuts to her arms and legs. She was distressed due to breaking up with her boyfriend. She had been making threats to the boyfriend and girl she suspected of him of cheating with. She told the MHLT that she was an angry person due to her childhood. She stated she could not hold down a job due to the anger, she requested medication to help with this, and also stated she needed housing. ED staff referred Elouise to the Steam Café and helped her made an appointment with her GP to discuss her medication. There was no documentation within the ED record of curiosity or exploration of domestic abuse within her family following this attendance. Child A was late into school because Rachel had been with Elouise at

the hospital following her taking an overdose. Child A was not in school the following day as Rachel was still dealing with Elouise's poor mental health.

14.379. Also, on 20th January 2022, Clive was seen at home by CMHT. He stated there was now a restraining order against him for stalking Rachel. He stated she would return to the relationship if police and her family did not put pressure on her. Clive stated he was being investigated for benefit fraud as he did not report Rachel moving out. During the appointment, the police called Clive. Police suspect he broke into his own house before Christmas. He stated he had an ASC carer, but they had stopped coming.

14.380. A few days later, Elouise was killed by her father.

15. Summary

"Victims need to be told what is out there to help them." (Rachel)

15.1. Coercive control entraps a partner or family member into a relationship[97] and Clive used his illness, and the need to be cared for, as a tool to entrap Elouise, her siblings, and her mother. Clive had controlled and abused his family for many years. It is clear from the chronology that he had a series of physical health problems, some of which resulted from his lifestyle choices, and some he may have exaggerated to gain sympathy, evade blame for his behaviours, or to benefit in other ways.

15.2. Rachel reflected that she was always waiting for the right conversation to happen with professionals. She said she was ready to ask for help, but she was always spoken to in front of Clive and therefore denied any issues. Mia confirmed this and reflected on many times where Clive would have them all lined up on the sofa, sitting quietly while a social worker or other professional spoke to them, with Clive in the room or in earshot.

15.3. Rachel had been Clive's carer, often being the main point of contact for health and social care professionals, and it would also appear that Elouise was expected to care for him, especially after her parents separated. During the period Elouise was residing with her father and being his sole carer, her mental wellbeing deteriorated, along with her behaviour. She became a risk to herself, and also to others during this time.

15.4. It has long been recognised that fathers are often "invisible" to child protection proceedings, even when they are the cause of the risk of harm.[98] Whilst involved

[97] Stark, E *Coercive Control: How Men Entrap Women in Personal Life* (2009)
[98] The Safeguarding Practice Review Panel *The Myth of Invisible Men* (2021) The Myth of Invisible Men

with CSC, Clive was largely invisible – despite their involvement being due to his alleged behaviour - and the planning involving him throughout the children protection, and Child in Needs processes were never completed.

15.5. For a period, Elouise asked for help via her college DSL, who supported her wellbeing and raised concerns with CSC. However, from Elouise's perspective it felt that these pleas for help went unanswered as Clive remained in the home for some time, until Rachel found the strength to report him to police and follow through with a permanent separation.

15.6. Prior to Rachel and Clive separating, Elouise took herself away to Lincolnshire, to escape Clive's behaviour, and whilst there she was attempting to secure housing. Her expectations were high, and when she realised that she would have to stay with her grandmother, could not be rehoused in her own property, and her father remained living with the family, this is the point when her behaviour first started to deteriorate.

15.7. As mentioned above, Elouise took over the role of carer from Rachel, and she lived with her father. During this time, her access to acute care escalated - often in parallel to Clive's involvement with police and accessing acute care. They were both self-harming, talking about suicidal ideation and experiencing physical symptoms of stress and anxiety such as chest pains.

15.8. Research has found that perpetrators of domestic abuse continue to use coercive control against their children after their ex-partner has separated from them,[99] and the Domestic Abuse Act 2021 legislated for children as direct victims of domestic abuse. However, Elouise was largely invisible to the majority of services, as both a victim of Clive's coercive behaviour, but also as his carer – which further exacerbated her entrapment.

15.9. Rachel recollected that Clive was largely invisible to agencies as an abuser because of the disabilities he presented to everyone. She said that "he knew he was above the law" because of the disabilities.

15.10. Once separated from Rachel, Clive made it obvious that he was unable – or possibly unwilling - to care for himself. He quickly got into rent arrears, due to not applying for the correct benefits. He was also liable for "bedroom tax" due to remaining in the three-bedroom family home – whilst the family lived in a cramped two-bedroom property with Rachels mother. Clive refused to take on the tenancy as a sole tenant, and because of the arrears on the property – half of which Rachel was liable for, despite not residing at the property while they were being amassed

[99] Katz, E et al "When Coercive Control Continues to Harm Children: Post-Separation Fathering, Stalking and Domestic Violence" *Child Abuse Review* (29) (2020) pp.310-324

– this blocked Rachel and the children from moving into their own social housing property.

15.11. The period following separation from an abuser is the most dangerous for a victim.[100] Abusers require complete control over their victim; this includes the children within a family. Clive continued to have control over Elouise, as described above, and ultimately, he killed her when he perceived he had lost control over her. However, abusers also use self-harm, suicide threats and attempts, and self-neglect as a form of post separation emotional abuse.[101] Clive's lack of ability to care for himself following Rachel moving herself and the children out of the home, would have been performative, to elicit sympathy from Rachel, Elouise and the other children. This behaviour should be viewed as a continuation of the coercive and controlling behaviour he subjected his family to throughout his relationship with Rachel.

15.12. During Elouise's time in Lincolnshire, and also during the time she lived with Clive, she appeared to have mostly been responded to as an adult. Although when engaged with EDAN Lincs for a short period, she was provided with young adult's refuge information and given information about NACRO.[102]

15.13. Throughout the period of the review, Elouise was not always identified, or responded to, as a victim in her own right. Also, throughout the review, Clive was often invisible as a perpetrator of domestic abuse.

15.14. The Covid-19 Pandemic:

15.14.1. Much of the scoping period for this review fell during the period of national Covid-19 restrictions.

15.14.2. From March 2020 onwards national restrictions were placed on agencies and practitioners, some non-urgent services stopped, and some moved to online and/or telephone contact only.

15.14.3. During COVID restrictions, Clive was seen face to face by a GP on two occasions and a healthcare assistant on two occasions and had 13 telephone consultations with a GP. Elouise was also seen by her GP both face to face and via telephone consultation.

15.14.4. The Covid-19 pandemic placed strain on GP practices' management teams, due to staff sickness, and the need to allocate managerial staff to work within the Covid-19 vaccination programme.

[100] Post-Separation Emotional Abuse: How To Protect Yourself (nationallegalservice.co.uk)
[101] The Post Separation Abuse Wheel (dvact.org)
[102] Education, transition and support service for 16- & 17-year-olds in Lincolnshire

15.14.5. During the Covid-19 period, an unprecedented number of Universal Credit claims were made, due to people being furloughed[103] from their roles. Due to this, along with restrictions of movement of the public, and staff sickness, face to face meetings with the DWP were all cancelled. Elouise had interactions with DWP via her journal or by telephone.

15.14.6. During the scoping period of the review, the volume of work within NSFT was at its highest. The Covid-19 pandemic had significantly affected service delivery and there were fewer staff available to deliver patient care due to the number of staff vacancies. Telephone assessments were completed at the time which had an impact on the quality of assessments for individuals. Due to these issues, there were waiting lists for the Community Mental Health Team (CMHT). Clive was on a waiting list for initial assessment.

15.14.7. There was an expectation, within the Clinical Harm Review Policy, for patients on waiting lists to be contacted regularly, to monitor wellbeing. This policy was not followed during the scoping period, due to the capacity issues. To manage this a RAG system was introduced, with those assessed as red being contacted on a weekly basis and discussed at NSFT assurance meetings each week. Clive was RAG'ed as Red and there is evidence that he was contacted by a duty practitioner each week.

15.14.8. The Covid-19 restrictions led to schools being closed and had a massive impact on safeguarding and promoting the welfare of children, especially those living in homes where there was domestic abuse. During this time, education settings were required to offer places to vulnerable children, and the younger children's school offered spaces to Mia and Child A, which were declined, with the parents citing Clive's vulnerabilities due to underlying health conditions. During this period, Mia's school dropped off work in the form of workbooks, as the parents stated there was no Wi-Fi in the home, and the school provided free school meal vouchers. Child A was in infant school during the second period of Covid-19 restrictions; however, records indicate that she engaged with online learning during this period.

15.14.9. During this period, Mia's school demonstrated tenacity in attempting unannounced visits and stayed in contact with Rachel's mother to check on the children's welfare. Rachel's mother raised a concern with the secondary school DSL in March 2021, and the school liaised with Child A's school and made a report to CSC.

15.14.10. The children had been isolated by Clive all of their life, and the Covid-19 restrictions would have further exacerbated this control – particularly

[103] Temporary leave of absence from work during the Covid-19 pandemic restrictions

coming at a time when Elouise had started to raise awareness of Clive's behaviours within the home.

16. Individual agency analysis

16.1. Norfolk Constabulary

16.1.1. Domestic abuse accounts for nearly a quarter of all crime in Norfolk, and how the Force deals with domestic abuse is a priority.

16.1.2. Domestic abuse training delivered to Norfolk police officers covers coercive and controlling behaviour, stalking and harassment behaviour as well as the risk assessment process for domestic abuse incidents. There is also a full day's input to train new starters on the topics of Honour Based Abuse, Female Genital Mutilation and Forced Marriage.

16.1.3. As part of Norfolk Constabulary's work to improve investigation standards under 'Op Investigate', all sergeants receive a training day that explains investigative standards and expectations. Domestic abuse investigation is a theme throughout the training with a focus on evidence led investigations.[104]

16.1.4. Norfolk Constabulary provides bespoke training packages, relevant to specific roles, to other staff in other departments in the organisation. For example, the Contact and Control Room (CCR), Quality Assurance Team and the force's analytical department.

16.1.5. Norfolk Constabulary Domestic Abuse Force Policy was last reviewed in June 2022. As part of the scope of this DHR, the previous version dated March 2020 would have been in force.

16.1.6. There were missed opportunities in 2019 to arrest Clive, and there is no clear rationale within the policing paperwork to explain the lack of arrests made early in the scoping period. There were also opportunities to identify and investigate coercive and controlling behaviour, for example when Elouise reported Clive's use of weapons to threaten and control the family. However, following Rachel providing a statement in 2021 when Clive was arrested, police took all possible action to gather a case against Clive. This highlights the evidential difficulties police may face when a victim does not feel able to support a prosecution.

[104] Where the prosecution need not rely on the victim's evidence.

16.1.7. During the scope of the DHR there has been an amendment to the Domestic Abuse Policy. The policy previously dictated that every high-risk domestic abuse case that is NFA'd must be reviewed by a Detective Sergeant (DS). It has now been amended to reflect the same principle for DS oversight but for a crime that was at *any point* high risk not just for those being NFA'd whilst at high risk. This constitutes part of the High-Risk Domestic Investigations policy for supervisors.

16.1.8. Norfolk Constabulary has also adopted the 8 Point Plan (8PP) for investigations. The 8PP is a tool used to support officers at the creation and throughout the investigation. This is set by the 'Officer in the case' and reviewed by all supervisors at the start of any investigation, and supports, particularly in domestic abuse cases, the need for considering evidence led prosecution.

16.1.9. A 7 Point Plan (7PP) has been introduced to ensure a full supervisory review of all available evidence is completed prior an investigation being finalised and closed. This provides a secondary review tool to ensure no investigative opportunities have been missed.

16.2. NHS Norfolk and Waveney Integrated Care Board

16.2.1. Health settings are trusted environments, used by everyone. Because of this, they are places that can reach those from every background and walk of life who are subjected to domestic abuse, especially those who may not feel confident seeking help from other professionals. That is why it is critical to ensure awareness about domestic abuse is embedded into the safeguarding policy and practices of all health settings.

16.2.2. Practice A and Practice B have a Safeguarding policy and Domestic abuse policy, with named Safeguarding Leads. Any disclosures or concerns made to the practice are reported to the Safeguarding Lead. One of the surgeries Social Prescribers is a DA Champion which demonstrates that the surgery is engaging in the countywide Domestic Abuse Champions training. These resources are considered the benchmark for GP Practices in being prepared to respond well to domestic abuse, and safeguarding concerns.

16.2.3. Since March 2021 joint safeguarding adult and children level 3 training has been provided monthly provided by Norfolk and Waveney ICB which includes training on domestic abuse. Between 2021-2022 there was a drive to increase the number of Domestic Abuse champions in GP practices with 2-day Domestic Abuse champion training being available to practices. The ambition was training as many GPs as possible, however it was noted that many staff members in surgeries received the training but were unable to demonstrate how they measured training effectiveness.

16.2.4. The Care Quality Commission (CQC) have inspected both GP surgeries. Practice A was inspected in 2018, and Practice B was inspected in 2017. Both were rated good overall in the areas of care being safe, effective, caring, responsive and well-led. The CQC do not explicitly require processes and policies regarding domestic abuse, however they do require evidence of systems, processes and practices to keep people safe from abuse in general.[105]

16.2.5. The practices did not have any disclosures or indication of domestic abuse, therefore did not complete any DASH assessments. However, there is no evidence that that either practice asked routine enquiry questions of Clive, and when Elouise disclosed historic abuse from Clive, this was taken on face value and not explored with Elouise – for example to determine whether there were any current risks or residual effects from the abuse.

16.2.6. All GP practices have carer registration forms. Carers are entitled to a free flu vaccination, and the surgery may also offer; some flexibility with appointment times for the carer and the person being cared for, and an agreement to share information about the condition of the person being cared for, with their carer. Clive had stated to Practice B that Elouise was his carer since his wife had left him. There is no evidence that this was discussed further, and this was a potential missed opportunity for the GP to give Clive advice regarding a carers assessment for Elouise.

16.2.7. Practice could be improved around training for Practice A, as in December 2022 training for safeguarding was around 70%. The target range for training compliance is 90%, however Practice A have recognised the gap and are working on an approach to try and recover the drop-in compliance.

16.2.8. Since the commencement of this DHR, the Norfolk and Waveney ICB have included details of the NIDAS service in their safeguarding bulletin and during their safeguarding lead clinician meetings. Early learning from this review has also been included in the ICB level 3 joint Safeguarding Children and Adult training sessions since June 2022.

16.2.9. The ICB had also developed a template domestic abuse policy for GP Practices. This was reviewed by the Local Medical Committee, NIDAS, and the Head of Community Safety, and has been in circulation since Spring 2022.

[105] CQC Inspector Handbook: Safeguarding update

16.3. Children's Social Care

16.3.1. Between 2019 and 2022, the locality team engaged with Elouise's family were experiencing a high turnover of staff. There was a high number of agency staff and a high level of sickness across the social work teams, including within management roles. Cases were all allocated, however the changes in workers, sickness and high numbers of agency staff impacted on the quality and consistency of interventions. There was a lack of supervision, which led to poor decision making, and a poor response to Rachel, Elouise, and the children – as victims of domestic abuse.

16.3.2. The 2015 Ofsted inspection of Norfolk Children's Services judged the local authority as inadequate.[106] There followed two Ofsted monitoring visits, where issues continued to be identified, these issues included timeliness and quality of assessment, quality of care plans, and issues around supervision.[107] A further Ofsted inspection was carried out in November 2017, which was judged overall as requires improvement.[108] A Ofsted focused visit in late 2019 found improvements had been made.[109]

16.3.3. In November 2022, a full Ofsted inspection judged the local authority as good overall[110] and found that significant improvements had been made. In December 2021, a Head of Social Work (HoSW) had been recruited, with a new focus on workforce stability, recruiting permanent social workers and improving performance and quality. Currently, the social work teams are fully staffed, and sickness is at minimum level.

16.3.4. The 2022 Ofsted inspection found some areas which still required improvement, these included "the practice response to children aged 16 and 17 who present as homeless", and "the recognition of and response to children who are experiencing neglect over a prolonged period of time". These are two areas of significance for Elouise and her family.

16.3.5. In 2019 a specialist Domestic Abuse worker role was introduced to within the CSC teams. This role was intended to support families where domestic abuse has been identified as an issue. The role works alongside the allocated social worker. Rachel and Elouise would have benefited from support from this role, however not offered this specialist support. This may be because the role did not become fully embedded in CSC work until

106 50004306 (ofsted.gov.uk)
107 2762848 (ofsted.gov.uk)
108 50000266 (ofsted.gov.uk)
109 50120838 (ofsted.gov.uk)
110 50204404 (ofsted.gov.uk)

around 2022, as the COVID-19 restrictions made it difficult for CSC practitioners to liaise and work in collaboration.

16.3.6. Since 2019 there has been a focus across CSC, to rethink the use of pre-proceedings and effective child protection planning. Decision making for the most vulnerable children is more robust, staff are having regular reflective conversations with HOSW and senior leaders including Coming into Care Conversations (CCC) where appropriate and are liaising with legal colleagues as routine. The pre-proceedings process means that parents are informed of their rights and can seek and gain legal advice as to next actions.

16.3.7. The frequency to visit children is clearly set out in statute, however there is an improved expectation that that children are visited at a frequency that meets their needs and risks, whether CIN or CP and that they are seen in a variety of settings, away from the family home, and alone. Much more direct work is completed and analysed to ensure the voices of children are fully captured.

16.3.8. The decision to close the Child Protection plan after only three months was poor practice. Clive was able to claim that things were calm in the household and that the children were happy. A further period of Child Protection involvement may have tested this, if during that time he had been compelled to be involved in the process.

16.3.9. A longer period of child protection involvement may have also afforded closer support of Rachel, a victim of long-term domestic abuse, who would have required longer than three months of intervention to build rapport and trust with professionals – against a backdrop of coercive control from Clive spanning more than twenty years. A longer period of child protection involvement may have also allowed some support of Elouise and may have assured her that CSC were taking the abuse seriously.

16.3.10. The lack of supervision during this time enabled this decision to be made without challenge. This practice would no longer be possible, as all decisions to step down must be agreed by the Head of Social Work, and practice guidance explicitly includes a requirement for all Child Protection plans to continue beyond the initial three-month review, except in very exceptional circumstances. This is a change which has been implemented since the scoping period of this review.

16.3.11. The decision to plan under Child in Need, and the apparent acceptance of Elouise's retraction of abuse in October 2019, indicates a lack of recognition of the level of control which Clive had over Rachel, and Elouise. As Professor Monckton Smith warns, "coercion may often look like

consent". This control may have also extended to the social workers,[111] who may have also been afraid of Clive.[112]

16.3.12. There was a lack of recognition and exploration of the family history and family dynamics when decision making, from initial referrals through to decisions to step down and/or close the CSC interventions. This is contrary to CSC policy and good practice and should have been highlighted in supervision session.

16.3.13. Between 2019 and 2022 there had been six different Social Workers, and three Independent Chairs involved with the family, plus a period of work carried out by a Family Support Worker. This meant the family did not receive consistent support and did not have the opportunity to build trust in one person. It is also not clear whether the children were routinely seen alone, or away from Clive. Considering the backdrop of coercion which the family were all living with, this was not good practice.

16.3.14. During CSC involvement with the family, it was often recorded that both Clive and Rachel were refusing help, hiding the behaviours, and placing the blame onto Elouise. There were expectations placed upon Rachel, who was a victim of domestic abuse and coercive control, to ask for help and to break free from the relationship. Learning from this review highlights the dangers of placing these expectations onto abused mothers.[113]

16.3.15. To gain the trust of victims of coercive and controlling behaviour, practitioners must demonstrate an awareness of the victims' possible experiences. The language used within the CSC casefiles linked to Elouise's family, includes "disguised compliance" "avoidance" and "non-engagement". If this language was used within core groups, child in need meetings, and other meetings which Rachel may have been in attendance, this would have dissuaded her from putting her trust into CSC professionals.

16.3.16. Victim blaming language and behaviour will form wider learning for this review, however it is vital that CSC professionals, who have such a pivotal role in responding to domestic abuse, develop language which does not risk placing the blame for the family's situation onto the non-abusive parent.

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[111] Mandel, D et al *How Domestic Violence Perpetrators Manipulate Systems* Safe and Together (2021)
[112] Humphreys, C "Domestic Violence and Child Protection: Exploring the role of perpetrator risk assessments" *Child and Family Social Work* (2007)
[113] Thompson, L "Impossible Expectations: A Study of Abused Mothers in the Child Protection System" *Family Law Quarterly* (32) (2020)

16.4. Department for Work and Pensions

16.4.1. The Department for Work and Pensions has domestic abuse guidance, which is available on an internal intranet site, for all staff to access. The domestic abuse guidance is refreshed on a regular basis.

16.4.2. Universal Credit (UC) has specific guidance on how to support UC claimants affected by current or recent domestic abuse.

16.4.3. Staff have access to a District Provision Tool that contains information relating to provision delivered by Jobcentre Plus, providers and local authorities. Staff will use the information to signpost claimants to the most appropriate support available.

16.4.4. The Jobcentre at Town A, where both Elouise and Clive were linked, has a domestic abuse subject matter expert, who other staff can consult for advice. The subject matter expert attends networking meetings where best practices are shared, and they are responsible for cascading this learning. Elouise was signposted by her work coach to a Leeway in November 2021.

16.4.5. Elouise was supported by a specialist youth work coach whose role is to support claimants aged 16 -24 years old.

16.4.6. Elouise was claiming Universal Credit at times as a fulltime student and at other times as unemployed and seeking employment. For Elouise to receive Universal Credit, she needed to have a "claimant commitment"[114] in place, this was Elouise's record of her responsibilities that she accepted in return for receiving UC. She also accepted the consequences of not meeting the commitments, which meant that Elouise's UC payments may be cut if she didn't meet her responsibilities. This is called a sanction.

16.4.7. On the two occasions that Elouise was sanctioned due to non-compliance, a Decision Maker deemed that the correct processes had been followed and all the information available, including any information that Elouise had provided. The Decision Maker deemed that Elouise did not have good cause for not attending. As a result of the decision, Elouise's UC was reduced for a specific period. Elouise did have the right to request a mandatory reconsideration for each of these decisions, and this information was included in the decision letter that Elouise received. Elouise did not request a Mandatory reconsideration of either of these decisions. Elouise's

[114] This is a set of expectations that the DWP has of each claimant of Universal Credit, and which must be fulfilled for a payment of Universal Credit to be awarded. Specific requirements of the claimant commitment depend on the individual's circumstances, such as their health, caring responsibilities, and whether or not they are working.

young age and vulnerabilities should be taken into consideration, regarding the expectation to understand and follow processes.

16.4.8. Since the commencement of the DHR, the DWP reconsidered the decision of 9th November 2021 in respect of Elouise to apply a UC sanction for failing to comply with an interview requirement on 20th October 2021. The revised decision is that no sanction is to be applied in respect of this failure as Elouise's full range of vulnerabilities were not considered at the time of the decision.

16.4.9. DWP also reconsidered the decision of 20th December 2021 in respect of Elouise to apply a UC sanction for failing to comply with an interview requirement on 9th December 2021. At the time of the sanction, the information was not stored in one place on DWP systems. The available information was reviewed during the internal review process and identified that if the full range of vulnerabilities had been considered at the time, a sanction would not have been considered appropriate.

16.4.10. Information relating to Elouise's personal circumstances had been correctly recorded, but notes relating to Elouise's vulnerabilities were not held in one place, they were dotted across the claim and therefore not easily accessible by staff. DWP has made significant changes to the way it collates information relating to a customer who requires additional support, it has introduced an "Additional Support" tab on the Universal Credit platform this was introduced as part of broader work by the DWP. Information must be recorded in the "Additional Support' tab. Agents must record any temporary or long-term complex needs and how these affect the claimant's ability to use the Service. Any note must provide a clear overview of any complex need a claimant has, and any identified issues which require support and what support is being provided through the jobcentre and/or external partners or services. Support may be put in place on a one-off basis for a short, medium, or long period of time, or for recurring periods.

16.4.11. It is important to regularly review the entries on the claimant's 'Additional Support' tab and Profile notes screens to confirm if the complex needs are still relevant. If they are not, the tailored support or easements must be reviewed, and any pinned notes removed.

16.4.12. If the Additional Support tab facility had been available when Elouise was involved with DWP, agents would have been able to identify that Elouise had additional support needs and consider her full range of vulnerabilities. This would have included the work coach, team leader and decision maker also being able to view Elouise's additional support needs and taking these into consideration as part of the decision-making process.

16.4.13. The DWP have a National Six Point Plan (6PP) Framework, for DWP staff to follow when Managing Customer declarations of intention to Attempt Suicide or Self-Harm. The DWP 6PP framework was not correctly followed when the journal message sent by Elouise was received by DWP, this was a compliance issue with regards to correctly recording and reviewing the incident. The 6PP framework has recently been amended and now includes an expectation for the incident to be reviewed by a team leader.

16.5. Norfolk and Suffolk Foundation Trust

16.5.1. During the scoping period of the review, staff turnover was high. There had been no Service Manager[115] in post for a few months, and their role would be to oversee clinical and operational management for the teams supporting Clive.

16.5.2. During this period, sickness was an issue, not only due to the Covid-19 pandemic, but due to the lack of service management, which meant lack of oversight and some staff did not feel supported at this time. Limited staff cover resulted in the implementation of a Business Continuity Plan for several months from September 2021. A new service manager joined in October 2021. Since the review period, "safety huddles"[116] are now completed twice a day.

16.5.3. During the scoping period, mandatory safeguarding and domestic abuse training levels were not at the required level. This was due to the NHSE directive to stand down face to face training during the pandemic.

16.5.4. During spring 2023, the NSFT Safeguarding Team launched a bespoke package of domestic abuse training, which now includes the role of MARAC, completing a DASH and how to refer and signpost victims to specialist services. A training audit has been undertaken, which evidenced uptake of training exceeding the 90% target set in 2022.

16.5.5. As a direct result of this review, and other recent Norfolk and Suffolk Safeguarding Adult Reviews (SARs)[117] and Children's Safeguarding Practice Reviews (CSPRs),[118] improvements have been made to the triage process within the Youth Team. They now have a clear triage template that

[115] NSFT have not been able to clarify which teams were affected by the lack of management oversight, this is due to staff changes within the Safeguarding Team since the IMRs were written.
[116] These enables teams to have frequent but short meetings so that they can stay informed, review work, make plans and keep momentum to move ahead rapidly.
[117] Norfolk Safeguarding Adult Reviews
[118] Norfolk Child Safeguarding Practice Reviews

is easy to follow and allows the team to ensure there is documented rationale for any decisions made, including non-recent information. The aim of these changes is to negate the possibility of missing important factors in the future.

16.5.6. NSFT are currently piloting a new genogram application, which encourages and supports a Think Family approach across all services.

Elouise

16.5.7. Elouise was referred to NSFT when she was 17 years old, the referral was triaged and taken to a multi-agency 'intake' meeting. It was agreed following subsequent conversations with Norfolk CSC that as Elouise had a social worker and was under a Child in Need (CIN) plan that the Child Family and Young People Team (CFYP) would not be involved at this time. This would allow CSC to address the issues from a social context perspective around the impact of Elouise's father on her wellbeing. It was agreed that a re-referral could be made once the primary problems around the social context had been addressed. The multi-agency team identified that she was a victim of abuse as a child, however the mental health clinical notes do not specify if domestic abuse directed towards Elouise was considered as a factor. This approach proved to be problematic, as the abuse continued from when she was a child, and into her adulthood. Elouise should have been supported as a victim of domestic abuse, regardless of her age.

16.5.8. There also does not appear to have been any specific work undertaken with Elouise by CSC to address the "social issues" – and as NSFT did not link in with CSC after closing this case, this was not addressed, and she was effectively left without mental health support during a time when her mental wellbeing is evidenced to have been on the decline.

16.5.9. The DASH risk assessment was not used with Elouise or considered in respect of Elouise - this is contrary to the requirement within the NSFT domestic abuse policy, for both adults and children. In discussion with a practitioner linked to Elouise, they had considered her "childhood abuse" as impacting her current mental health, but there was no indication that domestic abuse from her father was considered as a risk factor.

16.5.10. Elouise being recognised as a victim of domestic abuse, in her own right, is learning for all agencies within this review. However, the key opportunity at this point, to provide support for Elouise as a victim of domestic abuse, with worsening mental ill health was missed by NSFT.

Clive

16.5.15. Clive had contact with NSFT Wellbeing Service (WBS) between August 2013 until December 2021; this equated to seven separate referrals of which six were self-referrals and one GP referral. On each of these occasions, he was either signposted to other services who could offer more appropriate support, for example benefits or housing, or he declined, or disengaged from the treatment. He was offered wellbeing workshops but did not attend.

16.5.16. At the time when Clive killed Elouise, he was awaiting allocation to NSFT secondary services and had engaged with the "weekly waiting list review" since April 2021. The initial engagement with secondary services in April 2021, had occurred following an overdose, when Clive was seen by the Mental Health Liaison Team (MHLT) within ED. The overdose followed Clive's arrest on 7th April 2021, in relation to an assault of his wife.

16.5.17. Clive had refused to engage with the MHLT at the time of his arrest but did engage when he attended hospital following the subsequent overdose. However, the domestic abuse incident was not considered in relation to wider family members, and the paperwork documented Clive as living alone. Practitioners did not Think Family during this engagement with Clive, this is wider learning from the review and is detailed at section 17.5.

16.5.18. The initial assessment for Clive with an allocated Lead Care Professional took place four days prior to Elouise's death. The assessment was unremarkable in its content, no significant risks were highlighted, and no findings of any impending risk of harm to others identified. This assessment was taken solely on face value from the information Clive gave. This is contrary to Trust policies which requires research of historic information and gathering of information from significant others when undertaking assessments. Had historic information been interrogated, it would have been identified that the Trust held contradictory and inconsistent information about Clive.

16.5.19. The Trust Clinical Risk Policy has been reviewed following this and other statutory reviews, resulting in the introduction of a Clinical Safety Forum, which aims to improve the culture in risk assessing. Risk assessment processes will include engagement with families and carers and will consider historic factors when making safety plans.

16.5.20. The professionals involved in Clive's care stated they would have had no reason to doubt what was being shared by Clive. However, clinical curiosity would have been appropriate given the known history of arrest, domestic abuse and overdose, and the potential unreliability of Clive's accounts.

16.5.21. Clive made use of support from NSFT First Response Service (FRS) in December 2021, NSFT Crisis Team (CT) in October 2021, and a 'My Recovery Plan' had been devised with Clive. This was good practice and led to better engagement in the regular weekly calls whilst he was waiting for allocation to the CMHT. There was good communication between CT, and they communicated information with CMHT from these contacts.

16.6. Lincolnshire Partnership Foundation Trust

16.6.1. LPFT provides a range of health and social care services for people of all ages within Lincolnshire. LPFT was established on 1st June 2002 when social care and health services, formerly provided by Lincolnshire County Council and Lincolnshire Healthcare NHS Trust, were brought together to create a new Trust providing mental health and substance misuse services for adults and mental healthcare for children.

16.6.2. All LPFT staff receive training on Domestic Abuse as per the Intercollegiate Document and are aware of what to do if they have concerns about this type of abuse. If staff were unsure, they can also access the Trust Safeguarding Team for advice Monday to Friday between the hours of 9am and 5pm. Each clinical team also has an allocated Safeguarding Champion.[119]

16.6.3. The Trust has a Safeguarding Policy (Policy 11) which incorporates the expected process that staff should follow if they receive a disclosure of domestic abuse- including completion of a DASH. The Trust has accessible flowcharts visible in all clinical areas that reflect this process for staff to refer to quickly and follow.

16.6.4. LPFT CAMHS Crisis and Enhanced Home Treatment Service (CCETT) staff were responsive to Elouise's needs when she felt that she needed support. CCETT showed evidence of working with Elouise, maintaining a patient centred way of working which helped to maintain her willingness to engage with services.

16.6.5. Both staff in the CCETT and Steps2Change services who engaged with Elouise were able to build an effective therapeutic rapport with Elouise, which allowed her to share detailed information about her past and current experiences. This allowed staff to be able to offer support that was tailored and appropriate to her presenting needs.

[119] These staff receive additional information, guidance, and supervision from the Trust Safeguarding Team

16.6.6. During Elouise's involvement, she disclosed previous domestic abuse but did not voice any current risk from Clive, stating that there were bail conditions in place and that she had no contact with him. The Trust flowchart instructs staff to complete a DASH whereby there is "current Domestic Abuse".[120] As no further questions were asked about the timescale of the abuse, ongoing threats of harassment and effects of the abuse – it was assumed that the abuse was historic. The presence of current bail conditions should have raised a concern, as this would indicate some level of risk to Elouise which required the protection of bail conditions.

16.6.7. The Trust has Safeguarding screening tools/assessment tools that are designed to identify concerns relating to safeguarding. The Child & Young Person Safeguarding Assessment prompts staff to ask the patient whether they have experienced any abuse in their lifetime, and whether the patient is currently under CSC, and requests the name and contact details of their social worker.

16.6.8. In relation to Elouise's care, the Child & Young Person Safeguarding Assessment was completed by CCETT following their assessment with her on the 8th of September 2019. This tool did not identify Elouise to be known to Children's services at that time. CCETT staff did identify through the assessment that Elouise was renting a room from two older adults, however, did not ask who these individuals were. Staff should have shown more professional curiosity around Elouise living conditions.

16.6.9. Due to Elouise's age, she was responded to as a young person, not as an adult. More recently, LPFT Children and Young People services have been granted access to the CSC system (CPIS) within their Access Team who screen new referrals. This is an initial pilot, there is the intention to rollout across Lincolnshire CAMHS in order to become standard procedure when responding to all children including 16- and 17-year-olds who indicate they have CSC involvement.

16.6.10. The Lincolnshire Safeguarding Children's Partnership (LSCP) has a Policy in place named "Arrangements for Children who are subject to a Child Protection Plan". This Policy was followed by CCETT and Steps2Change staff, but Elouise was not known to Lincolnshire CSC as they had not been informed by Norfolk CSC that Elouise was in their area. However, further exploration could have been undertaken into previous addresses which were present on the system and would have indicated that Elouise had recently moved from another local authority area.

[120] SafeLives guidance states that the DASH "is designed to be used for those suffering current rather than historic domestic abuse and ideally would be used close in time to the last incident of abuse that somebody has suffered."

16.6.11. Trust staff should have an awareness of how CSC can work across different local authority borders. This information has now been added to LPFT Safeguarding training and a bulletin has been sent out across the Trust in the Trust Communications email. The Steps 2 Change Service Manager has also sent all staff a communications email to remind staff to request contact details for Social Workers as soon as they are made aware that they are allocated to a child/young person.

16.6.12. During analysis of the case notes for the DHR it was identified that when Elouise was triaged and later assessed by CCETT, staff had not recommended any specific support that she could access whilst she awaited Steps2Change, such as KOOTH,[121] Shout,[122] or Childline.[123] The Service Manager for CCETT raised this at their monthly business meeting so that it can be shared across the teams within the service. Staff are provided with an up-to-date list of services to assist with signposting, referring or providing to patients to self-refer.[124]

16.6.13. It is a potential risk that a service like Steps2Change who mainly work with adults and have strict commissioning criteria in terms of disengagement and discharge processes can miss the significance of information when presented to them by a 16- or 17-year-old accessing their service. Staff are reminded of this on Trust Safeguarding training and the importance of treating the information they may routinely hear from an adult in a different way when heard from a child.

16.6.14. Steps2Change identified that Elouise was struggling with Post-Traumatic Stress Disorder symptoms and determined that CBT would be her most appropriate treatment. Elouise was kept informed via letters about delays in waiting times which also included reminders around what services she could contact if she felt unable to keep herself safe whilst waiting for treatment.

16.6.15. LPFT were unaware of the level of violence and abuse Elouise was faced with, and unaware of her vulnerabilities. This was partly due to a lack of the "correct" questions asked by practitioners and made more difficult by Lincolnshire CSC not being aware that Elouise was in their area, whilst subject to a CP Plan.

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[121] Kooth.com
[122] Shout
[123] Childline
[124] Lincolnshire Family Services Directory (lincsfamilydirectory.org.uk); Young people :: Lincolnshire Young Minds (lpft.nhs.uk)

16.7. Leeway Domestic Violence and Abuse Service

16.7.1. Leeway was commissioned by the Office of Police and Crime Commissioner Norfolk to provide the Norfolk high risk IDVA service during the scoping period for this review. The IDVA service provided emotional and practical support to service users who had been identified as being at high risk of significant of harm or homicide.[125]

16.7.2. Leeway have provided a number of services to victims who have experienced domestic abuse in Norfolk and Suffolk since 1974. The services include community services, residential services, children and young people services and training and consultation services.

16.7.3. At the time of the domestic homicide the IDVA Service had the Leading Lights accreditation which is the national standard of service for IDVA Services across the UK.

16.7.4. The service was overseen by an IDVA Coordinator and managed by The Community Services Manager within Leeway. There was a limited amount of administrative support provided by Leeway central services.

16.7.5. Staff turnover was consistent, with staff tending to remain working Leeway for several years, and there were low levels of sickness within the IDVA Service.

16.7.6. NIDAS accept referrals from GPs without DASH assessments as they recognise this may not be possible within a 10-minute consultation. Recognition and referral are accepted as sufficient and NIDAS will then undertake the DASH assessment. This has been communicated through forums for GPs and via the ICB safeguarding Spotlight newsletter.

16.7.7. Referrals into the IDVA service for Rachel and Elouise had contact attempted on the same day as the referral, so that immediate safeguarding measures could be implemented before the case being allocated to a named IDVA for ongoing support to be completed. All cases were allocated to a named IDVA whether the initial contact had been made, so that the

[125] The IDVA service ceased operating on 31st December 2021 and was replaced by NIDAS (Norfolk Integrated Domestic Abuse Service). NIDAS (Norfolk Integrated Domestic Abuse Service) is a partnership between agencies that provides a standardised service across Norfolk to victims of domestic abuse who are at high or medium risk of harm or homicide. NIDAS also offers dedicated support for children and young people, a domestic abuse champions network, and training for professionals.

IDVA would continue the contact attempts and remain responsible for oversight of the case.

16.7.8. When the IDVAs struggled to contact Elouise, they attempted to make contact via the allocated social worker.

16.7.9. Supervisions and case management sessions should be completed monthly with line managers, however in this case there is evidence to suggest that the case was only reviewed on one occasion during the period April 2019 to July 2019 when the case was open to Leeway.

16.7.10. Elouise's age was a significant factor in not being able to access safe accommodation in the form of refuge accommodation due to not being able to claim housing benefit. There was no evidence of the IDVA working collaboratively to explore this, however it was suggested that alternative accommodation would be provided by CSC in the form of sheltered accommodation.

16.7.11. When Elouise moved to Lincolnshire, it was unclear whether she intended to stay there or planned to return to Norfolk. Elouise was advised by the IDVA that she would need to be referred to local DA services, if she was going to stay in Lincolnshire. Elouise advised the Leeway IDVA that she had been in contact with EDAN Lincs, who liaised with Leeway and raised concerns regarding disclosures after speaking to Elouise. Once Elouise was in Lincolnshire a MARAC-to-MARAC transfer was requested, although there is no evidence that this happened, and this should have been followed up by the Leeway IDVA.

16.7.12. Elouise had initially been assessed as high risk, but over a period it had been difficult to complete risk assessments as there was limited engagement, and when the engagement took place, it was often rushed and time limited. Therefore, there was not always a clear picture of risk levels. New MARAC processes have encouraged professionals' meetings, for example when there are concerns around risk and non-engagement, this collaborative working would have been beneficial to Elouise's situation.

16.8. Domestic Abuse Charity A

16.8.1. Domestic Abuse Charity A supports women and children affected by domestic abuse, commissioned at this time by the Office of the Police and Crime Commissioner, for support to standard and medium risk victims. All Domestic Abuse Charity A workers attend domestic abuse training and safeguarding training as part of their induction, safeguarding training is renewed annually.

16.8.2. Domestic Abuse Charity A offers long term support to women and children for up to a year, giving them the time to fully recover from the trauma of abuse. As well as offering outreach support at this time, Domestic Abuse Charity A was offering group recovery programmes, drop-in sessions, and training.

16.8.3. Elouise was referred into the service by College A, and the two agencies worked closely together to support Elouise. The work that Domestic Abuse Charity A completed with Elouise was to offer support and advocacy around her experiences of domestic abuse, and support around the safety concerns that were quickly identified.

16.8.4. Elouise told Domestic Abuse Charity A several times that she felt let down by CSC. She had requested a change of social worker, and she said she didn't understand why they were not helping her. She was desperate to leave home and live somewhere safe. Elouise had a good understanding of how Clive was grooming the social worker, which to Elouise must have made him appear even more powerful. She said she felt tricked by CSC into returning to the family home when she had just wanted to leave.

16.8.5. Elouise did not remain engaged with Domestic Abuse Charity A services. the Domestic Abuse Charity A worker tried to encourage engagement by offering joint visits with college staff, and were very flexible around days, times and venues for meetings. At the time of disengagement with the service, there was an imminent Child Protection Conference planned, although Domestic Abuse Charity A were not invited to the conference.

16.9. EDAN Lincs

16.9.1. EDAN Lincs is a voluntary organisation with the objective of supporting and empowering all those affected by domestic abuse in Lincolnshire. They provide support and assistance to women, men and children suffering, or fleeing from domestic abuse.

16.9.2. EDAN Lincs service is voluntary and is under pinned by policies and procedures in line with Lincolnshire Domestic Abuse Partnership (LDAP). There is a plethora of assessment tools and guidance available in-house, and all EDAN Lincs' staff can access and utilise the "professionals' hub" provided by the LDAP if required.

16.9.3. All those working for EDAN Lincs undertake mandatory training, which is in line with Safer Lincolnshire Partnership agreements. The training provided,

includes knowledge and awareness of domestic violence and abuse, domestic abuse in practice, Coercive and Controlling Behaviour, stalking, safeguarding in children and adults, and children who experience domestic abuse. All domestic abuse workers require mandatory training in the use of completing a DASH risk assessment.

16.9.4. During the period of support, there was no specific policy regarding the disclosure of weapons, however since this incident EDAN Lincs have developed a Managers Guide in respect of disclosure of weapons and reporting to police. These are on a case-by-case basis.

16.9.5. Elouise was engaged with EDAN Lincs' Triage Outreach Service for a short period, during this time support was offered to Elouise regarding the availability of refuge provision. EDAN Lincs' shared information with Leeway, who in turn shared information with Norfolk police and MARAC. Elouise was provided with relevant local domestic abuse agency information, whom she could refer herself to in respect of accessing and or continued supportive accommodation.

16.9.6. Given that Elouise was not open to EDAN Lincs' service, the triage worker encouraged Norfolk CSC to complete a further DASH risk assessment based on the recent threat of harm that was alleged by Elouise.

16.9.7. Elouise was not at the point where she could emotionally understand the barriers that she was facing. The Triage worker took steps during the contacts that she had with Elouise, to manage her expectations and to explain the procedural complications of going to a refuge.

16.10. Norfolk Community Health and Care NHS Trust

16.10.1. Norfolk Community Health and Care NHS Trust (NCHC) provides community-based NHS health and care via more than 70 different service locations across Norfolk, serving a population of nearly 900,000 people.

16.10.2. NCHC have a domestic abuse policy in place. Which encourages individuals disclosing domestic abuse to refer into a specialist agency. NCHC also have domestic abuse champions in place, who can complete a DASH risk assessment with victims.

16.10.3. During the contacts NCHC had with Clive, there were no disclosures of domestic abuse or documented suspicions that Clive was a perpetrator or victim of domestic abuse. Therefore, DASH assessment was not completed.

16.10.4. During the scoping period, Clive had contact from three NCHC services; Community Speech and Language Therapy, Community Specialist Palliative Care Service and Community Heart Failure Nursing Service.

16.10.5. During earlier contacts, whilst Rachel was still living in the family home, there was a lack of direct communication with Clive. SALT only had telephone contact with Clive or Rachel – who was also unnamed on the records - and the majority of contact was administrative in arranging appointments rather than direct clinical advice or treatment. There is evidence that the service was sensitive to Clive's needs in relation to persistence in trying to see him. Four different appointments were made, but Clive either failed to attend or cancelled on the day. Clive was finally asked to take ownership, to complete a one-week food record and return to the SALT service. When this was not returned, he was discharged.

16.10.6. There were missed opportunities for the Speech and Language Team to consider if there were any safeguarding concerns relating to the number of missed appointments, and the lack of direct contact with Clive, whilst his wife was the main contact, for cancelling appointments on his behalf.

16.10.7. During the latter part of the scoping period, when Rachel had left the family home, there is evidence of practitioners hearing Clive's voice in relation to his health needs and concerns. They showed compassion and tried to understand Clive's lived experience. This is particularly evident in the contact with the Community Palliative Care Service where Clive was able to express himself about the impact of his illness, and within a group setting where he could articulate the burden of breathlessness with clinicians and fellow patients.

16.10.8. Clinicians across all NCHC services took an approach that promoted self-management, responsibility, and accountability for Clive to manage his own health concerns. This was not always appreciated by Clive. Where there were support needs identified for which Clive was unable to manage independently, and which put him at risk – for example running out of food and electricity – action was swiftly taken to raise the concerns and facilitate referrals to support Clive.

16.10.9. Elouise was named only in the NCHC records "unnamed 19-year-old daughter". Throughout the engagement with Clive, no professional curiosity was employed about a young person, in the home, who Clive referred to as his "carer". Consideration should have been given to offering a carer assessment for Elouise, and/or a referral to young carers. Although, it is not clear whether her details were requested and refused.

16.10.10. Although limited to two telephone assessments and one face to face contact during a breathlessness support group, the Community Specialist Palliative Care Nurse and Occupational Therapist did appear to be sensitive to the needs of Clive in the context of his immediate care needs and wellbeing. When Clive reported that he had no food or electricity in his property there was swift action taken by the Occupational Therapist to refer to Social Care for support with this.

16.10.11. The documentation suggests Clive's one attendance at the breathlessness support group was a positive one. Clive is reported as engaged and appears to have felt in a safe space to speak openly about feeling frustration, upset and a burden in relation to his breathlessness.

16.10.12. There were no documented discussions or concerns relating to Clive being a perpetrator or victim of Domestic Abuse and there was not any known contact from any partner agency to discuss domestic abuse concerns, nor requests to share information in regard to safeguarding concerns, until after the death of Elouise. There were, however, some missed opportunities to be professionally curious and explore with Clive aspects that presented in clinicians' interactions with him.

16.10.13. There was a lack of consideration as to whether there were any Safeguarding concerns relating to the lack of contact following Clive's non-attendance at two breathlessness management groups, and the lack of contact after enquiry letters were sent out by the Specialist Palliative Care Service.

16.10.14. In fourteen contacts with NCHC clinicians: three were face to face in a clinic setting; seven were conversations with Clive on the phone; four were phone calls with Clive's ex-wife/partner with one of these being at his request due to poor memory; there were no contacts with Clive in his own home.

16.10.15. During conversations between Clive and the Heart Failure Nurse, he would become extremely anxious when speaking about his wife and daughter, and irate when discussing missed appointments. This emotional dysregulation and volatility did not appear to raise any concerns. There were also several mentions of Clive's poor mental health when he was in contact with the Heart Failure Nurse. There were barriers to the initial escalation of these concerns to the NSFT First Response Team as the clinician could not get through. A SystmOne Task was sent to the GP raising the concerns, however there is a lack of documented plan as to how these issues were to be addressed, it seems to be assumed that these issues would be addressed by the GP following the Task. However, a clinician-to-clinician discussion - either NCHC clinician to mental health

team or GP – would have been more proactive and provide assurance about who was doing what in terms of his needs. A discussion with the mental health team or GP may have also highlighted known domestic abuse concerns that NCHC were not aware of. This may have changed the perspective of the NCHC clinicians and potentially encouraged greater professional curiosity in that context.

16.10.16. Since the review period, the NCHC Safeguarding Adults Policy has been updated, where a patient did not attend/was not brought to an appointment, staff are encouraged to consider if a domestic abuse, or safeguarding concern should be raised. The guidance includes decision support tools, for both community and clinic services. The policy has been launched in summer 2024.

16.11. Adult Social Care

16.11.1. ASC received two contact referrals for Elouise, neither of which warranted opening a case and as such Elouise was never allocated a social care worker.

16.11.2. Most of ASC's involvement with Elouise and Clive during the scoping period came from police notifying ASC of upcoming MARAC meetings. No action was requested from ASC. Details of the incidents, which triggered the MARAC were not shared with ASC. Referrals for Elouise and Clive alluded to Rachel as a perpetrator and Clive being a victim, with no mention of other family members.

16.11.3. No contact between ASC and CSC is recorded on either Elouise or Clive's files. No liaison or triangulating of information was undertaken with police or CSC at any time.

16.11.4. Despite ASC being aware of seven MARAC referrals, combined with the knowledge that Clive was now separated from his wife, ASC did not consider that Elouise may have been the victim of domestic abuse or was vulnerable to violence. This was due to each MARAC case being viewed in isolation rather than the cumulative risk being considered. More recently, all ASC staff are expected to attend DASH training to help increase understanding of risk.

16.11.5. Elouise was not considered by ASC to have care and support needs under the Care Act, or that she was unable to protect herself because of any care and support needs.

16.11.6. ASC were alerted to the need to assess Clive to determine his care and support needs; however, despite numerous attempts, only information and advice relating to Norfolk County Council's support services, housing and finance could be provided.

16.11.7. Norfolk County Council Practitioners attempted to assess Clive at his property using Norfolk First Support (NFS) Services, a practical, strengths-based approach; however, he declined the service after one single visit; further offers for NFS to support were made but declined by Clive. Requests by Elouise for support for her father progressed his case to the waiting list for a face-to-face assessment. Clive was not considered to be at risk and the case remained on the holding list awaiting allocation of a practitioner until the case was closed on 13th April 2022.

16.11.8. No carers assessment was offered to Elouise, who was identified as a carer in contact referrals from health professionals, and in the referrals Elouise and her father made to ASC. This is an overarching lesson for the DHR a whole. Completion of a carers assessment could have offered an opportunity for Elouise to disclose information, and express her wishes and feelings, which may have enabled practitioners to identify risks and offer support.

16.12. Cambridgeshire Community Services

16.12.1. The family were known to Norfolk Healthy Child Programme (NHCP) since each of the children's births. The NHCP is an evidenced based early intervention and prevention public health programme, which focuses on a universal preventative service for children and families. It also identifies families that need additional support and children who are at risk of poorer outcomes.

16.12.2. When the children were babies and infants, the family were open to the universal pathway,[126] the family engaged with the service, Rachel attended baby clinic when asked and there is evidence of meaningful engagement. Routine enquiry is part of the universal offer to families, and domestic abuse was discussed at appropriate times with Rachel who never disclosed any domestic abuse. Rachel reported that Clive was supportive, that she was his main carer, and his health was a worry. Although the service was aware of two MARACs, and notifications were received identifying Rachel as a victim of domestic abuse.

16.12.3. During the scoping period there were eight health visitors, and three MASH health practitioners involved with the family, therefore it was difficult for a practitioner to develop a meaningful relationship with this family. Five home

[126] See table at s.7

visits were arranged during the scoping period, three of these were completed, and two of these were joint visits with CSC. During these home visits, Rachel and Child A were always present and Clive was present, however he was generally upstairs in bed, and only engaged once. Elouise, Dan, and Mia were not present at the home visits.

16.12.4. There is no evidence of a paediatrician being invited to any of the seven strategy meetings which were held from February 2019. There was also no evidence of consideration of a medical assessment for the children, despite disclosures of physical abuse to the children.

16.12.5. From the initial strategy discussion in February 2019 when Elouise reported that Clive assaulted her, none of the children were seen by NHCP service until October 2019. At the time of this strategy discussion Child A would have been three years old, however there is no evidence of any joint social work and health assessments. This is contrary to the Norfolk Safeguarding Children Partnership (NSCP) Joint Assessments Policy, which requires a joint health and social work assessment to take place when there is a child in the family under five years old. During this time, the health visitor attempted to contact the social worker, however received no response.

16.12.6. During the August 2019 strategy discussion, the health visitor raised concerns that the children had not been listened to by previous professionals involved, along with Rachel's non-engagement and Clive's extreme and aggressive behaviours and use of weapons. The health visitor raised concerns that Rachel was using Clive's health condition to justify his anger and aggression. The health visitor formed an accurate analysis of the family at the time and an appropriate challenge made by the health visitor; however, this was also not acted upon.

16.12.7. In October 2019, a health needs assessment was completed following an action from the ICPC the previous month. Child A was assessed as having normal social and emotional development; however, the heath visitor was worried about this as she felt it was not a true reflection, and felt it suggested that Child A had learnt how to mask her emotions and behave well in public.

16.12.8. The health visitor contacted the social worker in March 2020 and was informed that the Child Protection plan had been stepped down to Child in Need – which had subsequently been closed due to lack of parental engagement with the plan. There is no evidence of NHCP challenging this, and the health visitor did not see the family again until December 2020.

16.12.9. The NCSP Medical Examinations Policy states where there are safeguarding concerns raised regarding physical abuse, with potential

injury, a paediatrician should attend a strategy discussion, which should be held the same day. A paediatrician should have therefore been invited to the November 2020 strategy discussion, as the safeguarding referral had indicated that Mia had bruising. The health visitor challenged this decision; however, the decision was not changed.

16.12.10. From the review of the health records there is evidence of some missed opportunities to escalate or seek safeguarding supervision around the decision making in this case. This could be due to the high number of practitioners involved with the family, meaning not one practitioner had a meaningful relationship with the family. Safeguarding supervision and a safeguarding duty phone are easily accessible to practitioners when they are worried about a family, however there is little evidence to suggest that these support mechanisms were used. During interviews with the health visitors for this review, all staff demonstrated stress when discussing this case and they were all deeply upset by Elouise's death.

16.12.11. Throughout NCSP's involvement with the family, there was a lack of autonomous thinking and reflection, which resulted in a lack of worry for the children and an inability to analyse and challenge CSC decision making.

16.13. East of England Ambulance Service

16.13.1. EEAST have policies and procedures in place for safeguarding. The creation of these policies is referenced by national and regional guidance. Policies are reviewed yearly to reflect the dynamic changes within the safeguarding arena. The safeguarding team keeps a strategic overview on all safeguarding partnerships across the Eastern region and where necessary and appropriate Trust policy & procedures are changed where a need is identified.

16.13.2. The EEAST had eight contacts with Clive and six contacts with Elouise during the scoping period. Clive was taken to hospital on five occasions, and Elouise was taken to hospital on two occasions. Clive was assessed and discharged at the scene twice, and Elouise was assessed and discharged at the scene once. An ambulance was not sent following telephone triage advice on one occasion for Clive and on two occasions for Elouise. On one occasion, Elouise could not be located.

16.13.3. On five of the fourteen contacts the target response times were not met. EEAST have been experiencing year on year increase in call demand along with the wider pressures across the NHS that has led to ambulance response targets not being met across the country and not isolated to EEAST. This is hampered by the difficulty in recruiting and retaining qualified staff. As this is a system wide issue EEAST have put into place a

number of actions around triaging the most serious calls first through a clinical safety plan whilst working with Commissioners and Health Education England to tackle the staff vacancies.

16.13.4. There were also four occasions where Clive could have been referred by EEAST crew for mental health support and assessment, but a referral was not made. In terms of learning around missed referral opportunities, there are a series of actions currently taking place to increase referrals by Crew and EEAST staff. These include the roll out of level 3 safeguarding training for all registered practitioners and level 2 training for all non-registrants. EEAST have improved their Single Point of Contact pathways, in order that referrals are more relevant and progressing to the right places. All Single Point of Contact staff and supervisors are being provided with training to assist them in making appropriate referrals.

16.14. Education

16.14.1. Information was provided by each child's educational setting. This information was collated and analysed by the Norfolk County Council Education Safeguarding Team.

16.14.2. This review has highlighted how, for many children and young people experiencing domestic abuse, their early years setting, school or college may be the only place they feel safe. The actions of the schools and college in this case highlight the unique and important position education staff are in, to support children and young people experiencing domestic abuse and ensure they are safeguarded.

16.14.3. Notwithstanding the challenges which the Covid-19 pandemic presented, the education settings understood many aspects of the family dynamics well and provided creative ways to promote the welfare of the children, building positive relationships with their mother and maternal grandmother.

16.14.4. The college Student Welfare Manager was able to reflect on the benefits of a joined-up approach with services such as Domestic Abuse Charity A and Leeway. The joint work between Elouise's college and Domestic Abuse Charity A is an example of good practice. The Student Welfare Manager reflected that the team had benefitted from becoming Domestic Abuse Change Champions[127] and explained that although they did not regularly complete DASHs, as a result of being Champions, they knew where to access the tools and guidance to undertake this work.

[127] Domestic Abuse Change Champion

16.14.5. All of the education settings involved with Elouise and her siblings were signed up to the Operation Encompass scheme.[128] As a consequence, their safeguarding policies make appropriate reference to domestic abuse and includes their involvement in the scheme and the steps that they might follow in response to a notification. In addition, records provided by the Norfolk Integrated Domestic Abuse Service (NIDAS) indicate some staff from the College and Secondary Schools had accessed Domestic Abuse Change Champion training which would have given those settings access to additional guidance and support.

16.14.6. The education records indicate that the Designated Safeguarding Leads (DSLs) were aware of domestic abuse, they recognised the impact of abuse on the children and the college saw Elouise as a victim in her own right. All the education settings understood, to varying extent, that there was domestic abuse occurring within the family home through disclosures made by Elouise and her siblings at different times throughout the review period and from sharing of police information through the Operation Encompass.

16.14.7. The records provided by the education settings who contributed to this process provide an insight into what family life was like through the voices of the children and the experiences they shared with education professionals. It is evident that the education settings provided safe and secure spaces with trusted adult relationships enabling Elouise and her siblings to talk about their lived experiences at home and sharing relevant information with other professionals where necessary.

16.14.8. The college's assessment of Elouise's needs was based on an understanding of the level of difficulties she faced, and their response was appropriately multi-faceted in terms of the services they offered to help her access. Staff worked hard to support Elouise and considered carefully how best to engage her with services, by offering a range of options and encouraging her agency in choosing which she wanted to access. Elouise was initially reticent for college staff to contact CSC, but when staff felt the situation had reached the threshold for a safeguarding referral, they worked with Elouise to engage her in that process.

16.14.9. Responses to Elouise's disclosures were appropriate. College staff initially provided Elouise with support regarding low mood and her caring responsibilities but once she had begun to talk to staff, the Student Welfare Manager described it was like the 'flood gates' had opened, that Elouise had held this in for a prolonged period and needed to let it out. The Student Welfare Manager from the college said that staff had a gut feeling about how serious the situation was for Elouise and discussed the case in

[128] Operation Encompass

safeguarding meetings. Staff understood the serious nature of the risks to Elouise and the impact on her siblings as evidenced by the completion of the DASH, referrals to CSC and liaison with allocated social workers and siblings' schools.

16.14.10. The DASH provided a comprehensive account of the abuse suffered and the potentially high risk posed to Elouise, her mother and her siblings. The DASH clearly records Elouise's voice and her fears, she stated ''*I'm very frightened that he will hurt me and my sisters, my mum and (boyfriend) and his family. He is going to kill them.*'

16.14.11. In addition to the completion of the DASH and the referral to MARAC, it is evident that education professionals across the settings contributed to range safety measures for the family. These included changing drop off and pick up times at primary school, hosting IDVA meetings at the primary school, providing Elouise with a mobile phone, financially supporting her to get into college, and the offer of an emergency bag or for personal items to be kept at the college.

16.14.12. As detailed in the chronology, the education settings liaised with one another, sharing information to build a picture of the cumulative risks and needs of the family. There is evidence of interagency working through the referrals to CSC in response to concerns as well as supporting family through participation in Child in Need and Child Protection planning. The schools and colleges offered additional support to meet the children's needs and linked with other organisations such as the Benjamin Foundation[129] and Domestic Abuse Charity A. The college Student Welfare Manager talked about the positive relationship college staff had with Domestic Abuse Charity A and latterly Leeway and the flexible approach that Domestic Abuse Charity A took to engaging with Elouise at those points when she agreed to engage with the service.

16.14.13. At times it was not clear whether there was always a shared understanding of risk between education staff and other agencies. Learning from another local DHR[130] highlighted the difficulties for schools where thresholds for statutory intervention does not appear to be met and parents are not willing to engage with voluntary services, but children continue to experience parental conflict or domestic abuse and violence. In this case, the college Student Welfare Manager talked about the devasting consequences of Elouise not feeling believed and her perception that things in fact became a lot worse following her disclosures.

[129] www.benjaminfoundation.co.uk
[130] DHR Lynne Overview see pg. 53, pg. 54 para 3.6.17 pg. 98 para 7.6.3, pg. 99 para 8.2.1.3

16.14.14. The Education settings' direct contact with Clive was limited with the college only recording one contact to ask for an extension for one of Elouise's assignments. The records indicate that his interactions with the primary school were hostile ones; Clive was asked not to approach the primary school because of the negative impact of his behaviours towards female school staff. Whilst direct contact was limited, it is clear however that education settings understood the risk he posed through the children's disclosures and information shared in multi-agency meetings.

16.14.15. Education settings' contact with Rachel was more frequent, particularly after she had left Clive. It is evident from the chronology that - although difficult to reach at times - Rachel did attend meetings and spoke to staff including the Parent Support Adviser from the primary school feeling able to share some worries. The college Student Welfare Manager described Rachel as a quiet but loving mother who was proud of her children.

16.15. Change, Grow, Live

16.15.1. Change, Grow, Live (CGL) provides an alcohol and drug behaviour change service in Norfolk. They provide one to one working, or group sessions, and have "hubs" across Norfolk for people to access help and support.

16.15.2. Clive engaged with CGL between March 2019 and December 2019 primarily seeking support for Cocaine use. At assessment Clive reported regular alcohol use over four times per week and disclosed that historically his alcohol had led to someone else being injured. He stated that his alcohol use had not resulted in a physical dependency and therefore his main concern was his use of Cocaine.

16.15.3. During his involvement with CGL Clive's engagement was inconsistent. He was reallocated to the family team when CSC became involved.

16.15.4. It is evident that despite Clive's poor motivation, the team in Town B worked hard to engage him in the service, and he was allocated to the Think Family team, so that closer working with CSC could be achieved.

16.15.5. In early December 2019 Clive had disengaged and when contact was finally made Clive reported to be suffering with his general physical health but that he was drug free and happy to be discharged.

16.16. Norfolk and Waveney Mind

16.16.1. Norfolk and Waveney Mind is an independent charity which is part of the National Mind Federation, offering an extensive range of mental health services within the Norfolk and Waveney footprint.

16.16.2. In total Clive had nine contacts with the Mind Psych Liaison Service, of these seven were telephone support, one text and one face to face appointment. His support with Psych Liaison was sporadic due to his non-engagement. Psych Liaison made a further ten attempts to contact Clive, that either went to voicemail or were cancelled by Clive or Elouise due to his poor health. He was subsequently discharged from Psych Liaison on 14th June 2021.

16.16.3. Clive was referred to Crisis Community Support Service on 16th June 2021. In total Clive had ten contacts with the service, three were telephone and seven were face to face. There were a further nine attempts at contact, that went to voicemail or were cancelled by Clive due to poor health.

16.16.4. The main engagement with Clive were when he required a lift to appointments, and there were occasions where he wanted the worker to stay in the car and look after his five-year-old daughter, claiming that he had no childcare.

16.16.5. Clive's inappropriate use of the service, and lack of challenge around this, is an area of learning for Norfolk and Waveney Mind. Staff and volunteers should be encouraged to form and maintain boundaries, especially when responding to people who present challenges such as Clive.

16.16.6. Since the scoping period of the DHR, a review has been undertaken of the Non-Engagement Procedure, and the new procedure has been disseminated to staff.

16.16.7. During the period of Clive's involvement with Mind, separate systems for Psych Liaison and Crisis Community Support Service were being used, which were not linked. Since the scoping period of the review, a new case management system Iaptus has been successfully implemented. Iaptus is a client orientated management system which is designed to follow the individual, rather than focus on the service. This enables seamless integration between services. Had this system been in place when Mind supported Clive, it would have significantly enhanced the service's ability to follow his journey, coordinate input with Clive across the services, and to provide a more integrated support.

16.16.8. There was a lack of robust risk assessment completed in respect of Clive. The risk assessment which was completed lacked key information around Clive's potential harm to others. Following this DHR, the risk assessment has been reviewed and amended to ensure key information is collected through the referral, and in the initial assessment. A new Risk Management Policy and Procedure was implemented in January 2024.

16.16.9. During June 2023, the Mind "non-engagement" procedure was reviewed to ensure that the process is robust and those referring into Mind are advised when prospective clients are difficult to contact, and/or engage.

16.17. Hospital A

16.17.1. Both Clive and Elouise were mostly seen in Hospital A's Emergency Department (ED). Within this environment there is a short window in which staff can explore social concerns due to the acuity and fast flow of patients admitted to the area.

16.17.2. An electronic patient record has been commissioned and will be introduced in Hospital A, and across two other acute providers in Norfolk. This will include alerts of domestic abuse, and other vulnerabilities. During the scoping period for this review, domestic abuse enquiry, or any social input information was reliant upon staff entering the information manually. This information will be easier to share with the introduction of the new electronic patient record system.

16.17.3. It is difficult to track multiple Did Not Attends (DNAs) of appointments due to patient records being paper based, this is particularly difficult when patients are on multiple health pathways. This will be easier to track with the introduction of the new electronic patient record system.

16.17.4. The hospital Trust's Did Not Attend/Missed Appointments policy has recently been relaunched to include more curiosity around patients who may not be able to attend without support, and are therefore "not being brought", rather than choosing not to attend.

Elouise

16.17.5. Within the scope of the DHR, Elouise attended the Emergency Department (ED) on thirteen occasions. She was given, and missed, seven follow up appointments made for medical investigations. These had all been booked following her attendance to ED for chest pain.

16.17.6. There appeared to be lack of curiosity or exploration of the non-attendances at follow up appointments. Hospital A's patient information is kept in paper form; therefore, it is not easy to highlight non-attendance without reading and tracking letters that have been filed within the patient record. Within the acute trusts in Norfolk a joint acute trust patient electronic record is being developed.

16.17.7. In the six months prior to her death, Elouise attended the ED on four occasions; two of these were during the two weeks prior to her death. Both attendances were concerning her mental health and wanting to self-harm. She discussed that she could hear her mother and father shouting at each other in her head, but no exploration was recorded regarding domestic abuse.

16.17.8. Within the ED record there were domestic abuse and child protection alerts. When Elouise turned sixteen, she was automatically seen on the adult side of ED and on the majority of occasions Elouise attended ED with her mother or aunt. All her ED attendance letters were sent only to the GP, no other agency was informed of her attendances.

Clive

16.17.9. Clive attended ED on nine occasions, following these attendances he admitted as an inpatient on eight occasions. Most of the attendances to ED were due to his physical illnesses. From October 2021 there is documentation regarding Clive's mental health, which he attributed to his "relationship breakdown" and a pending court case.

16.17.10. Throughout the scoping period, Clive had been referred to consultants in General Surgery, Haematology, Cardiology, Gastroenterology and Neurology. Clive had discussed his misuse of steroids with practitioners and that his relationship had broken down. He had many "did not attends" for appointments, however as these were for different departments/consultants, it was impossible to track these, therefore his lack of attendance was not recognised holistically.

16.17.11. When Clive was admitted as an inpatient, the safeguarding enquiry questions were always asked but no information was provided from Clive regarding what was happening within the home environment.

16.18. Borough Council A

16.18.1. The Borough Council provides other services which Rachel would have accessed, such as Revenues and Benefits, however for the purposes of

the DHR, Rachel and Elouise's involvement with Borough Council A's Housing Options Team has been analysed.

16.18.2. Borough Council A staff have a good awareness of domestic abuse, know who to report domestic abuse concerns to, and where to refer when required. Frontline staff also know how to complete DASH assessments and how to escalate to MARAC. For less experienced staff, there are Safeguarding Leads, who are well promoted and easy to access.

16.18.3. Information on domestic abuse is regularly shared throughout the organisation, via communication updates and newsletters. The Borough Council also promotes Domestic Abuse Champions and has representatives from its Housing Options and Community Safety Teams attending the Domestic Abuse and Sexual Violence Group.

16.18.4. In addition to Domestic Abuse Champions, there are strong links with police colleagues within the Operational Partnership Team and local policing teams.

16.18.5. The Sanctuary Scheme sits within the Community Safety and Neighbourhood Nuisance Team. The scheme is managed by the Early Help Hub Co-Ordinator. The scheme is available where a victim of domestic abuse is the sole tenant of a property and there has been a risk assessment to identify suitable measures which can be put into place to reduce risk within the home. This was not introduced until the latter part of 2023 and would not have been suitable for the property which Rachel, and latterly Elouise, shared with Clive.

16.18.6. The Borough Council is currently reviewing their corporate induction training and, which will include domestic abuse training. Learning from this review will be included in the training.

16.18.7. During the review process, it was noted that outdated language was evident on the Housing Needs website. The language was specific to violence and did not include information or reference to Coercive and Controlling Behaviour. It was also noted that the page stated particular documents would be required for a housing application, which may have dissuaded someone considering fleeing. Learning from this review indicated the need for the webpage to be updated, and this was completed shortly after the review process began. This now reflects current language and has clearer guidance to those fleeing domestic abuse.

16.18.8. Elouise approached the Housing Options team for housing advice in May 2019 and spoke about her experiences of abuse from her father. Borough Council A practice is to share any safeguarding concerns with CSC,

however there is no evidence that this happened, although there was a record made by the Housing Options staff member that they intended to share the information with CSC; therefore, the omission may have been recording the information shared within Elouise's notes.

16.18.9. Information shows that Rachel approached Housing Options in April 2021 seeking alternative accommodation away from Clive and was currently living with her mother. Housing Options accepted a homeless duty as Rachel was unable to return to the marital home due to DA and notes from MARAC showed Rachel had declined refuge.

16.18.10. Rachel approached Housing Options in April 2021, as she had left the family home with the three younger children. Rachel was accepted as homeless. In August 2021, Rachel was nominated by Home Choice for a property in Town B. Housing Association A were also the landlords of the new property and stated that Rachel could not move into the new property until Clive agreed to take over the sole tenancy of the family home, along with taking the arrears which had accumulated after Rachel moved out.

16.18.11. Housing Options raised objections to this decision, suggesting to the Housing Association that Rachel be offered a licence to occupy[131] pending the tenancy action on Clive. Rachel was advised by the landlords that she could end her tenancy at the family home, to allow her to move to the new property.

16.18.12. By early November 2021, Housing Options noted no update from Housing Association A about allowing Rachel to move, and Rachel applied for another available property, which was refused due to the pending offer on the original property in Town B.

16.18.13. The Housing Options Team unsuccessfully challenged the decision regarding the need for Clive to have agreed to the assignment of the tenancy and arrears in order to allow the move to take place. This was particularly problematic due to the arrears that accumulated after Rachel left the property, due to Clive failing to submit a housing benefit claim.

16.18.14. This review has highlighted the need for Housing Options to develop an escalation process for housing staff to challenge decisions made by Registered Social Landlords (RSP) where domestic abuse victims require alternative accommodation and where it appears that the domestic abuse element is not given sufficient priority in the decision-making process.

[131] A personal agreement between a property owner and an occupier.

16.19. Housing Association A

16.19.1. Borough Council A advised the Housing Association that Rachel and the younger children had fled the family home due to Clive's behaviour, and that Rachel was now homeless and had approached Housing Options for support with this.

16.19.2. Following Rachel leaving the property, the District Council approached the Housing Association to request an internal transfer, however the policy at the time was for internal moves to only take place if the MARAC had made this an action. From the notes on the landlord's system, it would appear due to the MARAC not making this an action, they could not follow this through.

16.19.3. The Housing Association were trying to find Rachel somewhere else to live, however Clive refused to sign papers which would make him a sole tenant. This would also make him liable for the full arrears on the property. Rachel could have ended the tenancy, but this would have led to Clive being homeless, and Rachel did not want to do this.

17. Thematic analysis

17.1. Homicide Timeline

17.1.1. The analysis of agency involvement has been enhanced by the application of Professor Jane Monckton-Smith's[132] Eight Stages of Homicide, otherwise known as The Homicide Timeline.[133]

17.1.2. 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.

17.1.3. 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.

[132] Jane Monckton-Smith - Staff Profiles (glos.ac.uk)
[133] Monckton-Smith J *In Control: Dangerous Relationships and How They End in Murder* (2021)

17.1.4. Although the timeline was developed specifically for the identification of risk of homicide within intimate partner relationships, the panel have applied the timeline to Clive's behaviours within the family setting, therefore analysing his behaviours towards Rachel, and also towards Elouise.

17.1.5. The timeline has 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 identifiable as escalating and concerning. 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.

17.1.6. Stage one is the perpetrator's ability to be violent. Clive had a propensity for violence, he had been violent and controlling to Rachel and the children for many years – in fact during the whole of the relationship with Rachel which started when she was a teenager.

17.1.7. The family lived at stage three for many years. Clive controlled the family, not allowing people to visit and not allowing them to spend time outside of the house without him. He set up cameras in the house to monitor their actions, he relied heavily on Rachel to do everything for him, including speaking to healthcare professionals about appointments.

17.1.8. The stage four trigger came in the form of Elouise reaching an age where she wanted to go out with her friends. Elouise started college, and soon after she reported her father's abusive behaviour. Clive started to lose total control of the situation and escalated his behaviour. During 2019 he started to explicitly threaten violence towards Elouise and her boyfriend at the time, and on one occasion made threats with an axe and reversed at Elouise aggressively, indicating her would run her down with his car.

17.1.9. Although Rachel followed through with ending the relationship with Clive in early 2021, he maintained a level of control over Elouise for ten months. He used his physical health problems to elicit sympathy and guilt, which kept Elouise close for a little while longer. This can be seen as stage five circling back to stage three.

17.1.10. At the time of her death Elouise was residing with her mother. Clive was living alone, he had tried to use self-harm and threats of suicide to encourage Rachel and also Elouise back, however he appeared to have lost all control of them both, leading to the remaining stages of the timeline being reached in quick succession, until the ultimate act of destruction of Elouise, and in turn of Rachel, in January 2022.

17.1.11. Elouise was not always believed as a victim in her own right, she was seen as a child and not listened to. Her feelings were not validated by all agencies. The seriousness of the situation at home from Clive i.e. strangulation of Rachel, use of weapons, cruelty to pets, the threat of extreme physical violence, and threats to kill, was not recognised as an indicator of potential homicide (Jane Monkton Smith). Elouise had attempted suicide on several occasions, another indicator of a highly vulnerable and traumatised young woman. When the homicide occurred, Rachel had already moved out of the family home, so Clive was at the stage of having nothing else to lose. It was clear that the initial social worker believed Clive's account of events over Elouise's, but also admitted to finding him scary. The effect of this onslaught of daily abuse on the children living in that household was not properly considered.

17.1.12. The college were a protective factor, and Elouise had a safe person to talk to. There were limitations on what the college were able to do to support Elouise to keep herself safe.

17.1.13. Clive was very manipulative, he lied about his health conditions, he used emotional and physical abuse, threats and intimidation to control Rachel, Elouise, and the rest of the family.

17.2. Victim Blaming

17.2.1. There was a lot of victim blaming language evident throughout agency case notes, but also throughout the IMRs completed for this review.

17.2.2. Throughout the engagement with CSC there was a lack of understanding of the risk of harm posed by Clive, the barriers which Rachel would have faced to ending the relationship, and the level of control Clive held over all of the family members.

17.2.3. Upon reviewing the report, Rachel spoke about her fear of being judged as failing to protect her children, and that this would lead to them being removed from her care. Rachel reflected that this visceral fear of being deemed unfit to parent her children, led her to deny any abuse and remain with Clive for much longer than she would – had she been assured by professionals that she was not to blame.

17.2.4. Throughout the CSC engagement with Elouise there are comments made by social workers regarding her intention to obtain housing, and when she retracted her disclosures, following bail conditions being lifted and Clive

being able to again influence her – these retractions were accepted very with no evidenced consideration of coercion.

17.2.5. Throughout the case files, and the IMRs there is mention of Rachel "minimising" the abuse. A better word for this would be "normalising". Rachel lived with the control and violence day in, day out, and would have normalised the behaviour in order to survive. By stating that a victim minimises the abuse, it indicates that they understand it is abuse and choose not to acknowledge the seriousness of the risk.

17.2.6. Perpetrators of abuse minimise their behaviour, and often professionals minimise the risk of harm. For example, the social worker recorded in case notes that Clive was a scary man, yet the children were left to be living in the house with him – this is minimisation.

17.2.7. There was also a lot of references to "arguments" and "discord" throughout the case files, but also throughout the IMRs. It is vital that professionals understand the dynamics of domestic abuse and coercive control; victims do not have mutual, two-sided, arguments with their partners, and the issues which Rachel and the children faced was not "discord". It is important that abuse is named as abuse, always.

17.2.8. At the strategy meeting in May 2019, it was stated in the meeting records that professionals; *"felt this was a particularly difficult case as no new evidence has come to light regarding Clive and his domestic abuse, the only information is what Elouise discloses".* From this view it is difficult to understand if professionals considered the disclosures made by Elouise and the impact this had on her siblings, it is evident Elouise's voice was not heard or listened to and that professionals were seeking other verification of her allegations before allowing this to influence actions taken to protect the children.

17.2.9. Research shows that abusive fathers and men are often overlooked,[134] and professionals often focus on the mother/non-abusive parent to manage the risk posed by the other person.[135] Professionals concentrated on what Rachel was or was not doing, instead of addressing Clive's behaviours with him; or by identifying Clive's behaviours as coercively controlling and approaching Rachel was a plausible and safe plan to encourage her to disclose to them.

17.2.10. There was little to no questioning of the situation when Rachel was evicted from the refuge. This was taken on face value, and she was soon back home, where Clive soon re-joined the family, and Elouise was quickly

[134] The Myth of Invisible Men
[135] See n.112

coerced into withdrawing her allegations of abuse. Within the records, judgemental language was used regarding her return home, and subsequent relationship with Clive resuming. Considering how Rachel was judged and disbelieved by the refuge staff, based upon an account of another resident, is it easy to consider that any trust Rachel had in professionals to be able to protect her from Clive would have been diminished. Clive was the more reliable option at that time.

17.3. Elouise as a Victim of Domestic Abuse

"I feel anxious and angry when things are bad and dad is shouting…I feel the situation has got worse, it will continue to get worse, and I don't know what to do." Elouise 2019

17.3.1. Aside from Elouise's college and the specialist domestic abuse services who she engaged with; Elouise was not responded to as a victim in her own right.

17.3.2. The Domestic Abuse Act 2021 legislated for children as victims in their own right. This was following many years of research and campaigning, to highlight the effects of domestic abuse on children.[136]

17.3.3. To prove the offence of coercive and controlling behaviour, the perpetrator's behaviour must have had a "serious effect"[137] on the victim. To evidence whether the behaviour has had a serious effect, we must look at the victim before and after the coercive and controlling behaviour. However, because Elouise was subjected to Clive's behaviour from birth, it would be difficult to identify serious effect on Elouise in this way. Clive's behaviours would have been normal to Elouise and her siblings; in fact, Rachel told the Independent Chair that it wasn't until Elouise started to go to friends' houses that she saw how other fathers behaved.

17.3.4. As highlighted in s.17.1 above, Elouise starting college and creating a life outside of the family home was a trigger for Clive's behaviours to escalate. When Elouise started at college, she was described by the college staff during this time as being a "vibrant young person". However, following her father's abusive behaviour escalating, Elouise's disclosure of abuse to professionals, and her perception that nothing was going to change she

[136] See for example: Holt, S "The Impact of Exposure to Domestic Violence on Children and Young People: A Review of the Literature" *Child Abuse and Neglect* 32 (8) (2008); Stanley, N *Children Experiencing Domestic Violence: A Research Review* Research (2011); Szilassy, E "Making the Links Between Domestic Violence and Child Safeguarding: An Evidence-Based Pilot Training for General Practice" *Health and Social Care in the Community* (2017)
[137] Serious Crime Act s.76

withdrew from college, withdrew from any areas of support, and her behaviour became problematic. This can be identified as the serious effect of Clive's coercive and controlling behaviour. However, this never appeared to be considered.

17.3.5. During a Child in Need meeting in May 2019, there were discussions regarding Elouise returning home. These stemmed from a CSC Management Review where it was raised that Elouise could return home. Following this one comment, the plan for Elouise to return to the family home then appeared to remain throughout the CSC involvement with Elouise and indicates a lack of recognition of Elouise as a direct victim of her father's abuse.

17.3.6. Elouise had attended her GP surgery for face-to-face consultations. It is recorded that she disclosed witnessing and been a victim of domestic abuse as a child, and into adulthood. This was not recognised by practitioners as disclosing domestic abuse.

17.3.7. Elouise's age was a barrier to seeking, accessing, and being offered help and support. She had started to speak about her father's abusive behaviours when she was sixteen. When she was killed, Elouise had just turned nineteen. Throughout this time, Elouise was sitting between the children and adult systems. This was further exacerbated due to adultification; some children and young people behave more maturely than their age due to having adult responsibilities from a young age, and they are then in turn treated as if they are older than their age.

17.3.8. Elouise was reaching out for help, for herself and her siblings. When asked on one of the DASH assessments what she was afraid of, she stated: "*I'm very frightened that he will hurt me and my sisters, my mum and (boyfriend) and his family. He is going to kill them.*"

17.3.9. Elouise approached housing teams, she moved to Lincolnshire with her boyfriend and latterly moved in with "an older couple" which was not checked out by professionals who were advised of this. However, due to her age, she was limited in terms of refuge provision and/or welfare benefits to pay the rent for her own tenancy.

17.3.10. When she moved to Lincolnshire, she was still named on a Child Protection plan. However, there was no transfer of her case from Norfolk to Lincolnshire CSC, due to the temporary nature of her move to Lincolnshire. Although this followed due procedure, consideration should have been taken by Norfolk CSC to share information with Lincolnshire CSC about Elouise, her whereabouts, and the risks she faced from Clive. Lincolnshire CSC knew nothing about Elouise, who was a vulnerable young person

living in the County, and as described above in s.16.6, when LPFT became aware of the Child Protection plan, and duly contacted Lincolnshire CSC to share information, they did not know Elouise and no further action was taken.

17.3.11. Once Rachel moved out of the family home with the younger children, and Elouise remained with Clive, CSC were no longer involved with Elouise, and she did not have identified care and support needs to be supported by Adult Social Care. She did however remain with the same GP practice, from childhood into adulthood, yet there was no ongoing exploration of domestic abuse from the GP practice. This is despite the practice being aware of domestic abuse, due to Elouise's disclosures and CSC sharing information with the practice; and despite Elouise remaining living with her father.

17.3.12. Whilst living with her father, Elouise was not identified as requiring support as a young carer. NCHC, and Clive's GP practice were told by Clive that his "teenage daughter" was his carer, however no further action was taken by practitioners, including asking for Elouise's name. This was a further missed opportunity to recognise and respond to Elouise's needs as a vulnerable young person.

17.3.13. Since the commencement of this DHR, two hospital trusts within Norfolk introduced Health IDVAs. They were present within the safeguarding teams, provide training to staff and face to face support to patients disclosing domestic abuse. Unfortunately, this project ended in March 2025.

17.3.14. Norfolk County Council have recently completed a housing specific needs assessment in the County, part of this was the identification of available accommodation provision for children aged 16 and 17 years old. This needs assessment led to Norfolk County Council commissioning the DAHA[138] process.

17.4. Mental Health

17.4.1. The NHS England review, referenced above in s.10, identified the following recommendations:[139]

[138] Domestic Abuse Housing Alliance (DAHA)'s mission is to improve the housing sectors response to domestic abuse through the introduction and adoption of an established set of standards and an accreditation process.
[139] The learning from the NHSE review is available as an appendix to this DHR (see Appendix Two)

(1) A lack of professional curiosity - the Trust is recommended to use the learning from Elouise's death to brief all staff on the importance of being curious, and the need to share risk information with relevant agencies.

(2) Child safeguarding was not always considered – the Trust is recommended to ensure level 3 safeguarding includes the importance of escalating safeguarding concerns when they are not addressed by other agencies, but where risks remain.

(3) The Community Mental Health Team (CMHT) waiting list was too long – the Trust is recommended to ensure individuals on the waiting list for CMHT who go into crisis should receive appropriate follow-up care after the crisis, and not simply be re-added to the waiting list they are already on.

(4) Lack of regular contact with Clive when he was on the CMHT waiting list – the Trust is recommended to develop clear guidance on the how often individuals on the waiting list are contacted, taking into account risk management, including the views of carers and families as appropriate.

(5) Lack of evidence of multi-agency consideration when individuals are assessed by Mental Health Acute Liaison Team (MHLT) – the Trust is recommended to ensure MHLS explore additional factors with the individual and seek information from other services regarding risk management.

(6) Lack of evidence of multi-agency consideration when individuals are assessed by the Liaison and Diversion Service (L&DS) – the Trust is recommended that the L&DS must ensure CSC are alerted when an individual who is in contact with children and have been identified as posing a risk relating to alcohol and substance misuse and fail to engage with L&DS.

(7) Clive's children were not identified as carers – the Trust are recommended to reinforce with staff, the importance of referring carers – especially young carers – to the appropriate agency for assessment of their needs.

17.4.2. The Norfolk and Waveney Integrated Care Board (ICB) has the responsibility to maintain system oversight of the implementation of these recommendations, as they have oversight of NSFT. The ICB will therefore seek assurance from NSFT that all actions recommended by Niche Consultancy are implemented.

17.4.3. The findings from this DHR echo above learning, and the panel are grateful for the input of Niche Consultancy in supporting this targeted learning around mental health.

17.4.4. In addition to this learning, the lack of mental health representation within the Multi-Agency Safeguarding Hub (MASH) was also raised as gap in provision.

17.4.5. All services spoken to during the DHR process raised that they found it difficult to contact or gain access to mental health provision for the people they support.

18. Conclusion

18.1. The central learning from this review is that domestic abuse and coercive control must be recognised as a whole-family safeguarding issue. Rachel, Elouise, and the children were all living with the impact of Clive's abuse, but agencies did not consistently join this information together or respond to the risks as a whole family. Elouise should have been seen and responded to as a victim of domestic abuse in her own right. Rachel needed professionals to understand the barriers created by coercive control, rather than placing responsibility on her to manage or escape the abuse. The children needed agencies to recognise the cumulative harm of living with fear, control and violence. Clive's health and support needs required a response, but this should not have been separated from the risks he posed to his family. Future practice must ensure that information is shared, tested and acted upon, so that victims are believed, perpetrators are held accountable, and agencies work together to create a clear and coordinated plan for safety.

19. 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)

19.1. The learning from this review, has presented a series of thematic lessons. The following sections will detail these overarching lessons, which have been identified by all services involved in the review.

19.2. Think Family – Risk Assessment and Management

19.2.1. The family would like learning from this review to include the need to speak to everyone individually, away from the abuser, and other family members. Professionals should also consider how children present – taking Mia's

example of being lined up neatly and quietly on the sofa, nodding their heads and agreeing that everything was ok – whilst Clive was sitting nearby.

19.2.2. A Think Family approach refers to the steps taken by children's, young people's and adult practitioners to identify wider family needs, which extend beyond the individual they are supporting, or engaging with. The Think Family approach recognises and promotes the importance of all services to take whole-family approach.[140]

19.2.3. The Think Family approach should be used when assessing the needs of, and planning care packages for either the whole family, or for individual family members. It is particularly important that risk is assessed and managed through a Think Family lens.

19.2.4. Assessing and managing risk through a Think Family lens should not be constrained to considering those living within the same household. Family members can, and do, pose risks to one another even when they do not live together. For example, when Elouise left the family home in 2019, she was still at risk from Clive's behaviours, and when Rachel moved herself and the younger siblings out of the family home in 2021 everyone was still at risk from Clive and in fact Elouise's risk increased as she became his focus of control.

19.2.5. In the specific situation of this DHR, and as has been explored throughout this report, on many occasions the risk that Clive posed to the children, to Elouise and to Rachel was not properly assessed. To assess risk, all practitioners require a robust understanding of the dynamics of coercive control as an abusive behaviour which is "invisible in plain sight"[141] and the effects of this level of control on all members of the family. For example, the Child Protection and Child in Need plans included a requirement for Clive to attend anger management sessions. Perpetrating domestic abuse, and behaving in a coercively controlling manner, is not a matter of unmanaged anger. Badging the abuser's behaviours as being unmanaged anger, minimises the pervasiveness of abuse, and indicates that the perpetrator cannot help but lash out in temper. Coercive and controlling behaviour is intentional and targets intimate partners and family members. Unmanaged anger is sporadic and presumably targeted at whoever is around at the time.

19.2.6. In May 2019 police searched the family home following Elouise's disclosures to domestic abuse services, of Clive using weapons to

[140] Think Family - NHS Safeguarding
[141] Wiener, C "Seeing what is Invisible in Plain Sight: Policing Coercive Control " *The Howard Journal of Crime and Justice* (56)(2017) *Journal Link*

intimidate and threaten the children. Police found weapons which were old, and not in working order. No further action was taken, and the weapons were left in Clive's possession. This indicates a lack of understanding of coercive control, the use of weapons to threaten, and the seriousness of a situation where children were living in fear of these weapons. There is no indication that CSC took the use of the weapons – and the ongoing presence of the weapons – into account when assessing the risk of Clive to the children within the home. At this point the threshold for Child Protection was not met, and the Child in Need plan continued, requiring engagement from the parents to proceed.

19.2.7. A Think Family approach to risk assessment and risk management requires all family members to be considered. Throughout the scoping period plans were often made without Clive's input, this included plans which required his involvement. Norfolk Safeguarding Children's Partnership have recently introduced a range of resources to support practitioner's engagement of fathers.[142] **Recommendation 14**

19.2.8. There were also missed opportunities to engage Elouise's grandmother in conversations about risk. She was cited as offering Elouise a place to stay, however there is no record of Elouise's grandmother being involved in risk management and planning. **Recommendation 13**

19.2.9. During the period that CCS provided health visiting services, Clive did not engage with staff attending the home. However, he was known to be aggressive and volatile. Due to the practitioners not knowing Clive, or the older children, their work concentrated on Rachel and Child A. There was a lack of Think Family, in particular the older children remained invisible, with Mia and Dan not being offered health needs assessments following any of the strategy meetings. **Recommendation 12**

19.2.10. Clive's wider family were also not considered throughout his engagement with the Community Palliative Care Service. Clive's case files refer to Clive "sharing custody" of his five-year-old daughter, and reference to his 85-year-old mother. It is clearly documented that Clive had significant physical and mental health needs, he was struggling with activities of daily living and finances. He has a lack of food and electricity at times. Despite this there was not any documented consideration or discussions with Clive about how his difficulties might have impacted on his family. **Recommendation 13**

19.2.11. When Thinking Family, the needs of carers, and particularly young carers should be considered. When speaking to NSFT, Clive stated that Elouise

[142] Keeping Fathers in Sight: Good Practice Guides | NSCP (norfolklscp.org.uk)

"helped him because she worried about him". However, there was no exploration of this. **Recommendation 13**

19.2.12. There were no Genograms completed for either Elouise or Clive during their engagement with NSFT. The Trust is currently progressing a Quality Improvement Project to improve a Think Family approach across their services, this will include ensuring Genograms are completed in initial assessments and reviews to understand the holistic picture for better risk assessing and planning, including Domestic Abuse.

19.2.13. During an NSFT home visit to Clive, following Rachel moving out of the home, it is recorded that the house was cold, dirty, damp, and there was no food. Mia and Child A were present, and Mia was witnessed trying to light the fire, and that she ordered in food for their dinner. However, there was no further consideration of the welfare of the children. Mia indicated to the NSFT staff she was aware of Clive's self-harming behaviour and had been made aware of what to do if he needed help. There was no consideration of Mia as a carer for her father, or for Child A.

19.2.14. During this visit, it was also noted by the NSFT worker that Clive did not pay any attention to the children, or the conditions they were in, and seemed to be focused on himself as a victim. Following this visit, a safeguarding referral was made by NSFT into the MASH, however the referral was not accepted by the MASH. There was no reason for the referral being declined, however a CSC practitioner told NSFT that the family were known to CSC and these circumstances were not unusual for them. The NSFT staff member did not challenge this. **Recommendation 13**

19.2.15. It was highlighted by Elouise to a mental health practitioner that she was caring for her father, and despite there generally being good correspondence between Practice A and the mental health agencies in respect of Clive and Elouise, her role as Clive's carer was not shared with Practice A by mental health practitioners. This was a missed opportunity to have this captured within Elouise's patient care records, and appropriate support to be offered. The pressures of caring for her father may have impacted on her physical health and emotional wellbeing, and this information may have encouraged more professional curiosity from the GP, had they been aware. **Recommendation 13**

19.2.16. Mind were aware of Clive's behaviour, following an initial meeting between Clive and the community worker, Clive had threatened the worker whilst in his car. This does not appear to have been recorded anywhere as an indicator of risk. Also, during the period of engagement with Mind, Clive used the worker to care for Child A whilst he went to appointments. This

should have flagged a concern, whereupon Clive was comfortable leaving his child with a stranger. **Recommendation 13**

19.2.17. As detailed in the chronology, in September 2019, Clive raised his stick in anger at a CGL worker. There is no evidence that this threat of violence was recorded as a safeguarding issue, or that it led to consideration of Clive's risks of harm to others. During this period, Clive was presenting himself to CSC, police, and others as vulnerable and non-violent, which was undermining Elouise's disclosures of abuse upon her and her siblings. Had CGL shared this information about Clive's aggressive behaviour with CSC, it could have assisted with building a more realistic picture of his capacity for violence. **Recommendation 13**

19.2.18. NCHC were also aware of Clive's behavioural issues, as he had become agitated with their staff at times, and this did not lead to consideration about what this could mean for children and family members. **Recommendation 13**

19.2.19. There is no evidence that Clive was asked about his family and home life by NCHC. There was little to no professional curiosity regarding his dis-engagement and non-attendance, or any questions asked about who was providing his care. Rachel was recorded throughout as wife/partner, and Elouise as daughter – however both had been cited by Clive as his carers at different times. NCHC clinicians need to be professionally curious and consider taking a trauma informed approach to sensitively explore topics, behaviours and reactions of patients that could indicate underlying Safeguarding risks including Domestic Abuse. Clinicians to be less task focussed and think in a holistic manner.

19.2.20. Since the period of the DHR, a review of NCHC's Level 3 Safeguarding Core Mandatory training has been undertaken to ensure that content remains relevant and is being delivered. Think Family has been a running theme in NCHC Children's and Adults Safeguarding Group meetings with quality leads responsible for dissemination of information to frontline staff. A further awareness campaign was delivered during spring 2024, and ongoing encouragement of a Think Family approach continues in the form of newsletters, staff emails, and a presentation at the Children and Adult Safeguarding Group in summer 2024.

19.2.21. Another example of agencies and practitioners missing opportunities to identify effects of Clive's behaviours on all members of the family, was during the period where Clive was building up arrears on the family home and refusing to allow Rachel to remove herself from the tenancy, whilst Rachel and the children lived with her mother and could not move to a new tenancy due to these arrears. This does not appear to have been

recognised as ongoing control by Clive, which was continuing to affect all of the other members of the family, who remained homeless due to his behaviour. **Recommendation 5**

19.2.22. The NSFT Wellbeing Service (WBS) has been working on a process to ensure non-recent information is recorded and stored, in order to be used for future risk assessments, for both the patient and also for family/household members.

19.3Trauma Informed Professional Curiosity

19.3.1. Trauma informed practice is an approach that recognised and acknowledges trauma and its prevalence and supports the wellbeing of those who use and work in services. Trauma-informed practitioners assume that a client could have a trauma history and provide support with this in mind. Trauma-informed practice is a strengths-based framework which sees trauma survivors as individuals who manage the best as they can.

19.3.2. As introduced in s.12, Elouise had experiences of Adverse Childhood Experiences (ACEs) which would have caused her trauma, and her abusive father's behaviours into her teenage and early adult years would have continued to traumatise her. The whole household would have been living day to day with trauma due to Clive's behaviours.

19.3.3. The British Association of Social Workers (BASW)[143] have recently called for social workers to approach working with survivors in the context of their abuse, including holding perpetrators to account, whilst also ensuring that interventions remain child focused – and in the child's best interest. They argue that this approach will reduce practices which shame, penalise, and hold abused mothers solely responsible for their children's welfare.[144]

> *"The impact of living with domestic abuse is traumatic. Often, there are long-lasting outcomes for mental and physical wellbeing. Trauma-informed practice for social work is not about therapy and treatment, but about doing no further harm. It is about creating a safe environment, building trust, promoting collaboration and sharing power to be empowering and help a survivor regain confidence in their own*

[143] www.basw.co.uk | The professional association for social work and social workers

[144] BASW *England Domestic Abuse Practice Guidance: for Children and Family Social Workers* (March 2021) p.7 Available: Layout 1 (basw.co.uk)

ability to move forward and create a safe, nurturing home for their child or children."[145]

19.3.4. All services responding to victims of abuse, and early years trauma should adopt a trauma informed approach, this requires "an organisational transformation model that improves awareness of trauma and it's impacts, supports services to consider and put in place appropriate support, and prevents re-traumatising those accessing or working in services."[146] **Recommendation 11**

19.3.5. Trauma informed practice includes the ability to identify signs and symptoms of trauma, utilising a strengths-based model which empowers service users to collaborate in the design and delivery of their support – and asks, "what happened to you" instead of "what's wrong with you?"[147]

19.3.6. Women and girls' charity AVA provide key messages for those supporting victims of abuse. That Professionals should work in a way that understands trauma, its impact on the body and focus on interactions that maximise both physical and emotional safety. Also, that professionals must understand behaviour as a form of communication and consider what is going on under the surface for women, taking the time to be professionally curious, and focus on building trusting relationships with women that acknowledge their strengths and capabilities.[148]

19.3.7. There appeared to be a lack of trauma informed practice deployed by most of the professionals responding to Elouise's needs. All services responding to victims of abuse, and early years trauma should adopt a trauma informed approach, this requires "an organisational transformation model that improves awareness of trauma and it's impacts, supports services to consider and put in place appropriate support, and prevents re-traumatising those accessing or working in services."[149]

19.3.8. Norfolk Community Safety Partnership and Norfolk Safeguarding Adult Board have recently invested in trauma informed practice training. There is now a suite of training available; from an introductory session, through to a full day course, a session on reflective supervision, a "trauma toolbox" session and a two-day leadership conference entitled "organisational and secondary trauma including focus on wellbeing". Attendance across multi-

[145] *Ibid* p.30
[146] RELATE-framework.pdf (kent.gov.uk)
[147] See Trauma-informed practice: what it is and why NAPAC supports it | NAPAC Accessed 29th April 2021
[148] AVA Project *Breaking Down the Barriers: Findings of The National Commission on Domestic and Sexual Violence and Multiple Disadvantage* (2019) Available: Breaking-down-the-Barriers-full-report-.pdf (avaproject.org.uk) Accessed 30th April 2021
[149] RELATE-framework.pdf (kent.gov.uk)

agency partners is being monitored. Learning from this review will be shared to raise awareness of the availability of the training, along with the need for assurance that staff from across all agencies are accessing the training. **Recommendation 9**

19.3.9. For those professionals approaching people affected by trauma without an understanding of the long-lasting effects of trauma: **Recommendation 10**

> "'non-engagement (can be) seen as a refusal of services, not a common symptom of mental health, trauma and complex needs, when sometimes attending appointments can feel overwhelming and frightening'. [150]

19.3.10. Victims face multiple barriers to reporting domestic abuse. Although Elouise did disclose domestic abuse, it may be that her perception of nothing being done – and nothing changing – led her to lose faith in the systems which are set up to protect her.

19.3.11. Domestic abuse perpetrators use mental health as a tool to control, questioning the memory of experiences of abuse, placing the blame for their behaviour on the victim's mental health and over time this worsens the victim's mental health. Elouise returned home to live with Clive and the family, and soon after she retracted her allegations – and following this her mental health deteriorated.

19.3.12. It is also recognised that the Covid-19 restrictions would have exacerbated the isolation of the family, within the family home, which Elouise had by this point returned to. Home was not a safe place for Rachel or the children, however due to the restrictions they were home all the time. There would have been little, or no, opportunity for professionals to see Elouise, Rachel, and the children during this time. There would have been no opportunity for routine enquiry into domestic abuse, and/or the visible identification of harm.

19.3.13. Between March 2020 to summer 2021 there were periods of time where schools were closed, and throughout this period there was a lack of face-to-face contact with professionals, which may have reduced the opportunity for professional curiosity. However, once the restrictions were lifted, and after Rachel moved out of the family home, there continued to be a lack of professional curiosity, of Elouise's situation remaining in the family home

[150] Sharpen, J *Jumping through hoops: How are coordinated responses to multiple disadvantage meeting the needs of women?* (2018) Available Jumping-Through-Hoops_report_FINAL_SINGLE-PAGES.pdf (avaproject.org.uk) Accessed 29th April 2021

with Clive, and of Clive's behaviours towards Elouise, and the other children.

19.3.14. Professional curiosity is a practice where practitioners proactively try to understand what is happening within a family, or with an individual, rather than either making assumptions or accepting what they are told at face value. Ensuring that professional curiosity is also trauma informed, allows for the creation of safe spaces and respectful questioning, and where appropriate, respectful challenge.

19.3.15. Elouise's interactions with college staff should be highlighted as good practice, in terms of trauma informed professional curiosity. The college were proactive in asking questions of Elouise, and of other professionals, whilst being trauma informed in their support of Elouise.

19.3.16. The DHR has highlighted the importance of agencies having policies and procedures with expect consistent professional curiosity; this should also be combined with a Think Family approach, in order to be professionally curious around all members of the family and household.

19.3.17. Training in use of professional curiosity using a trauma informed approach continues to form part of the Safeguarding training currently provided by Norfolk and Waveney ICB. It is recognised that adopting trauma-informed practices can potentially improve patient engagement, treatment adherence, and health outcomes, as well as provider and staff wellness.

19.3.18. Professional curiosity is a large part of NCHC's Level three Safeguarding Adults and Children mandatory training, along with a section on trauma informed practice. A further professional curiosity awareness raised campaign has been delivered during spring/summer 2024, and as above, this will also be encouraged through newsletters, staff emails and within the Children and Adult Safeguarding Group. throughout 2024.

19.3.19. There should also be greater curiosity in relation to the lack of contact with an individual patient, when they do not attend planned appointments or the patient's voice is not heard above a carer's voice. In Clive's case, before they separated Rachel would call NCHC on his behalf most of the time, however no questions were asked about this.

19.3.20. Clive was never seen by NCHC professionals in his home environment. Given Clive's reported social and financial difficulties at home, there may have been value in seeing him at home. Whilst not essential to managing his health-related concerns for which he was under the care of NCHC services, it might have presented an opportunity to witness Clive having interactions with family.

19.4 Transitions

18.4.1. During the scoping period, Elouise transitioned from childhood to adulthood, although she was still under the age of twenty-five when she was killed.

18.4.2. Over the years there have been a range of research and learning around transitions. Including studies highlighting what components are required for a successful transition from child to adult services,[151] young people's experiences of transitions from child mental health services to adult mental health services[152] and also health services,[153] all of which highlight the risks of losing young people in the transition due to different thresholds, service criteria and levels of support offered to the different age groups.

18.4.3. At the same time that Elouise was potentially moving from child to adult services, she was also moving from Norfolk services to Lincolnshire services. This presented two different opportunities for Elouise to fall through the gaps.

18.4.4. Although Norfolk CSC did not identify Elouise as moving permanently to Lincolnshire, and therefore did not refer her to Lincolnshire CSC, it was a missed opportunity to alert Lincolnshire that Elouise, who was a vulnerable late teen/young adult, fleeing abuse from her father, was in their area. This led to a lack of joined up working between LPFT, EDAN Lincs, and both area's CSC teams – as no one really knew where she was or what her situation was.

18.4.5. For LPFT, further learning was identified for the Steps2Change service around how those who are 16-17 years old are considered by clinicians, especially when there is known CSC involvement and disengagement occurring. Clinicians should discuss this with their manager and/or Safeguarding team when they are then unable to establish who is managing the Child Protection Plan. This message was circulated to all Steps2Change Managers and the Quality Lead for the Service to ensure all staff in Steps2Change are aware of their roles and responsibilities around

[151] Cleverley, K et al "Identifying Core Components and Indicators of Successful Transitions from Child to Adult Mental Health Services: a Scoping Review" *European Child and Adolescent Psychiatry* 29 (2020) pp.107-121
[152] Broad K et al "Youth experiences of Transition from Child Mental Health Services to Adult Mental health Services: A Qualitative Thematic Synthesis" *BMC Psychiatry* 17 (2017)
[153] Brown, M "Transition from Child to Adult Health Services: A Qualitative Study of the Views and Experiences of Families of Young Adults with Intellectual Disabilities" *Journal of Clinical Nursing* 29 (2019) pp.195-207

the management of Young People accessing Steps2Change who are open to Children's services.

18.4.6. Norfolk's 2022 CSC Ofsted inspection identified an area of work needed around 16- and 17-year-olds who become homeless. CSC continue to work on improving this area. Some of the protocols have been re-written, and social workers continue to be trained around responding to young people in this age range and navigating services available for this age group. There is also ongoing developmental work between the adult and children's partnerships, around safeguarding during these transitions.

19.5 Collaborative working

18.5.1. Since the scoping period of this review, there are more collaborative initiatives between services, including co-located working and the relaunch of the Resolving Professional Disagreements Policy – which is intended to promote better partnership working. However, the learning around collaboration which has been identified within this review should be highlighted as examples of the pivotal nature of collaboration when responding to domestic abuse, and to the safeguarding of children and young people.

18.5.2. Rachel was referred to MARAC on 12th March 2019 and 26th September 2019. There were no actions arising from the initial MARAC discussions, the rationale for no actions was that Rachel was reportedly engaging with domestic abuse advocacy and CSC, although the information gathered for this review indicates to the contrary. The second MARAC for Rachel was referred by the family's allocated social worker. Rachel was not aware of the MARAC referral and had not consented to this. The concerns raised at this MARAC were of a much more serious nature, and professionals all appeared concerned about Rachel, who they had all struggled to make contact with. An action from this MARAC was for Lincolnshire Constabulary to place an "object marker" on the property where Elouise was residing in Lincolnshire – this was a positive action coming from the MARAC. However, this could have gone further and included advising Lincolnshire CSC that Elouise was residing in the area whilst the subject of a Child Protection plan. The second action was for the family's allocated social worker to include a possible Occupation Order and a Non-Molestation Order into Rachel's safety plan, and to discuss this with the IDVA. As highlighted above, there was no safety plan identified in the family's CSC files when they were reviewed for this DHR, which raises the question of whether this action was completed following the MARAC.

18.5.3. Elouise was referred to MARAC by her college; the meeting was held on 19th July 2019. The information leading to the MARAC referral was pertaining to the use of weapons by Clive, to cause fear and control. This information had been received from EDAN Lincs, who Elouise had approached whilst residing in Lincolnshire, EDAN Lincs had taken positive action by sharing this information with Norfolk services. At the MARAC meeting, Norfolk Police shared that they had reduced the risk to Elouise from Clive to medium. The rationale for this was that "*The offender has the potential to cause serious harm but is unlikely to do so unless there is a change in circumstances, for example the victim moves back in with the perpetrator."* This shows a lack of insight into the bigger picture, as since the strategy meeting held in May 2019, CSC had been encouraging plans for Elouise to move back home.

18.5.4. Throughout the minutes for all three MARAC meetings, the language of "minimisations" and "refusing to engage" with services was used unchallenged, including by the domestic abuse specialist. The purpose of the IDVA at the MARAC is to represent the wishes and feelings of the victim in the victim's absence,[154] and their role should include advocating on behalf of the victims; including challenging when victim blaming language and observations are made.

18.5.5. At this MARAC meeting the family's social worker, who was also Elouise's social worker as she was currently still sixteen years old, stated that Clive had told her "*this morning that he thinks Elouise is going between his mother (who is an alcoholic and a liar) and the other grandmother."* She stated that Clive was "*very charming"* and had got upset when he spoke about wanting to see Elouise. But then that Clive was planning to "*put in a complaint against Elouise for harassment".* Clive's voice, via the social worker, appeared to be louder than Elouise or Rachel's whose voices were not represented at this meeting.

18.5.6. Domestic Abuse Charity A didn't receive updates on minutes or actions from the MARAC meetings. This would have given them a clearer picture of which other agencies were involved with the whole family and a better understanding of family life for Elouise,

18.5.7. This MARAC meeting resulted in no actions, which indicates a lack of proactivity considering the weapons remained with Clive, whilst three other children remained in the family home.

18.5.8. There was also a lack of challenge from practitioners at Strategy Discussions and Child Protection Conferences. This includes the August

[154] Islands in the Stream

2019 Strategy Discussion, where the health visitor raised concerns that the children had been listened to by professionals – however this was not acted upon. Learning from this review highlights the need for professionals across all services to utilise the escalation process if they raise concerns which they do not feel are appropriately acted upon. **Recommendation 13**

18.5.9. The health visitor contacted the social worker in March 2020, and was informed that the Child Protection plan had been stepped down to Child in Need – which had subsequently been closed due to lack of parental engagement with the plan. There is no evidence of NHCP challenging this, and the health visitor did not see the family again until December 2020.

18.5.10. The decision from the Strategy Discussion in November 2020 was that the circumstances did not meet the threshold for a Section 47 assessment, despite Child A reporting in her wishes and feelings session that "daddy shouts at me, smacks me on the arm and all over, he shouts and hits Dan and Mia." The health visitor challenged this decision; however, the decision was not changed. As above, the escalation policy should have been followed at this point.

18.5.11. Elouise's college and the children's schools could have also utilised the escalation policy when their perception of the risk was not appreciated by other professionals in decision making roles. The schools were privy to different points of view and behaviours, and their viewpoints should have been considered. Elouise's college also tried to advocate for her, raising the "devastating consequences" of Elouise not feeling believed following the disclosures she made against her father.

18.5.12. As has been identified through the review, practitioners found it difficult to refer into mental health services, and to access CMHT – this is a lesson to be learnt from the NHS England review and also from this DHR.

18.5.13. Where NCHC staff have concerns about a patient in any context, clinicians should make every attempt to hold a verbal clinician to clinician conversation about the situation. Where there are barriers, staff need to be persistent in their pursuits to have these conversations. For example, the Heart Failure Nurse who had concerns about Clive's mental health attempted to contact both the NSFT First Response Team and GP surgery for a verbal conversation about their concerns. Unfortunately, she was unable to get through to have a conversation about her concerns.

18.5.14. There is no indication that Domestic Abuse was considered as part of NCHC discussions with Clive, but a conversation with NSFT or GP might have been used as a mechanism to share information and highlight known concerns about a history of domestic abuse that may have changed the

NCHC clinician's perspective and understanding and might have informed her decision making and professional curiosity. This may be particularly true considering the key entry in the documentation that Clive 'came across as very low in mood and extremely anxious talking about ex-wife and daughter'. The sharing of information would also have helped to determine if Clive's mental health and emotional dysregulation represented a deterioration in his health to be concerned about or presented as a risk to others or whether this was his normal presentation.

18.5.15. The size of this report indicates just how many agencies were involved with the family throughout the scoping period. However, at times there was not a joined-up approach. There were repeated DASHs completed, showing very concerning risks for the whole family, but there was no consistent plan cutting across all of the services.

18.5.16. There was a lack of information sharing at critical periods. CSC have recently invested in Group Supervision and Joint Agency Group Supervision (JAGS) which has proved effective in creating a collaborative "team around the family" and a professional "team around the practitioner". All agencies involved with families are invited to supervision to look at the worries and concerns, to think and reflect together as to the risks and then collaboratively plan a way forwards. Had the JAGS process been in place, there could have been a better mechanism to share information between agencies, and a far more robust multiagency safety plan could have been achieved.

18.5.17. Since the scoping period of the review, NIDAS has created a better partnership working across the Norfolk systems. This includes management of the Norfolk Domestic Abuse Champions Network which contains professionals across different agencies in Norfolk. NIDAS also provides training to their funding partners which includes Norfolk County Council. Therefore, NIDAS are seeking to standardise training for partner agencies and Domestic Abuse Champions across Norfolk so that agencies are aware of identification of risk and who to contact if they concerned about domestic abuse. The standardised approach to working with victims of domestic abuse promotes partnership working across Norfolk.

18.5.18. Following this review, Domestic Abuse Charity A will identify a senior practitioner within their local office and work to build stronger relationships with the CSC team, to enhance communication and promote domestic abuse awareness.

18.5.19. There are a lack of information sharing mechanisms throughout the full multi-agency scope in Norfolk. High risk MARAC names are shared with wider health and social care partners, such as hospital A, however wider

information about the victims or their children are not shared beyond those who attend the MASH. **Recommendation 9**

18.5.20. CSC Strategy Discussions now include the expectation of all agencies to provide a scaling number for assessing risks. Agencies are expected to provide a rationale for their thinking – which allows for a more robust and collaborative multiagency plan to be formed. However, it is important that all professionals attending these meetings have a clear and consistent view of the scaling rationales. **Recommendation 12**

19.6 Children as Victims

18.6.1. Following the introduction of children as victims in their own right, there is a need for multi-agency training to embed what this means in practice. This training will include direct input from Mia, who will share her experiences of abuse but also her experiences of being overlooked by professionals, as a victim in her own right. **Recommendation 13**

18.6.2. Practitioners must be made aware that just because the teenager moves out of the family home, as Elouise did – or the family move away from the perpetrator, as Rachel did; the domestic abuse and coercion does not simply end. Linked to this, it is vital that practitioners, particularly social workers, recognise that utilising older siblings to facilitate contact with an abusive parent is inappropriate, and dangerous.

18.6.3. Following all seven Strategy Discussions there was no role for NHCP. This decision making indicates limited understanding around the impact of experiencing domestic abuse on children's health and development. **Recommendation 13**

18.6.4. The 'Voice of the Child' must be accurately recorded on Athena by attending and investigating police officers on every occasion. In February 2022 Norfolk Constabulary promoted the use of the checklist for officers and mnemonic 'ARTHUR'[155] to reflect the lived experience of the child. **Recommendation 1.**

18.6.5. There is evidence within this review that Norfolk Constabulary did not always fully recognise, safeguard, or investigate allegations of Clive's crimes that were reported by Elouise. Norfolk Constabulary Force Policy around secondary safeguarding necessitates that intimate partner recorded

[155] See glossary - College of Policing: ARTHUR reminds staff to focus on the voice of the child

domestic related crimes will attract a secondary review by the Domestic Abuse Safeguarding Team in the MASH. Intra-familial recorded domestic incidents, such as the relationship between Elouise and Clive would be recorded on police systems as "Domestic Incident/Crime" but no DASH is completed, unless deemed appropriate by the attending officer and flagged to the MASH for their consultation. As cited in the analysis section, there were clear occasions where Elouise's voice as a victim in her own right was overshadowed when parallel investigations and safeguarding were being undertaken in relation to her mother Rachel. **Recommendation 2**

18.6.6. A DASH risk assessment should have been considered and completed with Elouise by NSFT staff, as a victim of domestic abuse. Staff need to develop their understanding of the changing dynamics of domestic abuse, and the fluidity of risk. In this case, as Elouise's role in the family changed, so did her exposure to domestic abuse. The Trust Safeguarding Team have developed and are rolling out bespoke training on completing DASH assessments and understanding the MARAC process.

18.6.7. Within Norfolk's new NIDAS service, there are family workers who would have worked with the children, including Elouise, and Rachel simultaneously. The workers meet outside of the home and utilise the child's school or other places of safety, to meet with the family members.

18.6.8. Considering the pivotal role education settings can take in the response to domestic abuse, further enhanced training – specific to education - should be made available across the education sector in Norfolk. There should be further opportunities introduced to empower education settings across Norfolk to become better equipped when responding to domestic abuse. Learning from this review will form part of this initiative. **Recommendation 6**

19. Recommendations

19.1. Norfolk Constabulary

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

19.1.2. 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.

19.2. NSFT

19.2.1. 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.

19.3. Hospital A

19.3.1. 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.

19.4. Housing Association A

19.4.1. 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.

19.5. Education

19.5.1. 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.

19.6. Norfolk Children Social Care

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

19.7. Domestic Abuse Charity A

19.7.1. 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.

19.8. Multi Agency Recommendations

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

19.8.2. 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.

19.8.3. 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.

19.8.4. 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[156] – and agencies should provide assurance that their key staff members have attended this training.

19.8.5. 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.

19.8.6. 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 [157], 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.

[156] Norfolk LSCP Signs of Safety: Family Network Approach
[157] Norfolk LSCP Policies and Procedures

Appendix One

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Appendix Two

Shared learning bulletin

NHS England

An independent review of mental health care and treatment by an NHS Mental Health Foundation Trust

Introduction

This document provides an overview of the findings of an independent review of the mental health care and treatment provided to a mental health service user (A). The homicide victim (B), occasionally stayed with, and cared for him some of the time.

Case background

At the time of the incident, A was living on his own. He was separated from his partner and family. A had multiple physical health problems and was taking prescribed medication for these. He had a diagnosis of depressed mood. A was in contact with his GP and specialist community services. A had some contact with Trust services in the past, but his most recent episode of care began roughly nine months before the incident. He had been arrested for assault on his partner resulting in actual bodily harm, domestic abuse (coercive and controlling behaviour) and drug abuse. A was referred to six NHS Trust services and assessed on 12 occasions. He was not assessed on two other occasions. The assessments were detailed and focused on his mental health needs.

Key Findings

Risk assessments

Risk assessments did not take a holistic view and did not always consider the risks associated with i) A's alcohol and substance misuse, ii) A being an alleged perpetrator of domestic violence, iii) the role of child safeguarding and child protection, and iv) the role of his children as young carers.

Lack of professional curiosity in risk assessments

Throughout his contact with the Trust A gave varying and inaccurate accounts of events and his history that were misleading and appeared to be self-serving. Despite this, assessing services did not explore the impact of risk factors or these inaccuracies further, often documenting A's version unverified into electronic records. Services did not check whether other services were involved with A and his family, or whether other services were aware of the risks identified. They did not clarify whether the events and history recounted by A were accurate. Services were not curious enough about the family circumstances and A's living situation. They did not consider risk or management of risk from a family perspective. They focused on A's stated needs.

Lack of awareness of child safeguarding

We found that services did not consider the impact of A's risk-taking behaviours and poor mental health on his children. It was known he continued to have contact with his children despite living separately from them. The impact of his behaviour on their mental health was not considered. Trust services only sought child safeguarding advice on one occasion but were instructed not to make a referral. The identified risks were left unaddressed. A told services he viewed his children as a protective factor in relation to his suicidal ideation, planning or intent. This was not challenged, and the impact of this on his children was not considered or explored.

Lack of awareness of domestic violence

Services did not consider or assess the impact of A as an alleged perpetrator of domestic abuse on his wider family. This was not considered in risk assessments conducted by Trust services. Information was not shared between services. When A disclosed to the Trust that he was seeing his partner and family despite a restraining order, they did not share this with other services who were managing the risks.

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Shared learning bulletin

Key Findings (continued)

Missed opportunities and referrals not acted on

There were two occasions when Trust services received referrals but did not act on them. The first time A declined to be seen by the Trust liaison and diversion service (L&D) when he was in police custody. The second time, roughly five months later, A was seen in the accident and emergency department, but the Trust mental health liaison service (MHLS) was too busy to assess him. Both referrals presented opportunities for the Trust to gather information, assess risk and liaise with other services involved in A's care, even if A refused to engage. These were missed opportunities for multi-agency oversight and communication.

Access to the Community Mental Health Team (CMHT)

Initially the CMHT responded promptly to A's referral to the team. However, there were service pressures which resulted in A not receiving a home visit until eight months after the referral and four months after it was accepted by the CMHT. A should have been prioritised given the risks identified and his family situation.

Use of waiting lists

A was placed on the CMHT waiting list and graded as amber and non-Care Programme Approach (nCPA). The Trust guidance does not state how frequently service users graded as medium to low risk should be contacted whilst on the waiting list. A was not contacted regularly by the CMHT whilst on the waiting list.

Invisibility of young carers

A identified his oldest child as his main carer. Another younger child also supported him. A was open about having contact with his other children. Our investigation found no evidence that A's children were considered as carers or offered a carer's assessment or any support.

Lack of follow up following referrals

On two occasions referrals were made by the Trust to other services. These referrals were subsequently rejected. There were no follow up actions taken by the referring Trust services in relation to considering alternative support. There was also a lack of follow up following Care Act (2014) referrals. There was no evidence of communication between the Trust and the County Council who were aware of the family.

Critical Learning Points

1. All registered and non-registered staff working with service users must be briefed on the importance of being curious when assessing and managing risk, especially when individuals have contact with children or are suspected to be perpetrators of domestic abuse. Staff must explore these factors with the patient/service user, and seek information from other services regarding risk management, before closing the referral or referring the individual elsewhere. The Trust must also ensure all staff working with service users are aware of the need to share such risk information with other relevant agencies and must demonstrate compliance with the safeguarding polices, and procedures.
2. The Trust must ensure Level 3 safeguarding training includes advice for professionals on the importance of escalating safeguarding concerns when they are not addressed by other agencies, but where the risks remain. The Trust must ensure this training captures the role of seeking advice, the importance of information sharing, and the importance of ensuring the advice given by other agencies is received and recorded in the correct format.
3. CMHTs should ensure individuals on their waiting list who go into crisis are reviewed after a crisis; they should receive appropriate follow-up care immediately as standard, not simply rejoin a waiting list they are already on.

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Critical Learning Points (continued)

4. The Trust should ensure services have clear guidance on the frequency of CMHT contact for all individuals whilst they are on a Trust CMHT waiting list, clearly distinguishing between people rated high, medium and low risk. This guidance should include actions to be undertaken when individuals go into crisis or when they disengage from services.
5. When a referral, made by a Trust service to another agency is not accepted, the referring Trust service must consider whether alternative support is required, and pursue that alternative support if it is required.
6. When individuals who have contact with children and have identified risks relating to both domestic abuse and substance misuse, refuse to engage with the Trust L&D service, the L&D service must ensure they alert child protection services, and any other relevant agencies, to this risk information before closing the referral. This is to ensure agencies can develop appropriate safety plans and risk management plans.
7. The Trust must reinforce (through training and policy guidance) the importance of referring carers, particularly young carers, and children, to the appropriate agency for assessment of their needs. Compliance with referrals for carer assessments should be evidenced through regular yearly audit.
8. The DHR should consider how to co-ordinate multi-agency involvement in cases like this. In this case there was a missed opportunity to have multi-agency oversight.

Learning Quadrant

Individual practice

- Are you curious when assessing and managing risk? Do you attempt to verify what patients/service users tell you?
- If you make a referral to another service and it is rejected, do you consider alternative services/ways of meeting the patient/service user's needs?
- Do you consider the needs of carers, including young carers and offer them a carer's assessment and support?
- Have you attended Level 3 safeguarding training? Are you aware of the importance of escalating safeguarding concerns when they are not addressed by other agencies and the risks remain?

Governance focused learning

- How are you supporting staff to be professionally curious?
- How are you ensuring that staff are attending Level 3 safeguarding training and are aware of the importance of escalating safeguarding concerns when they are not addressed by other agencies but where the risks remain?
- Does Trust mandatory training provide frontline staff with the necessary skills when assessing risk in cases involving mental illness, domestic abuse, access to children and substance and/or alcohol misuse?

Board assurance

- Where CMHTs are operating with a waiting list, is there clear guidance in place regarding how frequent contact should be with patients/service users who have been graded high, medium or low risk?
- Are individuals on the CMHT waiting list who go into crisis being reviewed and offered follow up by the CMHT on a standard basis? What systems are in place to monitor that this is the case?
- How are you assured that carers, including young carers are being offered a carer's assessment and that one is being completed?

System learning points

- How can the Trust work across the system with partners to ensure multi-agency involvement is co-ordinated and achieved in other similar cases?
- How are agencies ensuring that they communicating with one another about individuals who have contact with children and have identified substance misuse problems and refuse to engage with the Trust Liaison & Diversion service (or other Trust services)?
- Are Trust policies and training materials aligned with Adult and Child Safeguarding Boards regarding seeking advice, escalating concerns and information sharing?

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