Safer Lincolnshire Partnership

Domestic Homicide Review

Zac/July 2021

Overview Report

Author: Dr Liza Thompson

Commissioned by: Safer Lincolnshire Partnership

Review completed: July 2023

Page intentionally blank

Contents

1. Introduction 6
2. Confidentiality 6
3. Timescales 7
4. Methodology 8
5. Terms of Reference 11
6. Involvement of Family Members and Friends 12
7. Contributing Organisations 14
8. Review Panel Members 16
9. Independent Chair and Author 17
10. Other Reviews/investigations 18
11. Publication 18
12. Background Information 18
13. Equality and Diversity 21
14. Chronology 25
15. Overview 46
16. Analysis 48

16.1. Surrey Children's Services 48
16.2. Surrey Police 49
16.3. Surrey Hospital A 50
16.4. Surrey Hospital B 51
16.5. Surrey and Borders Partnership NHS Foundation Trust 52
16.6. Surrey District Council A – Housing 53
16.7. Probation Service 53
16.8. Lincolnshire Police 56
16.9. Lincolnshire County Council Children's Health and Children's Services 57
16.10. Lincolnshire Partnership NHS Foundation Trust 58
16.11. EDAN Lincs 61
16.12. We Are With You 61
16.13. United Lincolnshire Hospitals Trust 62
16.14. Lincolnshire Community Health Services 64
16.15. Lincolnshire Tier 2 Council A and Tier 2 Council B 65
16.16. Multi-Agency Risk Assessment Conferences (MARACs) 66

17. Conclusions 68

17.2. Relational Dynamics and Dual Allegations 68
17.3. Male Victims 70

17.4. Specialist Knowledge and Services 72
17.5. Multi-Agency Risk Assessment Conference (MARAC) 72
17.6. Trauma-informed Practices 73
17.7. COVID-19 Restrictions 75
18. Lessons to be Learned 76
19. Recommendations 77
19.2. Surrey Children's Services 77
19.3. Surrey Hospital B 77
19.4. Surrey and Borders Partnership NHS Trust 77
19.5. Surrey District Council A – Housing 78
19.6. Probation Service (Formerly National Probation Service) 78
19.7. Lincolnshire County Council – Children's Services 78
19.8. Lincolnshire Partnership NHS Foundation Trust 78
19.9. We Are With You 79
19.10. United Lincolnshire Hospital Trust 79
19.11. Lincolnshire Community Health Services 79
19.12. Lincolnshire Tier 2 Council A and Tier 2 Council B 79
19.13. Multi-agency Recommendations 80
Glossary of Terms 81
Bibliography 84

Page intentionally blank

1. Introduction

1.1. This Domestic Homicide Review (DHR) examines agency responses and support given to Zac – a resident of Town A, in Lincolnshire – prior to his death in July 2021.

1.2. On the day of his death, following reports that Zac had been stabbed in the chest, the police were called to an address that he had shared with Scarlett until a few months before.

1.3. Scarlett was arrested on the scene and charged with Zac's murder the following day. She was found guilty of manslaughter and sentenced to nine years' imprisonment in March 2022.

1.4. This DHR examines the involvement that organisations had with Zac, a 22-year-old white British male, and Scarlett, a 21-year-old white British female. The review period was set as 1st August 2018, which is when the relationship began, to July 2021, when Zac was killed.

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.

2. Confidentiality

2.1. The findings of this DHR are confidential. Information is available only to participating officers/professionals and their line managers, until after the DHR has been approved by the Home Office Quality Assurance Panel and published.

2.2. Dissemination is addressed in 11.3 below. As recommended by the statutory guidance, pseudonyms have been used, and precise dates obscured, to protect the identities of those involved. Pseudonyms were provided and agreed by Zac's mother.

2.3. Details of the deceased and perpetrator:

Name (Pseudonym)	Gender	Age at time of homicide	Relationship to deceased	Ethnicity	Disability	Religion
Zac	Male	22	*Deceased*	White British	Learning disability	None
Scarlett	Female	21	*Partner and Perpetrator*	White British	None	Church of England

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:
Phoebe	Mother	None
Louise	Sister-in-law	Aunt
George	Brother	None

3. Timescales

3.1. The initial DHR notification was received from Lincolnshire Police, by the Safer Lincolnshire Partnership, on 21st July 2021.

3.2. In accordance with Section 9 of the Domestic Violence, Crime and Victims Act 2004, a Safer Lincolnshire Partnership Core Panel meeting was held on 18th August 2021. The panel agreed that the criteria for a DHR had been met, and the Chair of the Safer Lincolnshire Partnership confirmed that a DHR would be conducted. The Home Office was notified of the decision and the commissioning of the DHR.

3.3. The review process was then paused pending the completion of the criminal trial, which took place in January/February 2022, and Scarlett was sentenced in March 2022.

3.4. The Independent Chair was appointed in January 2022. At the initial panel meeting on 19th January 2022, it became clear that the review would require a high level of input from Surrey services – where Zac and Scarlett had lived for most of their lives. A meeting was held on 24th February 2022 to discuss the logistics for this information request, and to determine who would be approached to represent Surrey services on a panel. It was agreed that a decision regarding representation would be made following receipt of chronologies. The deadline for this was set for 25th March 2022.

3.5. At the next panel meeting on 20th April 2022, the chronologies were scrutinised, and the Terms of Reference were agreed. Through this process, it was agreed which agencies,

from both areas, would be required to send Independent Management Reports (IMRs).[1] A deadline for completion of IMRs was set for 22nd July 2022. Some agencies required extra time for the IMRs, due to the volume of information that they held.

3.6. The panel met again on 14th September 2022. This date was sometime after the IMR deadline, due to the complexities of aligning the diaries of 19 agencies across two local authorities. Further questions were raised at the IMR review meeting, and the Independent Chair conducted numerous additional individual meetings with IMR authors to obtain answers to these questions.

3.7. The overview report was written throughout November 2022 to May 2023.

3.8. In July 2023, the Safer Lincolnshire Partnership signed off the report to be shared with Zac's mother, Phoebe. However, despite attempts spanning six months, Phoebe was not contactable; therefore, in January 2024, a decision was made to submit the report to the Home Office without Phoebe's input into the final version.

4. Methodology

4.1. The IMRs were completed by each organisation that had significant involvement with Zac and/or Scarlett.

4.2. Each IMR was written by a member of staff from the organisation to which it relates. Each was signed off by a senior manager of that organisation before being submitted to the DHR panel. Neither the IMR authors nor the senior managers had any involvement with Zac and/or Scarlett during the period covered by the review.

Agency/ Contributor	Nature of Contribution	Source of information
Surrey Children's Services	IMR	Review of Zac and Scarlett's files, including the MARAC held in September 2020. Interviews with Zac and Scarlett's personal advisors, and their line managers. Interview also undertaken with a Family Support Worker who supported Scarlett. Service managers were consulted to provide contextual information.
Surrey Police	IMR	Digital records relating to Zac and Scarlett were accessed.
South-East Coastal Ambulance Service	Summary report	All available records from 999 contacts were reviewed.

[1] An IMR is a written document, including a full chronology of the organisation's involvement, which is submitted on a template.

Surrey Hospital A	Summary report	Zac's medical notes and casualty cards were accessed. Clarity was sought from children's safeguarding team regarding care leavers. A meeting was held with the lead nurse of ED to clarify ED attendance.
Surrey Hospital B	Summary report	Hospital records reviewed.
Surrey and Borders Partnership NHS Trust	IMR	Zac's electronic record on SystmOne (S1). Information from assessments, risk assessments, care plans, case notes, and internal and inter-agency correspondence.
Surrey District Council A – Housing Team	IMR	Review of case notes, correspondence, and associated records. Policies and procedures were reviewed. Additional clarifications obtained from homelessness and advice and allocations teams. Discussions with Surrey Council Senior Policy Officer.
Probation Service (Formerly National Probation Service)	IMR	The NDELIUS case recording was accessed. Offender Assessment System (OASys) assessments reviewed. HMPPS Domestic Abuse Policy framework accessed and referenced throughout.
Lincolnshire Police	IMR	The following systems were accessed: Police National Computer (PNC). Police National Database (PND) – a national intelligence system. NICHE – the crime recording and intelligence systems. NSPIS – the Command-and-Control system, and custody system for Lincolnshire Police. HOLMES – a police information system in relation to the investigation. GENIE – an intelligence search engine. The officer dealing with the murder investigation was interviewed.

Lincolnshire County Council Children's Health and Children's Services	IMR	Records related to service provision for Zac, Scarlett, and Child A were reviewed from: Children's Health SystmOne. Children's Services MOSAIC records. Liaison with health visitors and the social worker team to ascertain additional and contextual information.
Lincolnshire Partnership NHS Trust	IMR	Electronic clinical patient records were reviewed. Relevant Trust policy and procedures were reviewed. Interviews were undertaken with CJL&D senior clinician and team manager; EIP team manager; perinatal mental health team manager; CMHT service manager.
EDAN Lincs	IMR	Modus case management system. Interviews with staff involved with the initial referral process.
We Are With You	IMR	Case management system Nebula was accessed.
United Lincolnshire Hospital NHS Trust	IMR	Medical records analysed. Liaison with safeguarding midwife and lead nurse for women's health regarding specific procedures.
Humber Teaching NHS Trust	Summary report	Entries recorded on SystmOne were accessed
Lincolnshire Community Health Services	IMR	Three of the six GPs who had contact with Scarlett were interviewed.
Lincolnshire Tier 2 Council A and Tier 2 Council B	IMR	Case notes were analysed. Enquires were made with the Homelessness Reduction and Private Sector Improvement managers.

4.3. The panel is aware that the following DHR overview report is a lengthy and detailed document. This was unavoidable due to both party's complex and protracted involvement with many services, both historically as children, and leading up to Zac's death when they were young adults.

4.4. The amount of information, from the large number of agencies, spanning two counties, illustrates the multifaceted and interwoven nature of Zac and Scarlett's access to services: as children and as adults; as individuals and as a couple; and also as parents.

4.5. The Executive Summary provides a condensed account of the review; however, the panel was clear that the detailed overview report was necessary to place the extensive learning from this review process into context whilst, vitally, telling Zac's story.

5. Terms of Reference

5.1. The Terms of Reference of the DHR were agreed on 20th April 2022. Due to the cross-border nature of the review, scoping dates were set for Lincolnshire first. Later, when the panel received more information, scoping dates were then set for Surrey.

5.2. As information was received from Surrey, the panel determined which agencies would provide reports. Due to the complexities and number of agencies involved, the Chair and panel were required to employ flexibility to manage the process iteratively.

5.3. As new information was received, the Terms of Reference were then developed.

5.4. This review will establish whether any agencies had identified possible and/or actual domestic abuse that may have been relevant to the death of Zac.

5.5. If such abuse took place and was not identified, the review will consider why it had not and how such abuse can be identified in future cases.

5.6. If domestic abuse was identified, this DHR will focus on whether each agency's response to it was in accordance with its own and multi-agency policies, protocols, and procedures that were in existence at the time. This includes the identity of risk and any safety plans put in place to reduce that risk. This review will also consider current legislation and good practice.

5.7. The full subjects of this review will be the victim, Zac, and the perpetrator, Scarlett.

5.8. Key Issues

5.8.1. The following issues were agreed by the panel, and Zac's mother, and were addressed by agencies within their IMRs:

- How effectively were disclosures or indicators of domestic abuse addressed? What was the response?

- Did agencies have policies and procedures for domestic abuse and safeguarding, and were these followed in this case? Has the review identified any gaps in these policies and procedures?

- What services were offered to Zac and/or Scarlett, and were they accessible and appropriate for their needs? Were there barriers to access for either party?

- When and how were Zac and/or Scarlett's care leaver status considered?

- What knowledge did each agency have that indicated Scarlett might be a perpetrator of domestic abuse against Zac, and how did they respond to this?

- What processes do agencies have in place to respond to situations where both parties are violent and where it is difficult to identify a clear perpetrator of domestic abuse/coercive control?

- What impact did Zac and Scarlett's movement across areas have on service delivery?

- Did the MARAC in either area provide support/reassurance for agencies working with Zac in relation to the risk of domestic abuse?

- How did agencies take account of any diversity issues, namely disability, age, and gender, when completing assessments and providing services to Zac and/or Scarlett? What reasonable adjustments were made to services to accommodate Zac and/or Scarlett? In what ways were Zac and/or Scarlett's ability to understand information assessed?

- Were there issues in relation to capacity or resources within agencies that impacted on their ability to provide services to Zac and Scarlett, and to work effectively with other agencies? Consideration was also given to any additional capacity/resource issues with agency contact due to the COVID-19 pandemic.

- How did agencies ensure that the wishes and feelings of Zac and/or Scarlett were gathered, in relation to the services that were provided or being offered?

- What learning has emerged for agencies, and are there any examples of innovative/outstanding practice arising from the review?

- What cross-area information sharing, and/or collaborative working, did agencies undertake when Scarlett and Zac moved between Surrey and Lincolnshire.

6. Involvement of Family Members and Friends

6.1. Lincolnshire CSP, the Independent Chair, and everyone involved with this DHR extends their deepest condolences to Zac's family. His death, and the circumstances surrounding the incident, are tragic and have affected many members of both families. The Chair and the panel are extremely grateful to Phoebe for being so generous with her time and her memories of her son, Zac.

6.2. The Independent Chair reached out to Phoebe, and to Zac's father, following the sentencing report in March 2022. Initially, Zac's father responded; however, following two unsuccessful phone appointments with him, a message was sent to the Chair via his Victim Support Homicide Caseworker to advise that he did not wish to be part of the DHR process. Phoebe contacted the Independent Chair, via her Victim Support Homicide Caseworker, in June 2022. A virtual introduction meeting was booked for a few days later. At this meeting, a plan was made for the Independent Chair to visit Phoebe in Surrey.

6.3. The initial visit, which was booked for the following week, was cancelled by Phoebe because she was unwell; therefore, a subsequent meeting was agreed for August 2022. Phoebe's Victim Support Homicide Caseworker was also present at this meeting. The Chair spoke with Phoebe about Zac, gaining an insight into his childhood and relationship with Scarlett. Phoebe asked pertinent questions that were fed back to the panel at the IMR review meeting in September 2022: these questions formed part of the discussions and, subsequently, are weaved into the review.

6.4. At the IMR review meeting in September 2022, it was agreed that Scarlett's aunt, Louise, and Zac's brother, George should also be invited to be part of the review. It was thought that their input would provide an additional understanding of the relationship between Zac and Scarlett, as they had all lived together at various times. The Chair wrote to these family members on 23rd September 2022.

6.5. On 25th October 2022, the Chair contacted Phoebe's Homicide Caseworker to request pseudonyms for the family members and to ask if she would follow up with her son, George, and his wife, Louise about their involvement in the review. On 9th November 2022, the case worker replied with pseudonyms. Phoebe also confirmed that she had spoken to George: he and Louise had declined to be part of the review.

6.6. Also in January 2023, the Independent Chair wrote to Scarlett's grandmother. She was invited to be part of the review due to her involvement with Zac and Scarlett at key points in their lives. To date, there has been no response received.

6.7. Lincolnshire CSP wrote to Scarlett in March 2022, inviting her to be part of the review process. The Independent Chair followed this up with a further letter in January 2023. In July 2023, Scarlett reached out to the Chair via her custody probation officer. Scarlett indicated at this time that she would like input into the review. Although at this stage the report had been completed, the Chair indicated that she would be happy to speak with Scarlett. However, over the next couple of months, despite liaison between the Chair and Scarlett's custody probation officer, a meeting did not go ahead, and Scarlett no longer wished to engage with the process.

6.8. In July 2023, at the point the review process was completed, the Chair contacted Phoebe's Homicide Caseworker to make arrangements for sharing the report with Phoebe. A date was set for a meeting between the caseworker, the Chair, and Phoebe. However, prior to this meeting, the caseworker was informed that Phoebe was unable to engage with the process: the reasons were not shared with the caseworker or the Independent Chair.

6.9. In order to allow time for Phoebe to engage with the DHR process through to completion, the panel paused the final sign off and Home Office submission process – from July 2023 until January 2024. To date, neither the Homicide Caseworker nor Independent Chair have been able to contact Phoebe and have not been able to provide her with the opportunity to see the review through to completion.

7. Contributing Organisations

7.1. The following table details the contributing agencies and the services relevant to the review.

Agency/ Contributor	Services relevant to the review
Surrey County Council Children's Services	Both parties were engaged with the Care Leavers Service (CLS), and if a child has been looked after, the local authority has a duty as a corporate parent to provide for the child until they reach 18. Then they are offered CLS until they reach 25. They were both allocated a personal advisor (PA), who took over as the primary worker.
Surrey Police	During 2019 – 2021, domestic abuse incidents were investigated as follows: Standard risk – Neighbourhood Patrol Team (NPT). Medium and high risk – investigated by Divisional Safeguarding Investigation Units (SIUs).
Surrey Hospital A	Emergency Department
Surrey Hospital B	Emergency Department
Surrey and Borders Partnership NHS Trust	CAMHs – Child and Adolescent Mental Health Services – assess and treat young people with emotional, behavioural, or mental health difficulties. CJLDS – Criminal Justice Liaison and Diversion Service – where medical professionals are situated in custody suites to allow them to assess all detained persons as they are booked in, and if they are referred when concerns are identified.
Surrey District Council A	Assistance with homelessness and housing assistance.
Probation Service (Formerly National Probation Service)	Both parties were actively being managed by Probation during the scope of the review – in Surrey and in Lincolnshire.
Lincolnshire Police	Lincolnshire Police respond and attend domestic abuse incidents. Usually, investigations for domestic abuse will be conducted by CID. PVP may be involved in some cases.
Lincolnshire County Council Children's Health and	Children's Health (0-19 service) delivers the Healthy Child Programme[2] within Lincolnshire.

[2] The Department of Health 2009

Children's Services	Children's Services were working with the family through child protection, Child in Need plans, and care proceedings during the scoping period. This included a "mother and baby" placement, which Zac was also able to join.
Lincolnshire Partnership NHS Trust	Scarlett was referred to the perinatal team on two occasions, although she did not reach the criteria. Zac had contact with the Criminal Justice Liaison and Diversion (CJL&D) service. The aim of the service is to assess people at the earliest point within the criminal justice system to identify any vulnerabilities that may be contributing to offending behaviour. Entry point into the service is when an individual is arrested on suspicion of committing a criminal offence and detained in police custody. He also had contact with Early Intervention in Psychosis (EIP) service – a county-wide, community-based service, delivered through a multidisciplinary team. It aims to reduce distress, maintain independence and integrity of care networks, shorten illness, prevent relapse, promote recovery and social inclusion, and minimise the impact of disabilities. The Community Mental Health Team (CMHT) also supported Zac while he was residing in Lincoln. CMHTs provide recovery-based interventions and support people to live with a mental health condition. The teams include administrative support staff, community psychiatric nurses (CPNs), occupational therapists (OTs), psychiatrists, psychologists, recovery practitioners, social workers, and support workers.
EDAN Lincs	EDAN Lincs is the provider for Lincolnshire Independent Domestic Violence Advisor (IDVA) service. It provides a specialist service for males and females, aged 16 and over, who have been referred into a Multi-Agency Risk Assessment Conference (MARAC). Zac was identified by EDAN Lincs as a victim from the MARAC transfer in from Surrey, and Scarlett was referred to the service on two occasions but had no involvement with them. A county-wide outreach service is also available. This service is not linked to the MARAC and offers emotional and practical support to anyone affected by domestic abuse.
We Are With You	We Are With You is a treatment service for individuals that have substance misuse issues, by provision of psychosocial and pharmacological support. Zac was supported by the service.

United Lincolnshire Hospitals NHS Trust	Scarlett and Zac were involved with the Trust's maternity provision.
Humber Teaching NHS Foundation Trust	Scarlett received health visiting support whilst she was living in the mother and baby placement in Hull.
Lincolnshire Community Health Services (LCHS)	LCHS delivers a range of community health services and also manages two Lincolnshire GP practices, including Practice A (mentioned in this report). Scarlett used this service.
Lincolnshire Tier 2 Council A	Zac received services from Council A in June 2021 for homelessness.
Lincolnshire Tier 2 Council B	Scarlett received services from Council B, predominantly Housing, and there was occasional reference to Zac in her case notes.

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 Zac and/or Scarlett.

8.2. The members of the panel were:

Agency	**Name**	**Job Title**
Lincolnshire Police	Richard Myszczyszyn	Head of Protecting Vulnerable Persons (PVP)
Lincolnshire Police	Sarah Norburn	DA Co-ordinator
Surrey Police	Andrew Pope	Statutory Reviews Lead
Lincolnshire Integrated Care Board	Claire Tozer	Safeguarding Children and Adults Lead Nurse
Surrey Heartlands Integrated Care Board	Helen Milton	Designated Nurse, Safeguarding Adults
Lincolnshire Community Health Service	Gemma Cross	Named Nurse for Safeguarding
United Lincolnshire Hospitals NHS Trust	Elaine Todd	Named Nurse, Safeguarding Children and Young People
Lincolnshire Partnership NHS Foundation Trust	Tony Mansfield	Head of Safeguarding, Public Protection & Mental Capacity

Lincolnshire Tier 2 Council B	Peter Hunn	Community Safety Manager
Lincolnshire County Council, Children's Health and Children's Services	Rachel Freeman	Head of Service – Children in Care and Residential Estates
Lincolnshire County Council, Children's Health	Claire Saggiorato	Safeguarding Lead Nurse, Children's Health
Surrey Children's Services	Jan Smith	South East Targeted Youth Support Service Manager
Ending Domestic Abuse Now Lincs	Jane Keenlyside	MARAC Manager
We Are With You	Lisa Brooks	Operations Manager
Surrey A Borough Council	Matt Gough	Interim Head of Housing, Exchequer, & Development
Probation Service (East Midlands region)	Rachel Crook	Deputy Head, East and West Lincolnshire PDU

8.3. Support to the members of the panel was provided by:

Agency	**Name**	**Job Title**
Legal Services Lincolnshire	Toni Geraghty	Assistant Chief Legal Officer
Lincolnshire County Council	Jade Thursby	DA Business Manager / DHR Co-ordinator
Lincolnshire County Council	Teresa Tennant	Senior Business Support Officer – DHR Admin
Lincolnshire Partnership NHS Foundation Trust	Samantha Harris	Consultant Clinical Psychologist and Professional Lead for Psychology and the Psychological Professions – provided an oversight of the review regarding autism
Lincolnshire County Council	Andrew Morris	Corporate Parenting Manager – provided an oversight of the review regarding care leavers

8.4. Panel members hold senior positions in their organisations and have not had contact or involvement with Zac or Scarlett. The panel met on seven occasions during the DHR.

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. She 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 Adults 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 Advisory 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 Lincolnshire Community Safety Partnership or with agencies involved in this review.

10. Other Reviews/investigations

10.1. In February 2022, Scarlett was found guilty of Zac's manslaughter. The following month, she was sentenced to nine years' imprisonment with a recommendation that she serves at least six years.

10.2. A complaint was under investigation by Lincolnshire Police in relation to the way in which the family's concerns re. risk of harm posed to Zac from Scarlett prior to his death, and other subsequent interactions, were managed.

10.3. This complaint was referred to the Independent Office of Police Conduct (IOPC),[3] who returned the complaint to the force – for the force to deal with 'as it saw fit'.

10.4. The investigation is now completed, with no further action required.

11. Publication

11.1. This overview report will be published on the websites of The Safer Lincolnshire Partnership.

11.2. Family members will be provided with the website addresses and also offered hard copies of the report.

11.3. Further dissemination will include:

- Members of the Safer Lincolnshire Partnership
- Lincolnshire Safeguarding Children Partnership
- Lincolnshire Integrated Care Board
- Lincolnshire Safeguarding Adults Board
- Lincolnshire Police and Crime Commissioner
- Organisations represented on the Review Panel.

12. Background Information

[3] Independent Office for Police Conduct

12.1. When speaking to the Chair, Phoebe explained how Zac had been born premature and only weighed 5lb 1 ounce at birth. She said that he had started off tiny but had grown to 6ft 4 inches as an adult. She said that he was diagnosed with autistic spectrum disorder in 2012, and that he also had oral and physical dyspraxia.[4]

12.2. Zac had grown up in a home where there was violence. His father was abusive towards Phoebe, and, in 2012, his siblings were taken into local authority care. Zac moved into a foster placement one month later. This was his only foster placement, and for four years it was stable and positive.

12.3. Zac was taking prescribed medication, and whilst at school, he had an Education and Health Care Plan (EHCP).[5] He attended specialist schools, and his foster placement had been sourced for his specific needs.

12.4. Zac loved football. His mother told the Chair that he learnt best when he was learning through football. He was very good at computers, but not so good at reading people and situations. He struggled with communication and social situations. After leaving the foster placement, he lived back at the family home for a short time, before being accommodated at a YMCA[6] around the time that he met Scarlett. Whilst living back at home, he had been attacked by some local youths: his mother said that this was due to his autism.

12.5. Zac and Scarlett initially met on social media, as they had mutual friends, and their families are related through marriage. Sometime in December 2018, when they were both living in YMCAs in different parts of Surrey, Zac and Scarlett began a relationship. As detailed in the chronology below, the police were involved with the couple due to third-party reports of violence from the start of their relationship. This is also reflected in what Phoebe told the Chair.

12.6. Phoebe said that Scarlett was quick-witted and was able to manipulate situations to her benefit, whereas Zac struggled to communicate. Phoebe quickly realised that the relationship was not a healthy one. Her view was that Scarlett would speak on behalf of Zac. Furthermore, where he had previously engaged well with his personal advisor (PA),[7] she believed that once in a relationship with Scarlett, he started to miss appointments and calls from his PA. Phoebe told the Chair that, on occasions, the PA would visit Zac, and Scarlett would answer the door and state that he wasn't available. Zac and Scarlett's PAs both confirmed that Scarlett was very good at making herself heard.

12.7. On 11th May 2021, a probation assessment, which was undertaken with Scarlett at the end of her Community Supervision Order, summarised that:

[4] N.B. The autistic community generally prefer to identify as "autistic persons" rather than "person with autism". This report will use these two terms interchangeably, as we do not know what Zac's preference would be.

[5] This is a document that sets out the education, healthcare, and social care needs of a child or young person for whom extra support is needed in school, beyond that which the school can provide.

[6] YMCA England & Wales - We believe in young people

[7] A personal advisor is a focal point to ensure a care leaver is provided with the correct level of support.

“Scarlett is a vulnerable, young woman that has spent a large part of her life in institutions (care and psychiatric hospital settings). She has been diagnosed with an unstable personality disorder as well as other mental health conditions. This diagnosis affects how she thinks, perceives, feels, and relates to others, and is characterised by impulsive, irresponsible, and reckless behaviour. Indeed, her offending indicates poor emotional control and impulsive actions when she is feeling threatened or feeling unsafe. The offences demonstrate Scarlett has difficulties in managing her emotions when her emotions are heightened. She used violence against the victims who would have felt physical pain and been shocked by her behaviour”.

12.8. Phoebe would not allow the couple to stay with her, as they were always “bickering”, and Zac’s two younger siblings had recently returned to her care. The couple would therefore stay with Zac’s brother, George, who is married to Scarlett’s aunt, Louise.

12.9. Phoebe told the Chair that when they argued, Zac would get aggravated and tried to walk away with frustration, but Scarlett would push him for a response. She said that Scarlett would attack Zac first, and he would retaliate in self-defence. She always saw him with bruises, which was corroborated by Zac’s PA.

12.10. Phoebe believed that Scarlett controlled her son. She stated that Scarlett took his money, and that she would manipulate him and lie to isolate him from his family. She said that she saw Zac lose a lot of weight after he moved in with Scarlett.

12.11. The PAs for Zac and Scarlett both stated that the relationship was nuanced and very complex. They felt that the relationship did not fit into a “standard” power and control model of perpetrator and victim.

12.12. Zac’s PA’s view was that when working with Zac 1:1, he engaged with support and was self-led to accessed services over time. However, as he was pulled into a relationship with Scarlett, a chaotic lifestyle ensued, which dominated the last three years of his life.

12.13. Scarlett’s PA gave insights into the relationship, stating that both parties entered the relationship having been affected by childhood trauma. They both lacked emotional regulation, and both had learnt violent behaviours.

12.14. At times, Zac was violent. It was believed that this was either him lashing out in frustration at Scarlett’s manipulative behaviours, or, at other times, that he was violent when trying to stop her from self-harming.

12.15. Their experiences of childhood foster placements were acutely different. Scarlett had been in over 13 placements, including a secure placement, which had all broken down due to her behaviour. Zac’s one foster placement had been stable and lasted for four years, until he was of an age to choose to return home.

12.16. At times, Zac did not give consent and did not want his PA talking to other professionals. This increased when Scarlett became pregnant, as the couple feared

social care involvement with the baby. This created a further barrier in the relationship between Zac and his PA. The PA reflected that she felt that this fear was driven by Scarlett more than Zac, as she had very recently lost the care of her elder child within the child protection system.

12.17. Phoebe told the Chair that her family believed that Zac or Scarlett would die at the hands of the other, but the likelihood was that Scarlett would kill Zac. His maternal grandmother reportedly raised this with the police prior to his death. Phoebe told the Chair that the family didn't feel their concerns were taken seriously. This concern was subject to a separate complaint, which is not within the remit of this review (see section 10).

12.18. Everyone the Chair spoke with, felt that Scarlett was very much in control of the relationship, and that Zac's violent outbursts were the result of frustrations due to his additional needs and Scarlett's behaviours. They also said that the size difference, of over a foot in height, meant that officers responding to calls may have assumed that Zac was always the aggressor, although his mother stated that he was always the one with injuries.

12.19. The PAs confirmed that they had tried to speak to both parties about domestic abuse on many occasions, but this was denied and then led to the couple disengaging with services for a while. Neither party seemed to recognise themselves as a victim, or indeed a perpetrator, of abuse.

12.20. However, Phoebe told the Chair that just before he died, following the separation and bail conditions being in place, Zac had begun to realise that Scarlett was controlling him. He had assured his mother that he no longer wanted to be in a relationship with Scarlett but wanted to stay involved in his son's life.

12.21. In 2019, just after Scarlett became pregnant, the couple moved from Surrey to Lincolnshire. This is where the incident leading to Zac's death occurred. Between 2018 and his death, the couple moved numerous times between the two counties, which obviously had some effect on service provision.

12.22. The push and pull of the two areas appear to stem from different family members. Zac's family lived in Surrey, and Scarlett's family lived in Lincolnshire. When Scarlett argued with her family in Lincolnshire, she took herself back to Surrey. It is understood that she would then reconcile and move back to Lincolnshire.

12.23. The dynamics of the two families are highly complex and marked by a legacy of trauma and dysfunction.

12.24. The family arguments, allegations, and counter-allegations were played out across social media and impacted Scarlett's mental health, as well as causing tensions in the relationship between Scarlett and Zac.

13. Equality and Diversity

13.1. The panel considered Zac's protected characteristics[8] and identified Sex, Disability, and Age as characteristics that may have impacted on how he was responded to by professionals, and/or his experiences of agency practice responses to his needs.

13.2. The response that Zac received from agencies and professionals would have been affected by him being a male. Assumptions may have been made that due to him being a male, and his height of 6ft 4 inches, he was always responsible for the violence. He may have been assumed to be the perpetrator in each situation. When he was identified as the victim, there were a lack of specialist male support services available locally: this led to referrals into generic services that provide domestic abuse support for all genders. There is evidence that when men are referred to generic genderless services, they are less likely to engage because they perceive that the services are only for women.[9]

13.3. A thematic analysis of 22 DHRs where the victim was male, found that professionals and systems were often dismissive of women's abusive acts against men, and men as victims were more likely to be arrested than their female partners.[10]

13.4. Research shows that men who wish to seek help as victims of domestic abuse are faced with barriers specific to their gender. These barriers include challenges to their masculinity, fear that their abuse will be disclosed to others, a lack of confidence in the responses they can expect, and invisibility of services specifically for men. Often, from the initial contact with services, they feel unable to disclose the abuse.[11] Other barriers identified through research include assumptions and expectations of men, which are based upon stereotypes, and services not being developed with the gender-specific needs of male victims at their centre.[12]

13.5. Those who did approach services for support, experienced a lack of helpfulness and felt discredited.[13]

13.6. Zac was living with ADHD and dyspraxia. He was diagnosed with ADHD as an adult, during the scope of this review. His family, and the PA who supported him, stated that his additional needs made it difficult for him to communicate his feelings.

13.7. When Zac was 13, he was diagnosed with autism spectrum disorder (ASD). This is a condition which is related to neurological development that impacts how a person understands and copes with a world where they often feel 'different'. It causes difficulties with social interaction and communication. The condition also includes

[8] The Equality Act 2010
[9] Wright, C. "The Absent Voice of Make Domestic Abuse Victims; The Marginalisation of Men in a System Originally Designed for Woman." *The Plymouth Law and Criminal Justice Review* (2016)
[10] Hope, K. et al. "What we can Learn from DHRs with Male Victims" *Partner Abuse* (2) (4) (2021)
[11] Huntley, A. et al. Help Seeking by Male Victims of Domestic Violence and Abuse: A Systemic Review and Qualitative evidence Synthesis" *BMJ Open* (9) (1) (2019)
[12] Bates, E. "Barriers to Men Seeking Help" *Journal of Interpersonal Violence* (37) (7) (2020)
[13] Taylor, J. et al. "Barriers to Men's Help Seeking for Intimate Partner Violence" *Journal of Interpersonal Violence* (37) (19) (October 2022)

limited and repetitive interests or patterns of behaviour, as well as sensory sensitivities. The word "spectrum" refers to the wide range of symptoms and severity.[14]

13.8. Zac's limitations, as detailed on his EHCP, included speech and language issues with poor pronunciation. He displayed oppositional behaviour at times and could be verbally aggressive towards peers and adults. Zac struggled to concentrate, and if he was not motivated, he would not engage. Zac found it difficult to maintain any sort of relationship. He found it hard to comprehend any change or disruption, and often lacked understanding of risk or danger. His skills are also listed and include communicating effectively in his school environment, having a group of friends at school, and being amicable with a great sense of humour.

13.9. Zac was assessed as having a low average IQ, so was not identified as having a learning disability (significantly low intellectual ability with associated difficulties in everyday living skills). However, his issues with communication may have placed him in a difficult position when dealing with professionals. A lack of communication ability may also have increased his dependency on Scarlett, who is described as very vocal and not being afraid to make herself heard. Communication is not just verbal, and Zac's diagnosed autism and dyspraxia would have made verbal and non-verbal communication difficult for Zac.[15] This may have led to intense frustration and lashing out.[16]

13.10. Zac was also very young. He had been living in a secure and positive foster care placement for four years and had moved back home for a short period. He was then involved in an altercation with his stepfather and could no longer live at home. Although Zac was 18 and therefore technically an adult, because of his various difficulties related to autism, ADHD, and dyspraxia, Zac's developmental abilities may not have been as advanced as his chronological age.

13.11. Children in the care system often face multiple disadvantages in terms of health, education, and future employment, and often present with greater mental health needs than other children. Transition from care is often experienced negatively, with inconsistent care and exacerbation of existing mental illness.[17] Transfers from children to adult services is not always smooth, with different criteria and service levels. For Zac, moving onto adult services meant that he had the option to engage. He was assumed to have capacity and therefore the ability, and right, to refuse to engage with services. When he was with Scarlett, she would refuse care on his behalf, and he was less likely to engage when with her.

13.12. As a care leaver, transitioning from a placement, he was vulnerable and potentially seeking a new stable relationship when he met Scarlett. Research has shown that positive transitioning from care is facilitated by authentic and consistent

[14] What is autism? - NHS (www.nhs.uk)
[15] Speech and Language – Dyspraxia Foundation
[16] Kusmierska, G. "Anger and Autism Spectrum Disorders: A Clinician's Perspective *Autism Spectrum News* (2014)
[17] Butterworth, S. et al. "Transitioning Care Leavers With Mental Health Needs: 'they set you up to fail!'" *Child and Adolescent Mental Health* (2016)

relationships with those who act in the role of the corporate parent. Furthermore, barriers to positive transitions from care include a lack of support for the psychological dimensions of transition, which is further exacerbated by insufficient support networks.[18] In Zac's circumstances, two matters that may have led to a problematic transition from care, are the move back home after care and before moving out to live semi-independently at the YMCA, and then secondly meeting Scarlett, who had a lack of respect for support services and whom professionals have stated only engaged with the services when she felt that she would benefit. Although this review has identified positive and consistent support offered to Zac from the Care Leaver's Service, the family and social networks around Zac were not supportive and sufficient for a positive transition into independent living as an adult.

13.13. Research indicates that leaving care services focus on providing support for practical outcomes such as housing and employment, sometimes to the detriment of support for emotional wellbeing and mental health,[19] and as with Zac, many care leavers reject the support post-care.[20]

13.14. Zac and Scarlett became parents not very long after leaving the care system. Care leavers who are to become parents will have pressure to evidence their parenting ability, despite their experiences of childhood not including positive parenting. They are expected to provide a stable home life and demonstrate independence skills to evidence that the baby is in the best place.[21]

13.15. Zac experienced parental mental illness, substance misuse, and domestic abuse in the home when growing up; and Scarlett was born dependent on illicit drugs, was cared for by others from a very young age, was in foster care by the age of five, and had lost her birth mother when she was in her teens. Between them, they did not have a stable parenting foundation. Phoebe told the Chair that she was upset when Scarlett became pregnant, as she knew how hard it would be for them.

13.16. Both Zac and Scarlett experienced Adverse Childhood Experiences (ACEs) whilst growing up. These experiences include things like physical and emotional abuse, neglect, caregiver mental illness or substance misuse, and household violence. Evidence has shown that the more ACEs a child has, the more likely they will be to suffer from physical health issues, such as heart disease or diabetes, poor mental health, poor academic achievement, or substance misuse later in life.[22]

[18] Atkinson, C. and Hyde, R. "Views About Transition: A Literature Review" *Journal of Children's Services* (14) (1) (2019)
[19] Dixon, J. "Young People Leaving Care: Health, Wellbeing and Outcomes" *Child and Family Social Work* (13) (2) (2018)
[20] Adley, N. and Jupp Kina, V. "Getting Behind the Closed Doors of Care Leavers: Understanding the Role of Emotional Support for the Young Person Leaving Care" *Child and Family Social Work* (22) (1) (2017)
[21] Care leavers | Becoming a parent - NELC | NELC (nelincs.gov.uk)

[22] What Are ACEs? And How Do They Relate to Toxic Stress? (harvard.edu)

13.17. ACEs and poor adult outcomes are heightened in looked after children and care leavers. The outcomes for these children are the same as the general population, described above; however, they occur more often and at an earlier age.[23]

13.18. Zac was a young male care leaver with several ACEs, a lack of positive and stable support networks, with additional needs around autism, ADHD, dyspraxia, and a relatively low IQ – leading to social, communication, and relational difficulties. As he left care, he entered a relationship with a female who he reportedly adored, and who had a history of violence, disengagement with services, self-harm, and a large number of her own ACEs. Zac and Scarlett may have bonded over their trauma. They became dependent upon each other, regardless of the physical and mental danger that they put each other in with their behaviour.

14. Chronology

14.1. The following section is a chronological overview of Zac and Scarlett's extensive and complex involvement with agencies, services, and professionals.

14.2. In January 2012, an Interim Care Order was granted for Zac and his siblings. His brother, George, moved into a residential placement, and his sisters were placed together with a foster carer. There was no available placement for Zac at this time; therefore, he remained at home with his mother and father until February 2012, when a foster placement was identified for Zac. This placement was specialised to support children with the specific behaviours and educational needs, which Zac required. Following the children's moves into local authority care, Zac's parents separated.

14.3. Zac remained with the same foster carers until September 2016, when he chose to return home to live with his mother and her new partner. It is recorded that during the period when Zac lived with the foster carers, his behaviour, management of his additional needs, his speech development, and schooling all improved.

14.4. From age five, Scarlett was subject of a Care Order and lived in numerous foster care and residential placements. More than 13 placements, including a secure placement, broke down due to Scarlett's behaviour, which was physically aggressive and destructive towards property and staff members. Also, between 2014 to 2017, there were approximately 50 recorded incidents of Scarlett self-harming. Throughout 2016 and 2017, Scarlett had numerous episodes of being missing from residential placements.

14.5. In December 2017, Zac was allocated a personal advisor (PA) by the Care Leavers Service in Surrey. He remained living at home with his mother, who was supporting him with his health needs and helping him attend his health appointments. He was not in education because a college place could not be found to accommodate his specific needs; however, he was attending a project with Youth Support Services, three times a week.

[23] Simkiss, D. "The Needs of Looked After Children from an Adverse Childhood Experiences perspective" *Paediatrics and Child Health* (29) (1) (2019)

14.6. In December 2017, Scarlett became pregnant, and there are incidents of violence between her and the baby's father, who was not Zac.

14.7. In February 2018, Phoebe reported to the police that Zac had been attacked by five males near the family home.

14.8. In July 2018, it is recorded that Scarlett was embroiled in an argument with Zac's family. This is reportedly over the plans for the wedding between George and Louise. At this point, Zac and Scarlett were not in a relationship.

14.9. In August 2018, Scarlett gave birth. She was provided with a "family assessment" placement. This is a 12-week supported and supervised placement.[24] Scarlett left this placement in October 2018, without her baby. The baby was made the subject of an Interim Care Order.

14.10. In November 2018, Scarlett was housed at a YMCA in Surrey.

14.11. During November 2018, Phoebe contacted Surrey CSC on two consecutive days to report that Zac could no longer live at her home due to his behaviour. She reported that he had been stealing to pay for cannabis and had smashed up the house. He had also threatened Phoebe's new partner with a hammer, and she raised a concern for her partner if Zac was to return to the house.

14.12. Zac's PA tried to work with him to plan for semi-independent accommodation. Zac stated that he had been attacked first and was retaliating. A warrant for Zac's arrest was issued, and two days later he was arrested for assault. He was seen by the SaBP Criminal Justice Liaison and Diversion Service (CJLDS). He described difficulties due to ASD, and that he required space to calm down when he became agitated. He explained that he struggled to manage his emotions when he was placed under stressful situations. Zac was then rehoused in a YMCA in Surrey, and it is around this time that the relationship between Zac and Scarlett began.

14.13. On 14th December 2018, Surrey Police were called to a verbal altercation at the YMCA where Scarlett was living. Upon attendance, neither reported concerns to the police. The police were called to the YMCA again later that day. Upon arrival, Scarlett stated that they had been "play fighting". The same day, Zac was seen at the local Emergency Department (ED) with a cut to the hand. He reported that he had punched a mirror.

14.14. Two weeks later, further concerns were raised by residents of the YMCA, as loud sounds indicating a physical altercation were coming from Scarlett's room. Later, Scarlett was seen to be bruised; however, she explained that they had been "play fighting". Two days later, Zac and Scarlett were present when a robbery took place in

[24] This is somewhere that can be used when there are worries that a child may not be safe living with their parent after birth. This type of placement is usually part of an interim care plan, during care proceedings.

the local town, and they were both arrested. During the arrest, Scarlett assaulted a police officer, for which she received a suspended prison sentence. Zac admitted being present during the robbery but denied any involvement. He was released due to insufficient evidence of his participation in the crime.

14.15. In January 2019, and following a referral by Zac's PA, a SaBP Children and Adolescent Mental Health Service (CAMHS) CYP assessment was undertaken for their Care Leaver's Service. It was shared that Zac's mother had been taking him to college because she did not feel that he would be able to manage the journey himself. Zac stated during the assessment that he had difficulties managing his anger. He spoke about his three-month relationship with Scarlett, stating that he spent time solely with her. The SaBP CAMHs risk assessment identified Zac as a medium risk to others.

14.16. Two weeks later, the police arrested Zac for assaulting Scarlett. He had been seen on CCTV head-butting Scarlett and putting his hands around her neck. Scarlett "begged" the police not to arrest Zac, claiming that she needed him as her carer, that his autism was the reason for the assault, and that she would take her own life if he was arrested. Scarlett refused to answer DASH[25] questions, and Zac supplied a "no comment" interview. He was bailed with conditions not to contact Scarlett.

14.17. Two weeks later, Scarlett took an overdose of medication and self-harmed. She was taken to hospital, and the next day, Scarlett and Zac were found to be together at a local hotel, which was in breach of his bail conditions. They stated that Scarlett was very low and suicidal, so Zac was caring for her. He was calm and left the hotel when the police told him to do so.

14.18. Zac stopped attending college during February 2019. On 4th February 2019, he sent a text to his PA. The text stated that he and Scarlett were moving to London, that he was an adult, and that the PA would not be able to change his mind. At this point, Zac continued to be subject to bail conditions and was awaiting a court hearing for assault on Scarlett. Despite Scarlett not supporting police action, the CPS agreed an "evidence-led"[26] charge due to the available evidence.

14.19. On 27th March 2019, Zac appeared in court in Surrey for the assault on Phoebe's partner. The hearing was adjourned until April 2019. Zac's PA was there to support him. It was recorded that he looked pale and tired, with scratches on his face that he stated were from their new puppy. Two days later, the police were called because Zac and Scarlett were fighting in the street. Scarlett was located and stated that she was trying to take her own life, and Zac had been stopping her from doing so. No further action for the police.

[25] The Domestic Abuse Stalking and Honour Based Abuse checklist was designed and implemented across all police services from March 2009. The questions provide insight into indicators of risk of harm and are now used widespread across all multi-agency partners.
[26] If the victim of domestic abuse decides not to support a prosecution, police and prosecutors should consider whether it is possible to bring a prosecution without that support. This is called an evidence-led prosecution.

14.20. On 4th April 2019, there was a report of a stolen car, stolen alcohol, and damage to Louise and George's house, where Zac and Scarlett had been staying. Zac had reportedly "flipped" and had kicked a wall. The couple then moved back to Phoebe's house but could not stay there and were placed in temporary bed and breakfast accommodation. It was recorded at this time that both had bruising to their faces, but neither would say what had happened.

14.21. On 5th April 2019, Zac requested a re-referral for SaBP CAMHS Care Leavers. The SaBP CAMHS leaving care service worker attempted to engage with Zac, calling his number and leaving voicemails and text messages.

14.22. On 13th April, the police were called to the temporary accommodation. The caller reported hearing Scarlett shout: "get your hands off my neck". Upon arrival, Zac had a scratch to his face and a reddening eye. Both stated that they had had a verbal argument, which resulted in Scarlett self-harming, and Zac's injury had occurred when he intervened. The police recorded this as a mental health concern, with no-crime. The police were called again to the same address four days later, where Scarlett had again tried to harm herself, and Zac had attempted to intervene. Scarlett was hyperventilating and pulling her hair out, and Zac was verbally aggressive. Eventually, they both calmed down and were left together.

14.23. On 17th April 2019, the SaBP CAMHS leaving care service worker attended the address where the couple were living. Zac came outside and had bruising to his face. He was offered support to sort out his benefits but declined this.

14.24. At this point, Zac's PA was concerned and attempted to reach out to him. She was concerned that Scarlett was writing the texts for him. The next day, the couple's PAs undertook an unannounced visit to drop off food vouchers. Scarlett and Zac were seen, and both were looking unclean with bruising and scratches on their faces. Scarlett spoke for Zac and herself, stating that neither of them wanted mental health input, and that they were fed up with professionals pushing them to engage.

14.25. Zac's PA spoke to Phoebe, and it became clear that Zac had given inconsistent reasons for the bruising. The same day, there was a case discussion due to concerns that Zac was being abused by Scarlett. It was agreed that the PA should speak with Zac alone.

14.26. On 26th April 2019, the SaBP CAMHS worker again tried to call Zac. There was no facility to leave a voicemail on Zac's phone. The SaBP CAMHS worker then liaised with the CSC Leaving Care Service, who stated no mental health concerns had been raised recently.

14.27. On 1st May 2019, Zac's PA made an unannounced visit with the SaBP CAMHS Care Leavers Service worker. Scarlett answered the door and stated that Zac did not want to see them. The PA insisted on seeing him, and they were waiting at the door for around 30 minutes. Scarlett became very angry and aggressive. Zac eventually came out of the property. He had a bruised eye and looked pale. He declined the offer of a meal in town and refused to leave the property to meet with them privately. The

workers provided him with a domestic abuse helpline number, which he said that he did not need nor want. He also stated that he did not want mental health support. He relayed the information about domestic abuse concerns to Scarlett, who became angry and shouted at the workers. They decided it was not in anyone's best interest to continue the meeting and left.

14.28. A week later, Zac's PA spoke with Phoebe, who raised a concern about the relationship with Scarlett. She said that Scarlett had stopped Zac speaking to anyone else, including family. Phoebe had been paying the rent "top up" for the temporary accommodation.

14.29. On 7th May 2019, SaBP CAMHS Care Leavers Service attended the couple's residence with Zac's PA. He declined to engage in conversation and asked to be discharged from SaBP CAMHS. This was actioned. There is no evidence that coercive and controlling behaviours were explored with Zac at this time.

14.30. A professionals' meeting was held on 15th May 2019, between Surrey District Council A Housing and both PAs. Phoebe's concerns about Scarlett controlling Zac were raised, and both PAs shared details of their respective clients' vulnerabilities, including Scarlett's mental health issues, and Zac's learning needs. They shared that Scarlett was controlling, and controlled Zac. They explained that since they had both reached 18, there was no statutory requirement for either party to engage with services. It was considered that supported housing may be more appropriate to support them as a couple. Actions were agreed, including joint welfare benefits claim and consideration of a supported accommodation space for them as a couple.

14.31. On the same day, the police were called to the property due to a disturbance. Scarlett had received confirmation that her son was to be adopted, which led to her hyperventilating and self-harming. Zac had been trying to contact health professionals, without success. Zac had left the scene, Scarlett had calmed, and the police left the scene with no further action. Later that evening, Zac presented at ED with a bite to the nose and stated that he had argued with his girlfriend. No further action was taken. There were no risk assessments completed at this time, and no immediate safeguarding concerns were raised. A SCARF was completed and shared with Surrey ASC.

14.32. On 16th May 2019, Zac attended the court hearing for the incident against Scarlett in January 2019. Phoebe attended with him. He was given a conditional discharge and a fine.

14.33. On 19th May 2019, the police were called to the temporary accommodation. The couple had been coming into the property, and CCTV had recorded Zac grabbing Scarlett by the throat and pushing her against the wall. When a neighbour had tried to call the police, Zac had taken his phone. The police arrested Zac on suspicion of assault. Scarlett self-harmed whilst Zac was being arrested and declined to support police action. However, the CCTV was used in evidence. A Multi Agency Risk

Assessment Conference (MARAC)[27] referral was made, and Scarlett was referred to domestic abuse services. Whilst in custody, Zac was seen by the SaBP CJLDS outreach, who made an ADHD assessment referral for him.

14.34. On 20th May 2019, the YMCA confirmed that they would not accept Scarlett and Zac as a couple, and the landlord of the temporary accommodation stated that Zac would not be allowed to return to the property due to bail conditions. Zac's entitlement to interim accommodation was no longer valid, but the accommodation would be kept open for Scarlett when she returned. At this point, her whereabouts were unknown.

14.35. By 3rd June 2019, Scarlett had not returned to the temporary accommodation, and Zac remained subject to bail conditions, which did not allow him to have contact with her. The temporary accommodation was cancelled. Phoebe was asked to pass this information to him. It is recorded that the couple were staying in London together.

14.36. On 6th June 2019, the police were called to Phoebe's home due to a disturbance involving the couple. Scarlett was having a mental health episode, and Zac was reportedly trying to stop her harming herself. The police classed this bail breach as a "technical breach" caused by Zac attempting to protect Scarlett from self-harming. Scarlett declined to support any further action. A DASH was completed and graded Zac as medium risk, and the couple were both graded as level 2/3 need for SCARF/VAAR.[28]

14.37. On 7th June 2019, there was a hearing for the assault on 19th May 2019. SaBP CJLDS had prepared a vulnerability report. In Zac's absence, his conditional bail was extended, and the hearing was adjourned until 4th July 2019. SaBP CJLDS had also made a referral for an ADHD assessment, and Zac was on the waiting list for this.

14.38. Due to the couple no longer requiring temporary accommodation, the decision was made to bring their homeless application to an end on 14th June 2019.

14.39. A Surrey MARAC meeting was held on 1st July 2019, where the couple were discussed following the incident on 19th May 2019. Following the MARAC, the co-ordinator contacted Housing to ascertain their homeless status. She was updated that their case was closed, and they were not currently accommodated by the local authority.

14.40. There was only one action arising from the Surrey MARAC meeting, which was for a domestic abuse outreach referral to be made for Scarlett as the victim.

[27] A MARAC is a meeting attended by agencies to discuss cases of domestic abuse that professionals consider to be "high risk".

[28] This is a Single Combined Assessment of Risk Form. It considers a series of factors specific to the person and in the circumstances – it covers both children and vulnerable adults. Red = high risk requiring specialist intervention, dealt with in four working hours. Amber = medium risk requiring targeted and timely intervention – dealt with in 24 working hours. Green = standard risk requiring early Help – dealt with in 72 working hours. Blue = non risk, this does not require any local authority intervention or support.

14.41. Zac appeared in court on 6th September 2019 – on two charges of assault occurring on 19th May 2019. He was given an 18-month community order, 20 days community service, and a fine.

14.42. On 11th September 2019, CSC received a SCARF level 2/3 from the police, stating that Zac was "both a victim and a perpetrator" of domestic abuse. A third party had called the police, hearing a scream from a female to "get off my throat". The couple had left the scene. The police caught up with them the following day, and they were both arrested. Zac declined to comment in interview, and Scarlett stated that she had been in hospital for three days following an attempt to take her own life. A risk assessment was completed as high, and MARAC and outreach referrals were made for Scarlett.

14.43. Zac moved back to his mother's house and re-engaged with his PA. He told his PA that he had separated from Scarlett and would require a single person homeless application. During the same period, Scarlett also contacted her PA for support with housing.

14.44. On 24th September 2019, Zac failed to attend his first probation meeting. He had moved to his father's caravan. His PA took him to his homelessness assessment. Due to his unkempt appearance, she bought him new shoes, socks, and some food. She also assisted with setting up a bank account in his name and transferring his welfare benefit payments into his account. Three days later, Housing sent him a letter confirming his eligibility for assistance.

14.45. On 30th September 2019, Zac failed to attend a second probation meeting. He was not contactable by phone.

14.46. On 2nd October 2019, the MARAC meeting was held in Surrey, and Scarlett's case was discussed. It was shared that she was currently wanted by Surrey Police for failing to appear at court for robbery. During this period, Scarlett moved into a supported housing provision, and Zac was bidding on supported accommodation properties as a single applicant. On 4th November 2019, Scarlett was sentenced to an 18-month suspended sentence order for the robbery offences in December 2018.

14.47. On the evening of 14th October 2019, Zac's father assaulted him. The police and ambulance were called, and Zac was treated at the scene for minor abrasions and a cut to the lip. He had also punched a table and had an injury to his hand. No safeguarding referral or alerts were raised. The police gave Zac and Scarlett, who was also at the scene, a lift to the train station, and they went to stay with a friend. His father was not arrested, and it was recorded that there were not any safeguarding considerations. SCARF level 1 was processed. The police completed a DASH risk assessment, but no further action was taken.

14.48. Zac's PA met with him on 16th October 2019. Scarlett was present and spoke for him, stating that they were going to live in Lincolnshire to stay with her family and would present as homeless there. Zac was advised not to do this, but Scarlett told the PA that Zac was unable to stay in Surrey due to "bullying from others". By 18th October

2019, it was recorded that the couple were staying with George and Louise in Lincolnshire. The PA offered to continue to visit Zac.

14.49. On 24th October 2019, Scarlett advised her probation officer that the couple were living with her grandmother in Lincolnshire. On 11th November 2019, Surrey requested Lincolnshire Probation take Scarlett's case over.

14.50. On 4th November 2019, the couple were back in Surrey for Scarlett's court case for burglary. During this time, the housing department in Surrey was still putting bids on properties for Zac in Surrey.

14.51. On 12th November 2019, Scarlett approached the housing department in Town A, Lincolnshire, requesting emergency accommodation. She stated that she was a care leaver, with recent placements breaking down. It is recorded that Zac was not a joint claimant for homelessness and was currently with Phoebe. Scarlett was assessed as eligible for assistance and was given appointments for 18th and 25th November 2019, which she missed.

14.52. On 20th November 2019, Scarlett attended a probation meeting with Louise in Lincolnshire. Referrals were made to assist her with obtaining ID, and she was advised about training opportunities. She further engaged with Probation via a phone appointment on 25th November 2019, and in person at an office appointment on 4th December 2019. The only concern raised was that she was reliant on Louise or her grandmother for lifts to appointments.

14.53. During November 2019, a pre-sentence report was completed for Scarlett. It was recommended that Scarlett would benefit from completing work to address her poor emotional management to social problems – to help her manage her emotions and to communicate without the use of violence. This assessment also considered Scarlett's maturity, her emotional and mental health issues, and her childhood and relationship experiences.

14.54. On 11th December 2019, Zac spoke with his PA and explained that he was back in Surrey following a separation from Scarlett. He was advised that Surrey District Council A Housing Team had a plan in place for him, and he just needed to contact them.

14.55. On 18th December 2019, Scarlett had a phone appointment with Probation. She said that she was travelling back to Surrey to have contact with her son. Later that day, she contacted housing in Lincolnshire and stated that she could no longer stay with Louise. She also stated that supported housing was not suitable, and that she wanted to be housed with her boyfriend, who was sofa-surfing in Surrey but who would join her. She advised that she was now pregnant. Housing advised her that she would be housed as a single person, and this may be a mother and baby unit. Scarlett terminated the call.

14.56. Following this call, she sent a text to her PA, stating that she would take her own life because she had had enough. The PA contacted Lincolnshire Police, who attended Louise's property where she was staying. She was found to be safe. She stated that she was feeling a bit down but was not planning on harming herself. Zac was also at the property.

14.57. Scarlett had a telephone appointment with Lincolnshire Probation on 30th December 2019 and stated that she was now back in Surrey. She reported that she was pregnant, not sure how many weeks, and indicated that she was going to have a termination. Later the same day, Scarlett attended a probation office in a neighbouring county to Surrey. She stated that she could no longer stay in Surrey with Phoebe and gave an address in another neighbouring county. She stated that she was still intending to return to Lincolnshire.

14.58. On 3rd January 2020, Zac was assaulted by Scarlett at the address that she had given Probation in the neighbouring county. When the police arrived, both parties were spoken to separately and both stated that the incident was accidental. Scarlett was arrested on suspicion of assault and admitted throwing an aerosol can at Zac. The case was filed as no further action. Zac was arrested for an outstanding warrant for non-compliance with probation. Both were assessed as 2/3 level of need. A SCARF was processed and shared with adult services, and a DASH was completed – with Zac being found as medium risk.

14.59. On 8th January 2020, during a car journey returning from an appointment regarding a termination, Scarlett became aggressive. Her PA was driving the car, having taken the couple to the appointment. Whilst on the motorway, the couple had an argument, and Scarlett tried to get to the back seat, from the front, to punch Zac. When it was safe to do so, the PA pulled over, and Scarlett got out of the car. The PA tried to speak to Zac alone, offering to help him find a safe place to stay, away from Scarlett. Zac did not accept this help, and they both left the scene. Zac did not have his own phone at this point, so professionals were not able to contact him directly. The PA reported this to the police, a safeguarding strategy meeting was held, and a referral to the Surrey MARAC was made – with Zac as the victim. Zac was not informed of this MARAC referral and was therefore not able to consent to the IDVA referral linked to the MARAC referral.

14.60. Zac's PA visited him the same day, when he confirmed that they had decided to go ahead with the pregnancy. She raised concerns with him about the relationship. He said that they did argue but were getting better, that he tried to punch walls or the bed so he wouldn't hurt Scarlett, and that Scarlett tended to throw things. The PA suggested strategies to manage arguments well and signposted them to relationship counselling.

14.61. When speaking to the Independent Chair of the review, the PAs were able to provide some context around the couple's decision not to go ahead with the planned termination. The termination had been organised because Scarlett knew that CSC would be involved with her pregnancy, and she was certain that she would have the baby removed from her care once it was born. Zac had persuaded her not to go through with

the termination, for them to keep the baby, and to move areas for a fresh start. The journey home from the cancelled appointment may have therefore been emotionally charged with fear for the future.

14.62. The police responded to the report from the PA, completed a DASH at standard risk, and a SCARF at 2/3 level of need.

14.63. Zac attended probation on 10th January 2020 and advised that he would be moving to Lincolnshire with Scarlett on 12th January 2020. Scarlett was 15 weeks pregnant. Zac had a visible bruise to his eye and told his worker that he had fallen. He also informed the worker during this appointment that he and his partner have a "volatile relationship" and that she was on probation for actual bodily harm (ABH). Whilst there is nothing recorded to indicate Zac made a disclosure about being the victim of domestic abuse, it is unclear whether there was any probing into the injury, thereby identifying him as a victim of domestic abuse.

14.64. On 14th January 2020, a strategy meeting for the unborn baby was held by Surrey CSC. Concerns were raised that both Scarlett and Zac posed a risk to the baby due to their behaviour. Lincolnshire CSC was advised that the couple were now in their area, and, on 16th January 2020, they began an assessment for the unborn baby.

14.65. On 21st January 2020, the unborn baby was allocated a social worker to begin working with the family at 20 weeks. It is recorded that Surrey would have considered a removal of the baby at birth; however, there were family members identified in Lincolnshire who may have been a protective factor.

14.66. A transfer MARAC was sent from Surrey to Lincolnshire, and this was a no-consent repeat MARAC.[29] It is noted that Zac had no phone; therefore, it was unknown whether he had been advised of the MARAC referral, and the case was noted as "dual perpetrators". The IDVA service in Lincolnshire, who picked this referral up, attempted to identify other professionals who could assist with engaging Zac in the process, with no success. The IDVA was therefore unable to contact Zac.

14.67. Scarlett had her first contact with midwifery on 22nd January 2020. She stated no current issues with mental health. Zac was present, so they did not undertake domestic abuse routine enquiry with Scarlett.

14.68. Both Zac and Scarlett failed to attend their probation meetings at the end of January 2020. Breach action was initiated for Zac on 3rd February 2020. Scarlett attended on 4th February 2020, with evidence of hospital appointments to show her reason for non-attendance.

14.69. During this period, an alert was added to Zac and Scarlett's probation case files, indicating a MARAC referral – with Zac as the victim, and the perpetrator being Scarlett.

[29] In Surrey, a repeat MARAC is the result of an incident occurring within 12 months of a previous MARAC – the incident itself does not have to reach the MARAC criteria of high risk. However, it is understood that this referral was made to Surrey MARAC due to the risk being assessed as high risk.

The record indicates the case was due to be heard at a Lincolnshire MARAC that week; however, no documents were uploaded onto the case file, and there is no subsequent information that refers to MARAC or any actions on either record resulting from the meeting. This highlights the benefit of a MARAC/domestic abuse single point of contact role within localised probation services, who would gather and share MARAC information regarding those who are involved with probation services.

14.70. The Lincolnshire MARAC meeting was held on 6th February 2020. It was shared that "both parties reported to be perpetrators". The community midwife was tasked with discussing domestic abuse with the couple, and to offer local support; however, she was requested not to speak about the MARAC, as the referral had been made without consent. This action was undertaken as requested. There was an alert recorded for professionals not to undertake lone visits. The case was closed to the IDVA service due to lack of consent.

14.71. On 10th February 2020, the couple met with Lincolnshire CSC for an initial visit. At this meeting, the reason for CSC involvement was discussed, including violence between the couple. On 18th and 24th February 2020, Scarlett failed to attend her probation appointments.

14.72. On 20th February 2020, Scarlett attended the antenatal clinic with Zac for an ultrasound scan. Attempts were made to speak to her alone to undertake routine domestic abuse enquiry, but this was not successful. She was provided with a further appointment on 24th February 2020, but she failed to attend due to lack of transport. She was not contactable by phone; therefore, the community midwife was asked to go to their property to offer a further appointment for 27th February 2020. This is despite the advice from MARAC regarding lone visits.

14.73. On 27th February 2020, Scarlett attended her ultrasound. A bruise was seen on her face, and she was taken aside and asked about it. She reported that it was from a new puppy jumping up and catching her face. This was further explored by the midwife, and Scarlett reported that she felt safe at home. The midwife spoke to the midwifery safeguarding lead, who shared the information with the family's social worker.

14.74. On 2nd March 2020, Scarlett had a phone appointment with Probation. On 4th March 2020, Zac attended his probation appointment. He gave a new address where he and Scarlett were living alone. On 9th March 2020, Scarlett's probation officer attended the property for a meeting. The bruise to her cheek was noted, and she gave the same reason that she had told the midwife, of the dog jumping up. She had a further phone appointment with Probation on 16th March 2020, where it was reported that she sounded flat, and she stated that she was feeling drained.

14.75. On 16th March 2020, a Child in Need meeting was held: this was attended by Scarlett, Zac, Louise, Scarlett's grandmother, the midwife, Family Group Conference[30] co-ordinator, and the social worker. It is recorded that concerns were raised regarding

[30] A Family Group Conference is a planning meeting led by the family and arranged by an independent person. The process ensures that families are at the centre of decision-making.

domestic abuse against one another, and they talked about their behaviours. Scarlett stated that her behaviour was due to her mental health but stated that she was feeling much better. A plan was developed around emotional and practical support for them both, including safety planning. They were advised of the need for legal planning due to the history, and an Initial Child Protection Conference (ICPC)[31] was booked for 2nd April 2020.

14.76. On 19th March 2020, the legal planning meeting was held and the threshold for pre-proceedings[32] was reached. On the same day, Zac appeared in court for breach of his probation order: this was adjourned, and he was given another probation meeting date for 25th March 2020, which he attended.

14.77. On 23rd March 2020, the national COVID-19 restrictions began. This restricted the movement of most members of the public; therefore, most meetings were held virtually for many months.[33]

14.78. On 2nd April 2020, the ICPC was held. This was conducted virtually due to the COVID-19 restrictions. At the meeting, it was shared that Scarlett's previous child had been placed in local authority care due to Scarlett's aggressive behaviour. Visits to the couple were only to be conducted in pairs. It was recorded that the couple both recognised the need to change and were engaging well with agencies. A Family Group Conference was to be convened. The unborn baby, due in June 2020, was made subject to a Child Protection Plan:[34] with a review conference being set for 25th June 2020, and Core Groups[35] to be held (starting on 15th April 2020).

14.79. Throughout April 2020, Scarlett and Zac engaged with probation.

14.80. The Core Group was held on 15th April 2020, and this was virtual. Both parents were assigned Parenting Assessments.[36] No concerns were raised regarding domestic abuse.

14.81. On 20th April 2020, Scarlett had an antenatal phone appointment. She was asked routine domestic abuse questions and denied any issues.

[31] An Initial Child Protection Conference is the meeting where the discussion first takes place, and a decision is made as to whether a child or young person should be placed on a Child Protection Plan. A Review Conference is the term used for subsequent conferences.
[32] The pre-proceedings process is a phase of work aimed at avoiding care proceedings. It clearly sets out for parents what concerns children's services have – makes clear what changes children's services would like the parents to make and identifies/puts in place extra help and services to support the family to achieve these changes.
[33] Coronavirus Act 2020
[34] This sets out what action needs to be taken, by when and by whom, to keep the child safe from harm, and promote their welfare.
[35] This is a meeting of all the relevant practitioners and family members who work together to create, implement, and review the Child Protection Plan.
[36] A parenting assessment is designed to work out what knowledge the parent has about their child's needs and analyses their ability to give the child "good enough" care.

14.82. On 24th April 2020, the pre-proceedings meeting was held. Both parents engaged with the process, and they agreed to assessments and the support offered by professionals.

14.83. Throughout May 2020, the couple both engaged with probation and attended all scans, anti-natal appointments, and meetings with the social worker. It is recorded that the overall feel was positive ahead of the baby being due the following month.

14.84. On 27th May 2020, Zac engaged with a cognitive assessment as part of the care proceedings for Child A. It was found that his IQ was in the low average range, and he showed a degree of challenge to his verbal abilities but not quite in the range of a learning disability diagnosis. His IQ was not at the level that would impair his parenting abilities. The report recommended a few actions for workers to support Zac, such as simple use of language and checking understanding.

14.85. On 1st June 2020, Scarlett was concerned about reduced foetal movements. She was advised to attend the clinic for a review; however, she was unable to secure transport to enable attendance because her family could not assist. Hospital transport was provided in the evening. Zac attended, but he waited outside due to COVID-19-related visiting restrictions. Routine domestic abuse questions were asked, and she reported feeling safe at home. She stated that she was determined to demonstrate that she was putting the baby first. A family member collected her.

14.86. Throughout June 2020, both parties engaged with their probation requirements.

14.87. A Core Group meeting was held on 10th June 2020, where feedback was positive.

14.88. On 18th June 2020, Scarlett attended the antenatal clinic due to reduced foetal movements and possible contractions. Zac was not initially allowed onto the ward due to COVID-19 restrictions: this caused Scarlett distress, and staff allowed him to enter. She was asked routine domestic abuse questions. There is no evidence that Zac was asked any routine enquiry domestic abuse questions. Scarlett was also upset because she was not feeling supported by her family and agreed to update her social worker about this.

14.89. A pre-birth assessment was completed on 23rd June 2020, and the social worker found that both parents had insight into concerns and capacity to meet the baby's needs; however, risks remained around the impact of the birth on the parents' relationship. The outcome recommended Care Proceedings[37] to be issued and a mother and baby placement to be sought. The parents agreed with this plan.

14.90. Two weeks later, Scarlett attended the maternity ward for an elective caesarean. Both Scarlett and Zac declined COVID-19 screening, and Zac stated that this was due to his autism. Routine domestic abuse enquiry was undertaken with

[37] Care Proceedings are court proceedings issued by the children's services department, when they have concerns about the welfare of a child and apply for permission to take action to protect the child.

Scarlett, with no issues disclosed; however, no routine enquiry completed with Zac at any time.

14.91. The baby (Child A) was born the following day. Zac was present throughout and was noted as being attentive to the baby's needs. No concerns were noted regarding Scarlett's care of the baby.

14.92. A mother and baby placement was sourced: to commence on 3rd July 2021 in another county. The social worker accompanied Scarlett and the baby to the placement, allowing Zac to spend some time with them before they left.

14.93. Throughout July 2020, both parties continued to engage with their probation requirements.

14.94. On 7th July 2020, Zac met with the social worker to discuss family time arrangements during the mother and baby placement. He agreed to a referral to We Are With You for support with his cannabis use. On 8th July 2020, it was agreed that Zac could join Scarlett and the baby at the placement after a period of isolation due to COVID-19 restrictions. Scarlett was assessed as doing well in the placement. She had no anxiety or depression symptoms reported and was recorded as being a "natural mother" to Child A.

14.95. On 10th July 2020, following the referral, Zac had a phone appointment with We Are With You. The referral from the social worker had been taken by telephone. It is We Are With You's policy that following a telephone referral, a referral form must be completed; however, on this occasion, this did not happen. The referral form includes a question about MARAC. However, as no referral form had been completed, the service did not have information about the MARAC pertaining to Zac being a victim of abuse.

14.96. During the initial call with Zac, he stated that he had a conviction for assault on his ex-partner and was currently on a probation order. Zac reported the domestic abuse incident had happened in April 2019. No further disclosures were made by Zac, and there was no further information received from the referrer about domestic abuse at this time.

14.97. Zac told We Are With You that he would soon be joining Scarlett in the mother and baby placement, which would have taken him out of their catchment area. However, due to the virtual nature of the meetings, it was agreed that they would keep his case open. Zac engaged well with the service, and he self-reported abstinence from cannabis throughout. Feedback from the placement was that there was no sign of cannabis use throughout.

14.98. The placement proceeded smoothly. On 17th August 2020, a case management hearing was held regarding the Interim Care Order[38] (ICO) application. Lincolnshire CSC decided not to proceed with the ICO, and the placement continued under a s.20.[39]

14.99. On 9th September 2020, the parenting assessment was completed, with feedback from the foster placement stating that Scarlett was fully able to meet Child A's needs. There had been a few minor disagreements between Zac and Scarlett during the placement; however, they reflected on these afterwards. There was no police involvement, and there were no incidents where Child A's safety was compromised.

14.100. The Housing Team at Lincolnshire Tier 2 Council B received Scarlett's probation order on 15th September 2020. This detailed robbery, assault to an emergency worker, and actual bodily harm. There were no references to domestic abuse, but it did indicate previous violent behaviour. Zac's probation order was received by the same team the following day: this detailed the 19th May 2019 assault on Scarlett. There were no current disclosures of domestic abuse recorded on either file. At this time, Scarlett and Zac were being supported by agencies to live together.

14.101. On 8th October 2020, the family moved to their new property in Town C, Lincolnshire, and on 10th October 2020, the s.20 status ended. A Child in Need plan[40] was set to take place. Visits were planned for twice daily for the first two weeks and then gradually reduced to fortnightly visits. A safety plan was completed.

14.102. Health visiting undertook appointments on 12th, 21st October, and 4th November 2020, with no concerns raised.

14.103. On 5th and 9th November 2020, Probation undertook home visits to Zac and Scarlett (respectively) and reported good engagement.

14.104. Zac's sister and boyfriend stayed with the couple for some time in November 2020, and on 16th November 2020, Lincolnshire CSC was contacted by Surrey CSC regarding allegations made by Zac's sister about arguments between the couple and Scarlett holding a bread knife at one point. She also alleged that Zac had bruising during this time; however, the professionals had been visiting during this period and had not identified any issues. Scarlett asked Zac's sister to leave on 17th November 2020, due to the allegations and because of arguing between her and her boyfriend. Scarlett had moved herself and Child A to Louise's house to get away from the arguing.

[38] This is a short-term court order which means that a child becomes looked after in the care system. An Interim Care Order is often made at the start of care proceedings, usually lasting until the court can make a final decision.

[39] Children Act 1989 – under s.20, the local authority has a duty to provide a child with somewhere to live if that child needs it.

[40] This is a plan that sets out what extra help children's services and other agencies – including health and education – will provide for a Child in Need and their family. The plan should be drawn up in partnership with the family and child if possible – after a Child in Need assessment.

14.105. Scarlett and Zac continued to engage with probation requirements throughout November 2020, including one visit to the home where they were both seen. No concerns were raised.

14.106. On 26th November 2020, Zac failed to attend his appointment with Probation. He was called on 30th November 2020 and came to the phone distressed and then hung up. There is no record of the probation officer following this up with the social worker. The same day, Scarlett contacted her probation officer to advise that she was going to Surrey to visit family so would miss her appointment.

14.107. The health visitor provided the family with a food hamper on 14th December 2020. Scarlett had raised that money was an issue due to high electricity bills. The health visitor advised them of the available support.

14.108. On 15th December 2020, the community parenting assessment was completed with a positive outcome: recommending that Child A remain in their parents' care.

14.109. On 22nd December 2020, Scarlett's PA visited the couple at home. It is recorded that they looked bright and healthy, with no visible bruises. They had a dog and a kitten.

14.110. The couple both continued to engage with probation requirements throughout December 2020.

14.111. On 8th January 2021, Scarlett's probation officer reported to the social worker that Scarlett and Zac had not been getting on. Scarlett had told them that she was experiencing low mood. The social worker attended the home. They reported that they had been arguing, and Zac had been caught by the door when Scarlett went to leave the room. There is no record that they were seen alone at this visit. Zac had a visible scratch to his face. Scarlett decided to stay at Louise's overnight to give them both some space. Scarlett reported feeling anxious, and the social worker assisted with obtaining a GP telephone appointment for her the same day, which resulted in a prescription for antidepressants.

14.112. Scarlett spoke to her probation officer (by telephone) on 11th January 2021. She reported that issues had settled down, and, on 14th January 2021, Zac had met with his probation officer and reported finding things hard because both he and Scarlett were tired and arguing.

14.113. On 14th January 2021, the GP and health visitor met to update on the concerns and history of the couple. There were no plans recorded from this meeting. On the same day, a health visitor went to the property and did not identify any concerns.

14.114. On 22nd January 2021, the GP attempted to follow up with Scarlett (via telephone) but did not get through. No further actions were taken.

14.115. On 27th January 2021, Zac's probation officer contacted the social worker to update that Zac had been removed from a programme aimed at managing emotions, as he was finding it difficult to understand. He stated that Zac's involvement was limited and assessed that he was unsuitable for remote programme delivery. He would now be attending the office for 1:1 work, to be completed face to face.

14.116. The social worker visited the couple on 27th January 2021, and both reported that their relationship was in a good place. They were using the safety plan around conflict and were recorded as being in good spirits and relaxed.

14.117. On 2nd February 2021, Zac reported to his probation officer that things at home were much better. The next day, Scarlett reported to her probation officer that they were not getting on well. She was tearful and talked about moving to a different area. There is no record of this being followed up with the social worker.

14.118. On 10th February 2021, the health visitor undertook a home visit and reported that, aside from some nappy rash, Child A was well. On the same day, Scarlett contacted the social worker to advise that Phoebe would be looking after Child A for a few days to give them a break. Scarlett was considering a move for the family back to Surrey, where she felt that she would get more support.

14.119. On 15th February 2021, Scarlett's PA contacted Surrey District Council A Housing to enquire about the couple moving to Surrey. The main reason given to moving was the expensive heating in the Lincolnshire property. An assessment meeting was booked for 1st March 2021, but there is no record of this going ahead.

14.120. On 19th February 2021, Scarlett contacted the GP surgery for consultation about ongoing ear infections. She was reluctant to be seen face to face. Scarlett was not asked about her low mood or antidepressants. The opportunity could have been taken to review her low mood, compliance with medication, or follow-up regarding a self-referral to Steps 2 Change. Many DHRs have found that more proactivity is needed from GPs when following up on previously disclosed issues around mental health.

14.121. On 23rd February 2021, Scarlett advised her probation officer that she was relocating to Surrey because she had cut ties with her family in Lincolnshire.

14.122. On 19th March 2021, Scarlett requested a meeting with Housing in Surrey, and a housing options appointment was booked for 25th March 2021. Lincolnshire CSC provided a travel warrant for the journey to Surrey for this appointment. They stayed with Phoebe.

14.123. On 7th April 2021, Scarlett updated the social worker that they were staying with friends following an altercation with Phoebe. She was also dealing with issues with family in Lincolnshire, who had refused to return her pets.

14.124. On 21st April 2021, the Lincolnshire GP practice discharged their duty because Scarlett stated that she was no longer in the area. The health visitor reminded Scarlett that she would need to register with a GP in Surrey.

14.125. During this time, Surrey Police became involved – following the altercation at Phoebe's home. Scarlett reported that Phoebe was responsible for a bruise to Zac's face, whilst Phoebe reported that Scarlett was responsible. A DASH was completed, which was assessed as standard risk. During this period, there were many allegations being made between the two families, and safe and well checks were made for Child A. On 24th April, Surrey Police found Scarlett and Zac arguing in the street. They left separately, as they were staying in different addresses.

14.126. Later that evening, the Lincolnshire CSC emergency duty team were made aware of an incident between Scarlett and Zac: this had happened in Surrey, where Zac pushed Scarlett and pinned her to the ground with his knees. He then fled with Child A, who was later returned to Scarlett's care. Zac was arrested the next day and bailed to stay away and make no contact with Scarlett. Initially, Scarlett supported the police action; however, she later withdrew support for a prosecution. The DASH was completed and was graded as medium risk, with SCARF level of need for the adults 2/3, and for Child A level 4. A Domestic Violence Protection Notice (DVPN)[41] was not considered following this incident, as it was a verbal argument and there was no use or threat of violence, which is one of the basic criteria for a DVPN.

14.127. A strategy meeting was held in Surrey, and s.47 enquiries[42] commenced. Lincolnshire CSC staff were involved in the discussions and provided updates.

14.128. Whist in custody, Zac was seen by the SaBP CJLDS. Zac self-reported his vulnerabilities as autism, depression, Asperger's,[43] and dyspraxia. He was assessed as a medium risk to others and low risk to self. He was signposted to a project for anger management and given other contacts for mental health support. He was released on bail the following day and moved to his father's caravan. He was allocated a SaBP CJLDS outreach worker.

14.129. There was liaison between Lincolnshire and Surrey to transfer the CSC and health visiting notes between areas. On 2nd May 2021, Surrey CSC visited Scarlett and Child A at the property where they were staying. It was deemed unsafe for her to stay there, due to unrelated child protection issues, and she was encouraged to move to emergency accommodation; however, she declined this. On 4th May, she withdrew support for prosecution of Zac.

14.130. On 5th May 2021, Scarlett accepted a sole tenancy for a property in Surrey, having removed Zac from the housing application. The plans were progressed, including finding her a removal van; however, on the day of the move, she declined to move and refused to answer phone calls made to her. When she was spoken to later that day, she confirmed that she had moved back to Lincolnshire with Child A.

---

[41] Crime and Security Act 2010 s.24-33 A Domestic Violence Protection Notice and subsequent order are aimed at perpetrators who present an ongoing risk of violence to the victim, with the objective of securing a co-ordinated approach across agencies for the protection of victims and the management of perpetrators.
[42] This is a Child Protection Investigation, which is carried out to assess if there is a risk of significant harm to a child.
[43] Asperger's Syndrome is a subset of autism – they are not classed as the same condition, although Asperger's falls under the umbrella term of autism since the introduction of the fifth Diagnostic and Statistical Manual of Mental Disorders in 2013.

14.131. On 19th May 2021, an ICPC was held. This was led by Surrey, as the responsible authority. Lincolnshire CSC attended, and a Child Protection Plan was put into place for Child A and shared with Lincolnshire. The pathway plan covered education, work health, managing emotions and behaviours, friends and family, and life skills for the couple. The plan also recommended family support work around domestic abuse, which probation agreed to complete with Zac. Scarlett had not given consent for Surrey CSC to share information with Lincolnshire CSC; therefore, they were only able to share safeguarding concerns and were unable to pass the pathway plan back to Lincolnshire when she moved back.

14.132. A social worker from Lincolnshire visited Scarlett and Child A on 21st May 2021, with some money for her. She confirmed that she knew Zac was not allowed to visit and confirmed that he had not been in touch. At a further home visit on 24th May, she confirmed that she intended to remain in Lincolnshire.

14.133. On 30th May 2021, whilst still on bail, Zac was arrested at the property in Lincolnshire, following an assault on Scarlett. A referral was made for Scarlett into EDAN Lincs: the local DA service.

14.134. Zac was referred to LPFT CJL&D, and an assessment was completed. Due to a set of circumstances that were largely out of their hands, the clinician who assessed Zac had not had sight of his Niche custody record prior to assessing him. Had they reviewed Niche prior to assessing him, they would have been aware that the incident had occurred in the context of domestic abuse.

14.135. Due to the circumstances, the clinician only had around 10 minutes to assess Zac and did not want to delay his release. The clinician chose to concentrate on the two areas in the referral: mental health and housing. Therefore, they did not touch upon domestic abuse. Zac did not mention being either a victim or a perpetrator of abuse.

14.136. Zac disclosed hearing voices, and self-declared diagnoses of autism, Asperger's, ADHD, and dyspraxia were recorded. A housing referral was made for him. Zac did not answer calls, which were made for a follow-up. If faced with only a short period of time for an assessment, priority should be given to agreeing contact details and arranging a follow-up consultation.

14.137. Following this interaction with Zac, the CJL&D practitioner did not complete a Child Protection Enquiry. When asked, the clinician stated that, at the time, they "did not realise it was a domestic [abuse incident] and just saw it as criminal damage". A CPE could have also been undertaken to triangulate and evidence the clinician's judgement regarding risk to children. In terms of the risk assessment and discussion with the clinician about this, there appears to have been an over-reliance on Zac's self-reporting regarding risk, without considering information from other sources, such as police colleagues, Niche, or Children Services.

14.138. Although Zac did not directly discuss domestic abuse, some of the issues that he had discussed were linked to mental health and housing and were indicators of abuse. For example, that he damaged property instead of hurting Scarlett, and he

stated that he heard voices that told him to harm Scarlett. His experience of hearing voices was later assessed as not being linked to psychosis. Within the contexts of these disclosures from Zac, the clinician stated that Zac was "timid and shy" and that he "adored his son". It was noted that he wanted to have contact with his son and wanted to be a good father because he never had that positive role model in his own childhood.

14.139. This rationale shows limited insight into the nuances of domestic abuse, particularly in relation to coercive and controlling behaviour. Within this context, property damage can be a threatening and intimidating behaviour that can make a victim fearful about what harm could potentially be inflicted on them directly. Therefore, more professional curiosity could have been demonstrated in exploring with Zac how he thought this behaviour might be perceived by Scarlett and Child A, and what impact it could have on them. This could have segued into a discussion about the Make a Change programme.[44]

14.140. On 31st May 2021, a Duty to Refer[45] was received by Council B Housing Team for Zac, and support for his homelessness was progressed during June and July 2021.

14.141. Zac attended the probation office on 2nd June 2021, with visible injuries to his eye, and he also showed the probation practitioner some recent self-inflicted injuries on his arms. Zac did not make a disclosure that the injury was inflicted by Scarlett but did report to be "upset for hurting Scarlett again". There is no evidence that Zac was signposted to domestic abuse support services following this incident or that there were further questions into the circumstances of receiving the injury to his eye. It seems the focus had been on his recent arrest as the perpetrator.

14.142. On 8th June 2021, the LPFT CJL&D interface referral was sent to Early Intervention in Psychosis (EIP) – to determine whether Zac's presentation was early onset psychosis or linked to his ongoing complexities. On 10th June 2021, it was confirmed that EIP was not suitable for Zac's needs. He confirmed that the decline in his mental health was due to "relationship issues". There was no further exploration of this by the EIP team, who recommended that an outpatient assessment should be completed for the CMHT.

14.143. As Zac was not eligible for a service from EIP, the CPN referred him on to Community Mental Health Team (CMHT) for assessment. However, it was noted in the EIP screening tool that he was currently out of the Lincolnshire area. A CMHT administrator contacted him to ascertain where he was living. Zac advised that he was still living in Surrey with his father but did intend to return to Lincolnshire so that he could have contact with his son. He was advised to seek a temporary registration with a GP in Surrey to get support and to request that his GP refer him back to LPFT's CMHT once he returned to Lincolnshire. He was then discharged from CMHT prior to assessment.

[44] Funding ended for this programme in March 2023 Lincolnshire — Make a Change
[45] Homelessness Reduction Act 2017 – a Duty to Refer is where a local authority has a duty to refer someone as homeless to a local authority of their choice. This is relevant to people leaving certain institutions and is relevant to Scarlett and Zac, as they were care leavers.

14.144. Zac's bail conditions were received by his housing officer on 10th June 2021. These detailed that Zac had been bailed until 29th June 2021, with conditions not to contact Scarlett nor attend his previous address.

14.145. A transfer in Child Protection Conference was held in Lincolnshire on 16th June 2021. The previous health visitor in Lincolnshire was reassigned to the family for continuity. Both parties were invited. Scarlett attended but Zac did not. The Chair attempted to call him directly after the meeting to update on the plans, but he did not answer. However, the social worker was able to update him on the outcomes of the meeting a few days later.

14.146. Case responsibility was transferred back to Lincolnshire. A Family Group Conference was planned, as was a meeting to organise safe contact. Consideration was also to be given to referring Scarlett for support from Safe Families and the Early Help Services: this was in progress at the time of the fatal incident. An appointment was made with the Lighthouse Project;[46] however, Scarlett did not attend this. A referral was made to EDAN Lincs for Scarlett; however, they were unable to contact her.

14.147. On 17th June 2021, Scarlett was referred to a perinatal mental health team and was also advised that she could self-refer into Steps2Change counselling. She was advised to attend her GP for a medication review.

14.148. On 18th June 2021, Scarlett called Tier 2 Council B's Housing Team because she had been advised by the police to leave her property, as she was under threat of violence from Zac. Scarlett stated that she had somewhere to stay for the night, that a DASH had been completed by Lincolnshire Police, that she was waiting for a call back from EDAN Lincs, and that she was being supported by her social worker. Scarlett was advised about the sanctuary scheme and was identified as priority need for housing services due to the domestic abuse and her young child.

14.149. The social worker visited Scarlett at Louise's house on 18th June 2021. She was very emotional and stated that it was "all too much". She scored high on tests, indicating concerns about depression and anxiety. A further visit was conducted to Scarlett on 21st June 2021, where she disclosed that upsetting messages had been sent between the families.

14.150. On 21st June 2021, the perinatal mental health team contacted Lincolnshire CSC to confirm that Scarlett did not meet the criteria for their service. It was raised at this point that Scarlett didn't have a Lincolnshire GP. With the support of the social worker, she registered with a Lincolnshire GP on 28th June 2021.

14.151. During the initial telephone consultation with the new GP, Scarlett disclosed a detailed history of domestic abuse and mental health issues. Scarlett was asked about any intentions of suicide, which she denied. There was no documentation to support any further exploration of domestic abuse, but a face-to-face appointment was offered for assessment. There is no evidence that a referral or alert to CSC was considered at this time.

[46] Home - The Lighthouse Project Spalding

14.152. The planned face-to-face appointment did not take place. The IMR author asked the GP if they had intended addressing domestic abuse at this face-to-face meeting. They advised that the purpose of the appointment was to address Scarlett's low mood and medication. She advised that the face-to-face appointment may have resulted in further exploration of Scarlett's disclosure of domestic abuse.

14.153. It is unclear where Zac was living during this time, and LPFT CMHT were unable to provide support because he was not registered with a GP in Lincolnshire. He confirmed that he was travelling between the two counties to see Child A and was advised by the LPFT CMHT to get a temporary GP in Surrey in order to have support whilst he was staying there. On 2nd July 2021, he approached Lincolnshire Council as homeless. On 5th July 2021, he advised his probation officer that he was in London, alone, with nowhere to stay. At this point, Scarlett was back at their previous property and had indicated that she would like a restraining order against him.

14.154. On the same day, Zac's probation officer raised a concern with the Core Group that, as Zac had nowhere to stay in Lincolnshire, he may request to stay with Scarlett. However, Scarlett stated that he would not be allowed in the property. The same day, a call was made to Lincolnshire housing department by Zac's sister, stating that he had nowhere to live.

14.155. Two days later, the social worker made a referral to EDAN Lincs for Scarlett, and she was encouraged to engage with the service.

14.156. The same day, Zac's sister spoke with the housing officer allocated to Zac and explained that he struggled to make and receive telephone calls. This was a barrier that staff were previously unaware of.

14.157. Scarlett spoke again to her GP: during a second telephone consultation. She again referenced being a victim of non-recent domestic abuse; however, this was not explored by the GP. Also again, CSC was not alerted to the issue of domestic abuse. This is poor practice, as Child A may have been at risk. This was further compounded by the fact that the GP had not yet seen Scarlett face to face.

14.158. A week later, probation had a phone appointment with Zac, who stated that he was in Brixton. However, when the probation officer spoke to Phoebe, she confirmed that he was in Lincolnshire and was staying with Louise and George because he wanted to be near Child A to visit.

14.159. Two days later, Scarlett stabbed Zac during an incident. Zac died at the scene. She was arrested for murder. She was found guilty of manslaughter and, in March 2022, was sentenced to nine years in prison.

15. Overview

15.1. Both Zac and Scarlett carried the impact of numerous ACEs into their adult lives. Their learnt behaviours, traumatic experiences, and trauma responses may have bonded them in a way that made it difficult for either to recognise how destructive their relationship was to themselves and each other.

15.2. Some of the professionals involved with the couple felt that Zac's behaviour was due to him attempting to stop Scarlett from harming herself, which led to her being harmed, and, just as often, Zac also being harmed. Scarlett became very distressed when Zac was being arrested, stating that he was her carer, and she couldn't cope without him. Similarly, Zac had made it clear to his PA that he adored Scarlett and wanted to make a life, and have a child, with her.

15.3. Both had been looked after children, and, prior to their relationship, the shared element of their childhoods was their local authority placements; however, these differed significantly. Zac had one positive and stable placement for the four years that he was in the care of the local authority, whilst Scarlett had around 13 placements, including residential homes.

15.4. As evidenced in the chronological overview above, throughout their relationship, Zac and Scarlett moved a significant number of times. This created an overriding sense of chaos and elicited a reactive response from professionals. This, in turn, created a challenge for each county's services, as often they would stay in various locations for brief periods of time, which hampered services' ability to effectively offer support.

15.5. Not at any point were the couple in a place of stability or permanency within Surrey. The impact of this was that professionals were often "chasing" Zac and Scarlett, as opposed to working with them.

15.6. The time the couple spent at the mother and baby placement, and then in Lincolnshire after the birth of Child A, was the couple's most stable period in their relationship and placement.

15.7. An overarching view from professionals is that they wanted the couple to succeed. The chronological overview evidences the level of support that they were offered from various agencies across both counties.

15.8. However, from the information analysed, agencies did not have a specialist response available to them when dealing with the couple, who appeared to be mutually violent to one another. The language used by some agencies and professionals is that of each party being either the perpetrator or the victim at different times.

15.9. Section 17 (below) will discuss how the concept of "typologies" can assist with understanding that the power and control dynamics of domestic abuse does not allow for these changeable roles, but that there are other "types" of intimate partner violence, which each need a specialist response of their own to reduce risk of harm to one or both parties.

15.10. An alternative view would be that Scarlett exerted power and control throughout, in the form of manipulative behaviours that she knew would illicit a reaction from Zac. Again, this will be discussed in section 17 to support a better understanding of the nuances and complexities of intimate partner violence in all its guises.

16. Analysis

16.1. Surrey Children's Services

16.1.1. At the time of Zac and Scarlett commencing their relationship, both were 18, at which point there is a transition in service provision. There are no longer any formal meetings for the young person in which to pull together agencies to co-ordinate their pathway plans. Access to support, services, and meetings with their PA are based on consent.

16.1.2. A key theme identified in the Surrey CSC report was the factor of age and consent. Zac would, at times, say to his PA that he did not want support, and although the PA thought that he was being influenced by Scarlett, she was limited as to how she could respond.

16.1.3. What is evident from this review, is that practitioners did all they could to maintain a positive relationship with Scarlett, and this may have meant, at times, treading on eggshells around her, and a reluctance to challenge her because of a fear that the relationship may break down. Her PA often encouraged her and praised small achievements to build Scarlett's confidence and self-esteem.

16.1.4. There was evidence of Zac's PA working hard to foster a relationship with him. It was clear that the PA was advocating, supporting, and trying to empower him, where he would allow her to. It is positive that from the age of 18, Zac had a consistent PA who understood his needs well and was tenacious in maintaining contact. The PA was able to have conversations with Zac about her worries for him being a victim of abuse from Scarlett, and also supportively challenging him when needed. It was positive to see that when he returned to Surrey in June 2021, he reached back out to the PA and Care Leaving Service for support. This indicates that he knew that he would be supported by the service if he needed it.

16.1.5. It is recognised that there are challenges, both internally and systemically, when both partners are viewed by professionals as being both victim and perpetrator of domestic abuse. There is a lack of understanding of how to intervene and address this complex aspect of intimate relationship violence, and once identified, there is no mechanisms or resources to address and support couples' experiences of this. Understandably, services are focused on responding where there is a clear victim and perpetrator. However, there is a lack of clarity in how to respond to couples where violence occurs both ways. This is further exacerbated where there is a lack of understanding within the relationship of unhealthy dynamics, and where parties are avoidant of being seen separately.

16.1.6. One area where Zac's PA could have addressed the relationship dynamics with him was around the couple's argument that when incidents had occurred, he had been trying to stop Scarlett from harming herself. It appears that he would do this by strangling her or holding her around the neck. Practical advice could have been given to him regarding the dangers of this, which includes a risk of death and invisible neurological

injuries.[47] It has also been found that non-fatal strangulation can increase aggression in the person being strangled.[48] The risks linked to non-fatal strangulation are so high that the Domestic Abuse Act 2021 made this a specific criminal act.[49] Raising this with him, and discussing better ways to stop Scarlett harming herself, would have been an example of a suitable intervention for situational couple violence.

16.1.7. Zac's PA stated that professionals were always "one step behind" Zac and Scarlett. This often led to reactive support being implemented; therefore, stability was not fostered within Surrey. A trauma-informed practice approach would enable an understanding of Scarlett's fight or flight response to professionals, especially following the local authority involvement with her elder son.

16.1.8. A trauma-informed approach could have also assisted organisations to help heal and build relationships with professionals. Surrey CSC's motivational interviewing approach would also support this practice, and the PA reflected whether, had this practice been utilised at the time, Zac may have responded differently to professionals.

16.1.9. Scarlett had a long history of violence towards professionals who were seeking to support her. Much of the work that was undertaken by Surrey CSC was reacting to emergency placement moves and the next crisis. They were unable to provide the therapeutic support that Scarlett needed to start working through her past trauma.

16.1.10. Although beyond the scope of a DHR, Surrey needs to be able to provide placement stability for all its young people. There was a marked difference between Zac and Scarlett's foster placement history, and it could be argued that had Zac not met Scarlett, he would have continued to engage with Surrey Care Leavers Service.

16.1.11. If a young person has experienced significant trauma that is impacting on their ability to maintain placements, they should be assigned a SaBP CAMHS professional that will stay with them throughout all placements – to ensure consistency of support and a high degree of trauma-informed therapeutic intervention.

16.1.12. Surrey CSC also recognised that there were some challenges when working at a distance from Lincolnshire and understanding the different ways of working across the borders. This is particularly pertinent in this case, where consent was refused by Scarlett and Zac for Surrey to attend the CP conferences.

16.2. Surrey Police

16.2.1. As detailed in the chronological overview, there is an extensive history of police involvement with the couple, due to domestic incidents involving Zac and Scarlett. The

[47] The horrifying harms of choking - new research — We Can't Consent To This (wecantconsenttothis.uk)
[48] Bichard, H. et al. "The Neurological Outcomes of Non-Fatal Strangulation in Domestic and Sexual Violence: A Systemic Review" *Neurological Rehabilitation: An International Journal* (May 2020) pp.1164-1192
[49] Serious Crime Act 2015 s.75A and s.75B

majority of these incidents were third-party reports, presenting indicators of domestic abuse rather than disclosures from the parties themselves.

16.2.2. When responding to reported incidents, the police were in an invidious position, in that several of the assaults upon Scarlett by Zac were because of Scarlett threatening or attempting self-harm, which necessitated Zac to intervene, resulting in a disturbance and often injuries to both parties. The circumstances presented to Surrey Police were also exacerbated when Zac was arrested, as Scarlett's reaction would be extremely emotional. Conversely, Scarlett would often justify Zac's behaviour by telling the police that it was his autism and ADHD that had sparked a reaction.

16.2.3. There was a reluctance on both sides to support any judicial proceedings; however, the police did proceed with led prosecutions authorised by the Crown Prosecution Service (CPS).

16.2.4. The police responses, actions, and outcomes – including the varied notifications to partner agencies through the SCARF submissions – were timely, sensitive where possible, and conformed to policy and procedure.

16.2.5. The incidents detailed in the chronology are clear in identifying when Scarlett was the 'perpetrator,' Zac the 'victim', and vice versa. The complication for police officers responding to an incident was that in many cases, Zac would receive a relatively minor injury whilst intervening and attempting to stop Scarlett self-harming. When the parties were separated to enable the police to take their respective accounts, their explanations tallied – whether these had been 'agreed' between them before police arrival or were a genuine version of events.

16.2.6. Therefore, any injury was, in most cases, sustained 'accidentally,' and with Zac's reluctance to disclose that he had been assaulted or to make a statement supporting a potential prosecution, the result was consistently no further action (NFA). On these occasions, evidence-led prosecutions were not a viable option because even where there was some corroborative evidence from a third party, Scarlett's actions invariably resulted in a 'mental health episode' outcome being recorded.

16.2.7. The learning for policing is in striving to understand the complexities of dealing with victims and perpetrators with mental health issues involved in volatile situations. There is a continuous cycle of learning for Surrey Police through reviews such as this, in order to enhance training, raise awareness, and ensure individuals have the skills at their disposal in order to minimise the risk to parties involved in abusive relationships.

16.3. Surrey Hospital A

16.3.1. Zac attended Surrey Hospital A's Emergency Department on four occasions during the scoping period. There were no disclosures of domestic abuse on any of these attendances; however, Zac was also not asked about domestic abuse on any of these occasions.

16.3.2. Hospital A had a domestic abuse policy and safeguarding adult policy in place when Zac attended in 2018. Surrey Hospital A followed the policies and procedures in place at the time of Zac's attendance; however, these policies have since been updated. For example, it was not clear from Zac's hospital notes whether staff had asked what had led him to punch the mirror when he attended in December 2018. This line of questioning would now be expected, with a further expectation to record this on the case notes.

16.3.3. Although not in place at the time, the hospital now has access to an Independent Domestic Abuse Advisor (IDVA) who can see patients that have consented to a referral. The hospital's safeguarding team participates in MARACs and refer into MARACs.

16.3.4. The "looked after child" alert is removed from the NHS Spine[50] when a person reaches 18. Therefore, the information about Zac being a care leaver would not have been available to the ED team. The panel discussed a recommendation for this to be reviewed; however, once a patient reaches 18, they would be required to "opt in" to this information being recorded, and this is beyond the scope of this review. Learning from this review will be shared with the Home Office and NHS England to raise this matter at a national level. (Recommendation twenty-three).

16.3.5. Patients presenting in ED with an overdose should have a "challenging behaviours" risk assessment completed. This was not completed in Zac's case. Although this may have been due to the inconsistency of his story, it is not clear from the notes whether the change in story was considered.

16.4. Surrey Hospital B

16.4.1. Zac was taken into the ED by the police following an incident in May 2019, reportedly with a bite to his nose. It was felt by staff in attendance that the police were able to provide the required immediate support to the victim, considering the possible crime having been committed. Domestic abuse is everyone's business, and hospital staff must not rely on the police and other agencies to complete DASH and refer to MARAC. Whilst the police obviously do risk assess victims of domestic abuse, staff in other roles may encourage more openness from a victim, and, once it becomes known that hospital staff will ask questions about domestic abuse, a victim may expect to be asked while alone in a medical consultation and use that opportunity to disclose the abuse.

16.4.2. Routine enquiry about domestic abuse is included on admission and assessment paperwork. However, further enquiry by medical staff regarding this injury may have elicited a disclosure. Medical staff are in a good position to engage a patient in a conversation about domestic abuse, and in Zac's case, it was known that the injury had been from an assault by his partner.

16.4.3. This was a missed opportunity. Learning from this review will be shared with Hospital B staff to encourage professional curiosity in circumstances such as these, and

[50] This is the digital central point, allowing key NHS inline services and allowing the exchange of information across local and national NHS systems.

a recommendation has been made for Surrey Hospital B to review their policies on completion of DASH risk assessments. (Recommendation three).

16.5. Surrey and Borders Partnership NHS Foundation Trust

16.5.1. Prior to the s75 agreement,[51] which ended in November 2019, both the Community Mental Health Recovery Service (CMHRS)[52] and I-access[53] were integrated health and social care teams. Therefore, any safeguarding concerns should have been discussed with ASC staff within the teams and/or the ASC safeguarding advisors and managers that covered the CMHRS and I-access at the time. They would have then decided if further enquiries were required under Care Act 2014 s42.[54] There is no evidence that any discussion took place, and it appears that staff did not consider Zac as a potential 'adult at risk' with care and support needs, despite being in contact with SaBP services.

16.5.2. It also appears that Zac's anger and housing issues were considered the primary issues, which had an impact on how the domestic abuse and other potential risks of abuse were perceived. Had adult safeguarding procedures been followed, this would have encompassed all the issues and risks to Zac under the safeguarding framework and co-ordinated multi-agency working.

16.5.3. Since the s75 agreement, all teams now report safeguarding concerns to MASH,[55] in line with all other Trust services. In addition, domestic abuse forms a significant part of SaBP safeguarding adults training. In more recent years, risk assessment training has been provided on an ad hoc basis, in partnership with domestic abuse outreach services. MARAC and DASH are discussed as part of safeguarding training, as well as coercion and control.

16.5.4. There were missed opportunities to speak to Zac and Scarlett individually about domestic abuse, particularly when workers saw the bruises and did not believe the explanation that was provided. Staff noted that they appeared to have a "volatile relationship" but did not attempt to speak to Zac or Scarlett separately. All people supported by SaBP services should be seen without their partners wherever possible.

---

[51] Section 75 relates to the NHS Act 2006, which allows the NHS and local authorities to jointly fund and commission health and social care services. This allows a local authority to commission health services and NHS commissioners to commission social care. It enables joint commissioning and integrated services.
[52] Our Community Mental Health Recovery Services are secondary mental health teams who provide assessments for evidence-based, time-limited treatment and psychological interventions for adults with severe and enduring mental health issues. The focus of their whole service is promoting recovery and independence and developing self-management strategies to encourage people to achieve their potential in the community.
[53] i-access drug and alcohol service supports people in Surrey who: want to reduce their Drinking; want help with problematic drug use; are highly dependent on alcohol; and want to stop drinking.
[54] This is a legal duty to make enquiries about safeguarding concerns. These duties apply to an adult who has needs for care and support – whether or not the local authority is meeting any of those needs.
[55] A Multi-Agency Safeguarding Hub – is a multi-agency team that identified risks to vulnerable adults and children.

16.5.5. As a result of this review, an audit of safeguarding adult enquiries – in relation to domestic abuse – should be carried out, across directorates, with a specific focus on "routine enquiry".

16.6. Surrey District Council A – Housing

16.6.1. Both Scarlett and Zac were provided with extensive support and advice by the Housing Team. The team worked closely with the couple's PAs, and with Zac's wider family when engagement with the couple proved difficult. The Housing Team ensured that information was shared and reported to both the police and the Care Leavers team.

16.6.2. Surrey District Council A Housing Team identified the couple's status as care leavers at an early stage of the involvement, and the level of engagement with the couple that followed was good practice.

16.6.3. As highlighted previously, there was close collaboration between Housing and the Leaving Care Team, information was shared in a timely manner, and regular contract was maintained at times when the situation was changing constantly.

16.6.4. There were a few instances where there could have been justification to bring an end to the council's housing duty, but the Housing Team continued to support and assist both parties.

16.6.5. The case has highlighted the need to ensure effective domestic abuse training is available for all.

16.6.6. There is also a need for robust and effective relationships to be maintained with local authority and community services who are providing support and assistance to people approaching the Housing Team for support. Proactive communication and partnership working should be encouraged at all times.

16.6.7. There were obvious challenges in the behaviour of both Scarlett and Zac when they were engaging with the Housing Team. This was particularly evident when there were concerns being raised about them living together. Consideration had to be given to their wish to continue to live together, whilst also acknowledging the wider concerns that this may have caused. It is essential that staff are provided with the information and resources to make these judgements but are also able to raise these concerns with the appropriate agencies, with a view to developing tailored support, specific to each circumstance.

16.7. Probation Service

16.7.1. It should be noted that there have been significant changes in practice within the Probation Service since the period under review. As outlined above, at the time of the period under review, the Probation Service was divided into two separate parts: with Community Rehabilitation Companies (CRCs) being responsible for the delivery of rehabilitative services to offenders who pose a low or medium risk of serious harm. Both

Zac and Scarlett would have been in this group, until June 2021, when the Probation Service took over responsibility for the management of all offenders. Policies and practices have now been merged and aligned. Since the period of the review, all staff within the unified service have completed mandatory training in domestic abuse and safeguarding.

16.7.2. A new countersigning framework has also been launched, requiring additional management oversight and countersigning of OASys assessments that have been completed in cases where there is domestic abuse and safeguarding identified.

16.7.3. Regardless of where the couple were living, the Probation Service was a constant throughout the period of this review. There is clear evidence of Probation's involvement in Core Group and Child Protection Conferences, with reports being prepared and submitted when required. In addition, there is clear evidence of information sharing with Surrey and Lincolnshire CSC by probation officers in terms of updating their whereabouts, changes of address, disclosures of difficulties in the relationship, and significant events.

16.7.4. An area of learning for Probation were the assumptions made, specifically in connection with gender and domestic abuse. Despite information being recorded that both Zac and Scarlett were violent against one another, the responses to incidents and presenting issues predominantly focused on Zac as a perpetrator of domestic abuse, and Scarlett as a victim. This assumption could be due to bias that is not discouraged by the current training, guidance, and assessment tools.

16.7.5. Zac was offered specific interventions to address his identified risk-related needs, and there is evidence that these were tailored to meet his learning needs. There is no indication that services were inaccessible for Zac. However, there is no evidence that Zac was supported or encouraged to access domestic abuse services as a victim.

16.7.6. Training and practice development sessions need to be introduced, to remind staff that domestic abuse can be perpetrated by any gender within any relationship. This will assist in removing any barriers to accessing services and for practitioners to consider referrals to domestic abuse services for male and female victims.

16.7.7. There are no explicit Probation Service processes in place to respond to situations where both parties are violent and/or abusive. Policy, however, refers to domestic abuse in its entirety and the potential for this to be committed by individuals regardless of their gender, along with expectations about the response and practice where there is evidence of domestic abuse. Consideration should be given to the application and interpretation of this policy where both parties within a relationship are violent towards one another.

16.7.8. It is crucial to have an investigative approach when people on probation present with injuries, or report "relationship difficulties", especially where there is a history of domestic abuse. There were two occasions where Zac attended appointments with visible injuries. On one occasion, his explanation of banging into a door was accepted, on the other, there is no evidence of exploration of the injury. At no time was Scarlett

considered by probation officers to possibly be a perpetrator of domestic abuse. The gender-based assumptions about victim and perpetrator appear to have reduced the curiosity of the staff.

16.7.9. As per HMPPS domestic abuse policy at the time, it is expected that all staff, in line with their role and responsibilities, are proactive in looking for indicators of domestic abuse, exercising professional curiosity, and maintaining an investigative approach.

16.7.10. In addition, the supervision and management of Scarlett became focused on her pregnancy and the child protection processes surrounding this, which could also have deflected from exploration of her behaviours within the relationship.

16.7.11. An OASys assessment should be reviewed upon a significant change in circumstances or evidence of change in risk levels. In the case of Scarlett, there is no evidence that the OASys assessment was reviewed following all significant changes in circumstances, for example, after the birth of Child A or moving from the mother and baby unit: both of which would constitute a significant change in circumstances.

16.7.12. As has been cited in other areas of this review, situational couple violence must also be considered as a relationship dynamic that requires a specific response. The Probation Service is potentially in a unique position, such as with Zac and Scarlett, in that each party had a separate probation officer. These practitioners could communicate and triangulate the information provided by each party to determine where power and control may lie. For example, in the case of domestic abuse and coercive control, or whether a couple may be mutually violent. A response to this would be different to a response to domestic abuse where one partner is controlled, isolated, undermined, and diminished by the other.

16.7.13. Given the identification of domestic abuse within her relationships, it would have been useful to include provision in Scarlett's sentence plan to assist her to understand her violent behaviour within intimate relationships and to learn skills to avoid any future incidents. At the time, however, there was no approved or accredited intervention for women as perpetrators of domestic abuse. This is currently in development.

16.7.14. A Spousal Assault Risk Assessment (SARA) was completed on Zac in July and August 2021. A SARA is a structured professional approach to risk assessment that bridges the gap between unstructured clinical judgment and actuarial approaches. Adequate reliability and validity for judgments concerning violence risk with adult male offenders has been established; however, there is further research required in relation to adult female offenders.

16.7.15. It is noted that, despite the indicators that Scarlett was the perpetrator of domestic abuse towards Zac, there was no SARA completed for her case until after the incident where she stabbed Zac, resulting in the DHR being commissioned. It is likely, however, that as the SARA tool has been developed and researched for adult male offenders, it is not routinely used for female perpetrators, and as such, any findings may not be as accurate. Policy states that a SARA assessment should be completed in all cases where there is evidence of domestic abuse; however, it is acknowledged that there

is insufficient research to evidence that it is an accurate tool to assess the risks posed by women. Further research linked to trauma-informed practice with women is ongoing within HMPPS.

16.7.16. Within the records for both Zac and Scarlett, there is evidence of regular cross-border work and information sharing when the individuals moved between Surrey and Lincolnshire. This included the following: information sharing with probation services in each area; requests for intelligence checks from the police in both Lincolnshire and Surrey; regular contact with allocated social workers for Child A; and Zac and Scarlett's PAs updating addresses, causes for concern, and changes in circumstances.

16.7.17. There is no evidence of ongoing liaison between the probation officers allocated to Zac and Scarlett. There is evidence of one conversation. However, during the few months prior to Zac's death, both were describing their relationship with their respective probation officers, and some sharing of this may have allowed for a more informed intervention with one or both. Discussions may have been informal and not recorded on their case files; however, this would raise the issue of accurate record keeping – either scenario raises lessons to be learnt when engaging with couples who are both known to be violent towards one another. (Recommendation nine)

16.7.18. People on probation who have a history of being in care, poor attachments, and who may have consequently become institutionalised, can often have an ambivalent relationship with services. At the point that other services begin to withdraw support due to perceived progress, it should not automatically follow that probation services should reduce their levels of contact. Consideration must be given to the impact of withdrawal of other services on the dynamic risk factors that may be present.

16.7.19. The Probation Service should also consider their approach to MARACs: as a unified service, they are in a strong position to introduce a unified response to information sharing with, and from, MARAC. A single point of contact role, within each geographical location, would reduce ambiguity about MARAC attendances, allocation of MARAC actions for Probation, and how/where to store information generated from MARAC.

16.8. Lincolnshire Police

16.8.1. Lincolnshire Police were first aware of Scarlett and Zac in early 2020, when Surrey MARAC informed them that they were both moving to Lincolnshire and that Scarlett was pregnant. Lincolnshire Police were involved in multi-agency meetings and discussions about the couple. Requests from partner agencies about their offending history were dealt with promptly.

16.8.2. Through the scoping period, Lincolnshire Police were only informed about two other domestic issues: one was from Surrey that involved Phoebe, which happened during a short period when the couple were staying with her; and the other incident was an assault on Scarlett by Zac on 30th May 2021, which led to Zac being arrested and subsequently bailed with conditions not to contact Scarlett.

16.8.3. Lincolnshire Police's Domestic Violence and Abuse Policy has been in place since September 2013 and is accessible to all officers. It is a comprehensive policy that contains detailed procedures for dealing with concerns about domestic violence, including procedures for risk assessments. One of the policy's principal aims is to adopt a proactive multi-agency approach in preventing and reducing domestic abuse.

16.8.4. The force introduced an action plan covering DVPNs and the DVDS in 2019/20, which focused on delivering this training to those operational officers who had not received it during their service. It is accepted that there are gaps in front-line officers' knowledge of DVPNs and DVPOs, and, since February 2022, Lincolnshire Police have instigated further DA Matters training to all front-line staff, where the use of DVPNs is being covered. This training is ongoing.[56] The learning of DVPNs has also been covered in other DHRs within Lincolnshire.

16.9. Lincolnshire County Council Children's Health and Children's Services

16.9.1. Lincolnshire CSC became aware of domestic abuse within the couple's relationship, upon transfer into Lincolnshire in January 2020. The case was subsequently allocated to a social worker, and a child and family assessment commenced. Further information regarding domestic abuse in the couple's relationship was shared by a representative of the social work team at the Lincolnshire MARAC in February 2020. Domestic abuse was included within the Child and Family Progress plan and was the significant reason for Child A being subject to multi-agency safeguarding processes.

16.9.2. Due to the MARAC, the health visitor was also aware of the violence within the relationship; however, there were no direct disclosures of abuse from either Scarlett or Zac to the health visitor. In line with children's health policies and procedures, Scarlett and Zac were asked about abuse; however, they both denied any incidents, aside from those that had been reported by the allocated social worker. Despite this, it would have been good practice for the health visitor to discuss services and alternative options for support.

16.9.3. The Domestic Abuse Act 2021 introduced the expectation for children to be responded to as victims of domestic abuse, in their own right. It is explicit in the actions of both Lincolnshire and Surrey CSC that they recognised the risk of harm from domestic abuse to Child A from pregnancy onwards, and that both local authorities acted upon this identified risk throughout their involvement with the family.

16.9.4. It is recognised that a period of stability was achieved for Zac and Scarlett when they moved to Lincolnshire, and their baby was born. They thrived when they were supported and contained in a foster placement, where they both had the structure, guidance, nurture, and boundaries in place to contain and meet their respective needs.

[56] For police: Domestic Abuse Matters | Safelives

16.9.5. The ability to secure a parent and child foster placement for two parents with a history of aggression and domestic abuse, especially during the COVID-19 restrictions, was an outstanding achievement.

16.9.6. There is evidence of excellent multi-agency communication and working, including cross-border working to ensure that information and risks were shared, and that safety planning was consistent between Lincolnshire and Surrey.

16.9.7. The foster carers did an exceptional job of supporting Scarlett and Zac. This support extended beyond the conclusion of the placement and offered Scarlett a period of stability that she may not have previously experienced.

16.9.8. Consideration should be given to developing safeguarding and domestic abuse policies, to include situations where it is difficult to identify the victim and the perpetrator. Furthermore, the DASH could be used more widely as a tool to inform assessments and safety planning. Where situational couple violence is evident, it is best practice for incidents to be discussed with both parties to enable there to be a thorough analysis of risk. This approach should be thoroughly risk assessed by domestic abuse specialists before both parties are brought together to discuss.

16.9.9. Scarlett and Zac faced additional challenges due to the complexity of their relationships with family members, who are all intrinsically linked with one another and appear to include attempts to manipulate, coerce, and control them, both individually and as a couple. When Scarlett and Zac returned to Surrey following an argument with Scarlett's family, the case was appropriately transferred to Surrey CSC and subsequently back into Lincolnshire when Scarlett returned shortly afterwards. Cross-border communication was excellent.

16.9.10. Both Surrey and Lincolnshire CSC, including children's health, were responsive to the needs of the family when they were in each area, regardless of who held case responsibility at the time. There is evidence that plans were shared to ensure continuity of support between the two areas. Visits were undertaken on behalf of Surrey when the family were in Lincolnshire and vice versa. Appropriate referrals were made back to services in Lincolnshire following the transfer-in Child Protection Conference in June 2021.

16.10. Lincolnshire Partnership NHS Foundation Trust

16.10.1. The CJL&D clinician's rationale for not completing a CPE – following their discussion with Zac in May 2021 – was problematic. The CJL&D identified Zac as a dedicated father and did not identify the incident as domestic abuse. Zac may have been keen to maintain a positive relationship with his son, and it may have been unclear to professionals who was doing what to whom within Zac's relationship with Scarlett; however, the offence that Zac was in custody for would have affected the baby.

16.10.2. Children who are living in a home where there is violence are directly affected by this behaviour.[57] The incident of criminal damage should have been recognised within the context of the family circumstances, with a Child Protection Enquiry being submitted to allow triangulation of information and a more accurate risk assessment. This would have also updated CSC of the mental health and housing plan in place for Zac.

16.10.3. There is some similar learning within this review to that which was identified within another local statutory, which relates to joint working between the police and CJL&D service. This is particularly important when trying to identify lead responsibility for certain safeguarding processes when the police are initially the key agency for responding and managing the concern that has often led to the arrest. The reviews have highlighted the difficulties in ensuring consistent yet proportionate responses to concerns that CJL&D staff may become aware of. It has also highlighted some gaps in knowledge of certain tools that can assist with progressing safeguarding processes, such as the use of the CPE and LPFT process for victims of domestic abuse who are not immediately accessible. (Recommendation twelve).

16.10.4. A positive aspect of practice, which was identified in this review, is the assertive approach taken by the CJL&D service when trying to engage with Zac when he was released from custody, where they attempted to contact him on eight separate occasions prior to making the decision to discharge him fully from the service. Given the nature of the client group that CJL&D work within the criminal justice system, service users will often be faced with several unmet needs and have difficulty engaging with support consistently. CJL&D clearly understands this and has formulated their post-release processes accordingly – to support people into services, to meet those needs, and reduce the risk of reoffending.

16.10.5. There was also evidence of good interagency working between CJL&D and Lincolnshire Tier 2 Council A. CJL&D made a housing referral to Lincolnshire Tier 2 Council A on 31st May 2021, due to Zac stating that he was homeless and had been sofa surfing between Scarlett's and his brother's homes. Following Zac's release from custody, both CJL&D and a housing officer from Lincolnshire Tier 2 Council A struggled to make contact with Zac by phone. However, they liaised regularly, and a reciprocal agreement was established whereby if one service did successfully speak with Zac, they would share information from the other service and ask Zac to contact them directly.

16.10.6. The review has also highlighted that assessments cannot be effectively completed at the point when people are due for release. This is a recommendation from this review, which will be addressed by the team manager for the CJL&D service, in conjunction with the relevant police custody inspectors to agree a process where staff can either arrange a follow-up telephone assessment or access an alternative part of the police station to complete an assessment. (Recommendation thirteen).

16.10.7. There were two occasions identified during the scoping period where discharge letters were not sent to GPs, in line with standard protocols. This issue has already been addressed by CJL&D because of learning from another Lincolnshire review, whereby

[57] Domestic Abuse Act 2021

the team manager is now conducting monthly random audits to provide assurance around a collection of core standards, with liaison with GPs being one of these standards. As a result of this DHR, the team manager has now rolled out the requirement for GP discharge letters to include all cases, whether conducted by clinicians or practitioners, whereas prior to this review, this was a requirement following clinical assessments only.

16.10.8. Expectations regarding LPFT's engagement with child protection processes are highlighted in the Trust's initial and refresher safeguarding children training. The CPN from EIP, who screened Zac, contacted the social worker to inform them that they were unable to attend the forthcoming child protection meeting on 16th June 2021. They left a message to state that Zac had not yet been accepted for further assessment within EIP. Expected practice is for staff to provide a written report and attend Child Protection Conferences; however, due to the short notice of this conference, the CPN was not able to attend. A minimum expectation is for the allocated social worker to be directly contacted and informed of LPFT's involvement, assessment, and plan. The CPN in this case confirmed that they had attempted to contact the allocated social worker.

16.10.9. Although Scarlett was not eligible for perinatal services within the scoping period of this review, it is worth noting an upcoming change in the perinatal qualifying criteria. This change was not because of this review. Scarlett's second referral to the perinatal service was declined due to the time in the postnatal year, which was 11.5 months post-partum, and there being no evidence of acute mental illness. The perinatal team manager has highlighted that although this would not have impacted on the decision-making for Scarlett, the cut-off for the perinatal service is being extended from 12 months to 24 months postnatally. This has been outlined in the NHS Long Term Plan and will benefit 24,000 women per year nationally by 2023/2024. Although Lincolnshire has been selected as an early implementor of the NHS Long Term Plan, the roll-out date for this change in qualifying criteria has not yet been confirmed. The perinatal team has recently recruited to ensure that they can meet this increased demand.

16.10.10. Although neither referral made for Scarlett to perinatal service was appropriate, the perinatal team did include signposting information to EDAN Lincs in the second decline letter. This letter was sent directly to Scarlett, copying in the referrer and Scarlett's registered GP in Surrey. Adapting the decline letter to incorporate signposting information for domestic abuse support is an appropriate and proportionate response for service users who will not be receiving ongoing support from LPFT.

16.10.11. The LPFT safeguarding team has produced a one-page Domestic Abuse Flow Chart that summarises its domestic abuse process in an accessible format. This should be visible and readily available in all clinical and patient-facing services for ease of reference.

16.10.12. None of the LPFT services were aware of Zac and/or Scarlett's leaving care status. This did not affect any of the services offered or provided. However, this review has identified that LPFT currently does not have a care leaver alert option on the clinical systems. This is identified as an area of learning. The Trust would benefit from a leaving

care alert being added to clinical systems, and this change will be made as a result of this review.

16.11. EDAN Lincs

16.11.1. EDAN Lincs did not have any involvement with either party; however, it followed best practice and its own policies to attempt contact on each occasion.

16.11.2. The review raises the issue of MARAC referrals without consent, the limits these place on the IDVA service's ability to offer specialist support, and the awareness that agencies referring into MARAC have about these limitations.

16.12. We Are With You

16.12.1. For the reasons described in the chronology above, the service was not aware that Zac had been subject of MARAC as a victim. We Are With You is invited to all Lincolnshire MARAC meetings, and it will attend in respect of service users identified on the agenda; however, at the point of referral in the service, the MARAC had already passed.

16.12.2. We Are With You was not invited to any of the multi-agency meetings, such as the Child Protection Conference or the Core Groups. It was unaware of the involvement of CSC, or any of the current issues of domestic abuse, and therefore did not request involvement with the meetings or provide information for the meetings.

16.12.3. Another area of learning for We Are With You is around supporting care leavers. During the telephone referral, the social worker had mentioned that Zac had been in care. This was the only mention of his care leaver status, which was not followed up during subsequent conversations with Zac. We Are With You does have mandatory training around working with a trauma-informed approach and training around ACEs; therefore, staff should be aware of leaving care services. Learning from this review will be shared with staff regarding leaving care services and the role of the PAs.

16.12.4. This review has highlighted the need for referrals to be submitted using the formal referral forms, which should be completed in full. Staff should be made aware of this requirement and empowered to refuse referrals that are submitted by telephone or on incomplete referral forms.

16.12.5. The service continued to support Zac, even though he was residing in a foster placement outside of the service's geographical reach. This was during the period of COVID-19 restrictions where we were unable to meet face to face. If these restrictions had not been in place at the time, best practice would have been to transfer Zac's treatment to the local service where he was residing. This would have supported face-to-face appointments and the opportunity to complete drug screening.

16.12.6. Zac continued to receive fortnightly appointments until the end of his engagement with We Are With You. This was effective practice because, once a client has reached abstinence, the frequency of appointments may be reduced, or they may

be referred on to its partner agency Double Impact,[58] who offer relapse prevention groups. Due to Zac being out of area and having ongoing social care involvement, appointments remained at this frequency to support his abstinence during the transition from foster placement, back into the community.

16.12.7. When taking a referral over the phone, this must always be followed up by a completed referral form from the referrer. This is to make sure that the relevant and correct information is shared about the client's circumstances, allowing appropriate risk assessments to be carried out and ensuring the service's proactive multi-agency involvement throughout the period of the treatment.

16.12.8. We Are With You has recently introduced specific Criminal Justice Recovery Workers; therefore, service users involved in offending behaviour, such as domestic abuse, are now allocated to these workers, who then work closely with Probation and other relevant agencies. This allows for more robust information sharing and close working approach. This was not in place at the time of Zac's period of treatment.

16.13. United Lincolnshire Hospitals Trust

16.13.1. ULHT safeguarding team deliver training to all clinical staff in relation to the recognition and management of domestic abuse disclosures and concerns. Locally recognised resources are available within the ULHT's Domestic Abuse Policy and via the Trust's intranet. In addition to the support available via the safeguarding team, ULHT has access to hospital IDVAs who provide training and support to staff members when required.

16.13.2. Compliance with ULHT-specific and local domestic abuse process is regularly audited by the safeguarding midwifery team. This is particularly in relation to compliance with routine enquiry. Concerns around identified non-compliance are escalated via divisional and Trust-wide safeguarding meetings.

16.13.3. Since 2021, all clinical staff have been required to complete training in relation to supporting patients with learning disabilities (LD) and autism. The Trust has access to LD Acute Liaison Nurses, who are employed by LPFT. They provide advice and support to staff in relation to managing patients with additional learning needs. In December 2021, ULHT's safeguarding team also recruited a Specialist Nurse for Safeguarding and LD, with the aim of supporting development and implementation of the wider LD agenda. Work is ongoing via internal communications, operational meetings, Champions meetings, safeguarding newsletters, and visibility visits in relation to raising the profile of these teams to ensure staff are aware of the support that they can offer when supporting the need for reasonable adjustments.

[58] Double Impact - Recovery from Addiction

16.13.4. Since the introduction of Maternity Medway,[59] the routine enquiry for domestic abuse is prompted within various workflows on the Maternity Medway system, at booking and at numerous intervals throughout the antenatal and postnatal periods. ULHT records suggest that Zac was present with Scarlett during several of her pre-COVID-19 hospital attendances, which hindered clinicians' ability to speak with Scarlett alone. The community midwife confirmed that she regularly discussed domestic abuse with Zac and Scarlett, as well as with Scarlett when she was alone; however, during this time, no abuse was disclosed.

16.13.5. Although information was shared at the February 2020 Lincolnshire MARAC that Scarlett was identified as a perpetrator of abuse towards Zac, there is no documented evidence to suggest that hospital midwives ever took the opportunity to ask Zac whether there were any concerns regarding abuse that he may have been experiencing from Scarlett.

16.13.6. It is not currently expected practice to undertake routine enquiry with the partners of women accessing hospital and community midwifery care; however, as it had already been identified that Zac was a victim of domestic abuse, it would not have been unreasonable to expect that an ongoing assessment of his risk of harm would have been considered by all midwifery staff involved with the couple.

16.13.7. Communications will be circulated within midwifery services – via mandatory domestic abuse training, regular newsletter, and safeguarding operational meetings – to reinforce the need for routine enquiries, in relation to domestic abuse, to be undertaken with the partners of pregnant women, where it is known that the pregnant woman is a perpetrator of domestic abuse. (Recommendation sixteen).

16.13.8. The review has evidenced attempts made by the hospital and community midwife to support Scarlett's concerns regarding her transport issues. Discretion was also utilised to support Zac's attendance with Scarlett during her foetal monitoring, thereby relieving Scarlett's anxieties, despite COVID-19 restrictions.

16.13.9. Staff were sensitive to Scarlett's needs in relation to her anxiety. On one occasion, when attending due to reduced foetal movements, Scarlett was visibly upset about having to attend alone. Staff members were sensitive to the situation and permitted Zac to be present in the room with Scarlett, despite COVID-19 restrictions being in place.

16.13.10. Scarlett and Zac's care leaver status was considered by the community midwife in terms of safety for, and impact on, the unborn baby. Alongside additional information received in relation to their complex social history, their care leaver status resulted in a safeguarding referral being made for the unborn baby. The referral was submitted earlier than the usual 20 weeks' gestation threshold to enable Lincolnshire CSC an opportunity to gather all relevant information from Surrey and other agencies,

[59] Maternity Medway is the electronic/digital patient record used to document Maternity involvement with pregnant women. In ULHT, it works alongside the hand-held record that is kept by the women throughout their pregnancy (and then filed in the ladies' paper records once delivered). It stores information re. any appointments attended, investigations undertaken, and discussions held with the pregnant women.

thereby expediting appropriate risk assessments and safety planning prior to baby's delivery.

16.13.11. There was evidence to confirm that Scarlett was engaged in all necessary discussions relating to her maternity care and that she had capacity to make decisions. There is no evidence to suggest her decision-making was coerced by Zac. However, as above, there is no evidence that consideration was given as to whether Zac may be controlled or coerced by Scarlett.

16.13.12. Following the birth of Child A – and CSC securing a foster placement for Zac, Scarlett, and the baby – information was shared with maternity services in County C, where the placement was located. This is in line with ULHT maternity guidelines. Information was also relayed back to ULHT maternity services from County C.

16.14. Lincolnshire Community Health Services

16.14.1. During the GP telephone consultations with Scarlett in June and July 2021, the GP identified that Scarlett was recorded as having recently separated from Zac. Despite discussions regarding non-recent domestic abuse, no safeguarding referrals were made for Child A, as the GP assumed the risk was negated due to the recent separation. In this decision-making, the GP showed no knowledge of the level of potential risk following separation of relationships where domestic abuse has been a factor. There was no professional curiosity employed by the GP as to whether the ex-partner in question was the father of Scarlett's child and whether there was ongoing abuse or harassment.

16.14.2. LCHS has current safeguarding policies that provide guidance and actions required to respond to indicators or disclosures of domestic abuse. Domestic abuse is included within the LCHS Safeguarding Induction and annual safeguarding mandatory training. The GP's interview reported to be aware of the LCHS policies; however, they did not follow LCHS adult safeguarding policies and did not seek advice or supervision regarding this patient.

16.14.3. It is important to note that all three GPs who were interviewed for the review, are employed by Practice A GP practice and not employed by LCHS; however, they do provide care for LCHS patients. All GPs advised that they were up to date with their mandatory safeguarding training. LCHS Learning and Development Team were able to confirm that two of the GPs were compliant with their required safeguarding training. The remaining GP was due to undertake their safeguarding update training.

16.14.4. With regards to safeguarding supervision, all three GPs advised that they have access to, and have regular conversation with, a Deputy Named Nurse for Safeguarding, who is employed by LCHS, and that they have a weekly clinical meeting that provides the opportunity for any safeguarding concerns to be discussed with the safeguarding lead for the practice.

16.14.5. The advanced practitioner in the Urgent Care Centre demonstrated good practice to follow up with the paediatrician in relation to the history of domestic abuse

and safeguarding issues. However, she did not adhere to LCHS discharge guidance by contacting the GP or health visitor to ensure the follow-up actions were completed. LCHS safeguarding team have completed further updates with Urgent Care teams regarding the importance of discharge follow-up communications, where children have safeguarding history.

16.14.6. Whilst there is evidence of identification of risk factors, including mental health and domestic abuse, by GP practice staff, there is no evidence of professional curiosity or use of expected risk assessments used to establish any current risks to Scarlett or Child A. This led to missed opportunities to identify and escalate potential domestic abuse risks present in the family unit.

16.14.7. The LCHS safeguarding team provides an advice hub for contacts from any LCHS staff members who have experienced concerns from a contact with a patient where their aggressive behaviour may be linked to possible domestic abuse and potential harm to others.

16.14.8. There is no evidence that the GP reviewed Scarlett's practice notes, which would have highlighted a long history of disengagement with health service. All staff are expected to review patient history where risk factors have been identified or if there is a safeguarding flag within the patient record. It is expected practice to complete relevant risk assessments to inform any future decision-making.

16.14.9. All staff are required to record the names and relationships of any persons who attend with a patient. This is covered within mandatory safeguarding training and safeguarding supervision that is offered to LCHS Urgent Treatment settings and GP practices.

16.14.10. All staff are expected to record any safeguarding conversations within the patient's record, which provides a reference for both practitioner and other health professionals that may be involved with that patient care. Expected standards of record keeping are covered within LCHS mandatory safeguarding training and is also included in all LCHS safeguarding policies.

16.14.11. If children with a safeguarding history attend LCHS Urgent Treatment Centres or out-of-hours settings, upon their discharge, contact should be made with their health visitor or GP, as part of LCHS Discharge Guidance.

16.15. Lincolnshire Tier 2 Council A and Tier 2 Council B

16.15.1. The local council services provided to both Zac and Scarlett were predominantly housing related. Services were provided mainly over the phone or through correspondence by email. Face-to-face appointments were available at the time if needed, but these were not suited to the circumstances.

16.15.2. This review has highlighted opportunities for professional curiosity to be used by council staff, to understand the detail behind comments or language. For example,

when a phrase such as “family troubles” is used. This is an issue that has previously been identified in local statutory reviews, which led to ongoing training for housing teams.

16.15.3. This review has also highlighted that information regarding an individual or household may be held within an organisation but not always on the same system. Having wider access to information could allow for additional risk assessment. In this case, both individuals were known to, or were receiving services from, neighbouring councils, and consideration could have been given to additional appropriate information sharing. This should also be considered with neighbouring authorities.

16.15.4. From the information held by the councils, it was not clear at the time that both parties were violent towards each other. Guidance on how to better identify that there may be violence from both parties, and how to address this whilst providing services, would be useful.

16.15.5. There was no record on either Council A or Council B’s notes that Zac was a victim of domestic abuse. However, there had been a MARAC in Lincolnshire where Zac was the victim. There was no attendance at MARAC or any actions for either Council A or Council B. There was no indication that flags were put on the system for future contact.

16.15.6. Consideration is needed for appropriate system flagging for individuals who have been referred to MARAC, and when there is no prior agency involvement to contribute and no action following the case meeting.

16.15.7. Each of the Lincolnshire Tier 2 Councils have recently created and appointed a new role of Domestic Abuse Officer (DAO). The DAO for each council will attend every MARAC meeting, and this officer will then link into all council departments to ensure all relevant council information is shared and that MARAC tasks are completed/ feedback is given.

16.15.8. Zac and Scarlett’s care leaver status was noted in the case files, and support was given to help them secure accommodation when the mother and baby placement was completed.

16.15.9. There was relevant cross-area information sharing and collaborative working between Surrey CSC, Lincolnshire CSC, Surrey District Council A Housing Team, and Lincolnshire Tier 2 Council B Housing Team.

16.16. Multi-Agency Risk Assessment Conferences (MARACs)

16.16.1. It is not known what discussions took place at either of the MARAC meetings held in Surrey because no minutes were taken. Furthermore, the only reference document available is the final composite version of the referral form, which contains the background information and the written updates provided by contributing agencies for all referrals. There is also a separate Action Log. There was only one action recorded: this related to the police contacting Housing to locate Scarlett.

16.16.2. Failing to record minutes on key discussions meant that there was no record of what topics were discussed and what rationale there might have been for raising or, of equal importance, not raising actions. Hence, it follows that key issues could have been discussed at considerable length prior to arriving on a decision; however, no record would exist, except for an action being raised, or no action being raised.

16.16.3. This gap left the Surrey MARAC vulnerable because the process was not sufficiently robust to withstand scrutiny, external or otherwise. This Domestic Homicide Review is a prime example of how the absence of key minutes has left the MARAC process unable to provide answers to relevant questions. It is not known what was discussed by attendees.

16.16.4. The matter regarding the lack of minutes being recorded at all Surrey MARACs has now been resolved. From April 2022, minutes at Surrey MARACs have been taken by a member of Surrey Council staff.

16.16.5. In Surrey, the statutory agency MARAC leads, and the current Chair, are striving to improve on the efficiency and effectiveness of the MARAC, and new practices are being introduced.

16.16.6. A Practitioners Group and Steering Group has been established in Surrey and is scheduled to meet quarterly to oversee and lead on process change and improvement.

16.16.7. The MARAC process was originally designed by SafeLives[60] to gather decision-making safeguarding leads, from statutory and voluntary sector services, to discuss high risk cases, thereby providing a forum to share specialist knowledge. Unfortunately, as has been seen in DHRs nationally, the process does not always work as intended. Zac and Scarlett were interchangeably referred to the MARACs as victims and/or perpetrators. The MARAC would have been the ideal mechanism to raise questions about the nature of the relationship, to make plans to adjust the response to the couple, and potentially raise the question of more suitable services. However, the most recent MARAC was a transfer in from Surrey to Lincolnshire, without the consent of the victim, and did not appear to elicit any robust actions.

16.16.8. Phoebe questioned why the Domestic Violence Disclosure Scheme (DVDS)[61] had not been considered – to inform Zac of Scarlett's violent past. She felt that if Zac had known about Scarlett's behaviour towards professionals, foster carers, and other people, he may not have stayed within the relationship. It could be argued that with the right information brought to the transfer in Lincolnshire MARAC, a DVDS may have been considered.

16.16.9. The DVDS is considered in all cases at both Surrey and Lincolnshire MARACs. However, when Zac was heard as the victim at Lincolnshire MARAC, this was as a transfer in from Surrey; therefore, agencies at the MARAC did not have Scarlett's historic information to make an informed decision about disclosure. Also, as a non-consent referral, Zac could not be contacted following the MARAC.

[60] Home | Safelives
[61] Domestic Violence Disclosure Scheme factsheet - GOV.UK (www.gov.uk)

16.16.10. It may also be the case that a decision was made not to share information about Scarlett's history with Zac, as most of the information held by the police was from her childhood. However, had there been information available regarding violence against her baby's father, ex-partners, and/or staff at the YMCA (as detailed in the chronology), this could have been shared with Zac to illustrate the risk that she posed.

16.16.11. It is also accepted that Zac may not have acted on this information. However, this review does highlight learning and makes recommendations regarding effective use of the MARAC forum, which in this case would include inviting professionals/services who had a good knowledge of the victim/perpetrator, and consideration of all available tools, such as the DVDS, to prevent future harm. (Recommendation twenty).

17. Conclusions

17.1. The following section details the learning themes identified throughout the review process.

17.2. Relational Dynamics and Dual Allegations

17.2.1. It was generally accepted throughout the majority of the agency IMRs that the couple had both been violent to one another at different times throughout their relationship. What differed between agencies was the language used in case files, and by IMR authors, to describe this dynamic.

17.2.2. Domestic abuse and coercive control, by their very nature, are all consuming and pervasive. An abusive and coercively controlling person will be abusive all the time, and their aim is to exert power and control over their partner or family member. It is therefore not possible, in terms of a power and control model of domestic abuse, for a couple to switch between the abuser and the victim.

17.2.3. In order to gain a better understanding of the nuances of relationship dynamics, it is important to broaden the scope of the behaviours beyond "victim" and "perpetrator". This requires the extension of language used, which in turn will enable the development of responses that are suitable for each relationship dynamic.

17.2.4. Michael P Johnson has introduced the concept of "typologies of intimate partner violence".[62] These typologies are as follows:

- Intimate Terrorism – this is the classic power and control dynamic where one partner exerts coercive control over their partner

- Violent Resistance – this is where the partner who has been abused and controlled retaliates, or uses self defence against the abuser

[62] Johnson, M. P. *A Typology of Domestic Violence: Intimate Terrorism, Violent Resistance, and Situational Couple Violence* (2008)

- Situational Couple Violence – this is where violence escalates from mutual arguments, this occurs between couples and there is not one partner exerting power and control over the other.

17.2.5. Academics argue that community services and therapeutic settings should be set up to identify the various typologies of intimate partner violence and treat these accordingly.[63] Johnson states that to identify the different typologies of abuse, the right questions need to be asked. For example, EDAN Lincs recorded in their IMR that they utilise a SafeLives screening toolkit when both partners are referred into their service as victims. Respect also provides a screening toolkit for use when working with male victims.[64] These are examples of asking better questions to establish dynamics in a relationship; however, it does only provide an understanding of who a perpetrator is and who is a victim. Johnson's Typologies go beyond this standard power and control model.

17.2.6. The author of the police IMR identified that there may have been elements of controlling behaviour on both sides. In support of this observation, Scarlett may be seen to have exercised a pattern of emotional abuse towards Zac by self-harming or threatening to do so. Zac frequently reacted by using excessive physical force when attempting to prevent Scarlett injuring herself, including many occasions of strangulation, which in and of itself is power laden. Scarlett claimed to be dependent on Zac, which afforded him a tacit degree of control in volatile situations; however, it is the level of physicality that is challenged and, as detailed, resulted in Zac's arrest on more than one occasion.

17.2.7. This analysis describes both partners as being mutually coercive, in their own ways. They were each referred into victim services, interchangeably, and expected to engage with services as victims of abuse. Interestingly, neither were referred into perpetrator programmes, and they were not spoken to about being mutually violent to one another, only about domestic abuse.

17.2.8. This review is not the vehicle to identify whether Scarlett or Zac were the victim or perpetrator of coercively controlling domestic abuse. This review's purpose is to identify gaps in knowledge and provision that could make the future safer. Furthermore, it should open the discussion regarding suitable assessments – leading to appropriate responses to relationship dynamics that are not healthy but do not sit within the classic power and control model of intimate partner violence.

17.2.9. For situations where there is situational violence, where there are no power and control dynamics, a referral into a programme working with both parties would be more suitable. A programme that addressed their violence towards one another – identifying the situations that escalated the violence and using the simple language of violence – would allow realistic safety plans to be developed, with both parties' input and agreement. These specific services do not currently exist in either Surrey or Lincolnshire. However,

[63] Friend, D.J. et al. "Typologies of Intimate Partner Violence: Evaluation of a Screening Instrument of Differentiation" *Journal of Family Violence* (2011)
[64] Respect Toolkit for work with male victims of domestic abuse | Respect

both areas are currently reviewing their specialist domestic abuse commissioning and will consider the learning from this review.

17.2.10. Within this review, agencies undertook a review exercise of their policies and procedures to identify whether situational couple violence, or the equivalent, was referenced. All do mention domestic abuse as being relevant to all genders and highlight that assessments must be completed with all parties when both appear to be victims and perpetrators interchangeably. However, as detailed above, this is not sufficient when identifying and responding to situational or mutual couple violence.

17.2.11. Specific policies for responding to families, or couples where both partners are violent, would provide agencies with mechanisms to assess and identify situational couple violence as possible dynamics in a relationship. Currently, this form of violence within the family is recognised and acknowledged by some individuals; however, a multi-agency policy would provide clarity for all agencies around suitable responses to situational couple violence. (Recommendation twenty-two).

17.3. Male Victims

17.3.1. As introduced in section 13, Zac's experiences of services would have been shaped by his gender. As the police IMR stated:

> *"It does not seem to have been explored with Zac that he could have been the victim or with Scarlett that she could have been the perpetrator".*

17.3.2. He was not asked about domestic abuse in the maternity ward, despite their routine enquiry process being in place. This is because the policy and the mechanism for routine enquiry is not currently set up for partners of pregnant women. Although the lack of questioning was not directly due to Zac's gender, the majority of pregnant women's partners will be male.

17.3.3. Probation stated that, gender had potentially confused the process because the practitioner may have made assumptions about perpetrators and risks. Much of Probation's training on domestic abuse had focused predominantly on male perpetrators and female victims, and there is potential learning when domestic abuse is present in a relationship and there are disclosures or physical indicators of domestic abuse by male victims.

17.3.4. When the social worker visited the couple's home in April 2019, they noted bruises and marks on Zac, but there is no evidence that this was explored further with Zac on his own. There is no evidence that staff explored any potential safeguarding concerns regarding domestic abuse in relation to him as the victim. The staff were more focused on supporting with food bank vouchers. This begs the question, what would the response have been if the bruising and marks had been visible on Scarlett?

17.3.5. Surrey CSC reflected that:

> *"There was professional awareness and recognition of Zac's learning needs and how this created vulnerabilities for Zac within the relationship, particularly in respect of coercive control and being isolated from family, friends, and professionals".*

17.3.6. The police reports also highlighted a worry that Scarlett would threaten self-harm if she did not see Zac, and she stated that Zac was her carer, creating an emotionally coercive and controlling aspect to their relationship dynamic.

17.3.7. There are certainly identifying features of coercive control being exercised by Scarlett onto Zac. However, Zac was not referred into a domestic abuse service designed specifically for men. The only referral that was made for him as a victim of domestic abuse was via a no-consent MARAC, which was no-consent because he was not aware of the referral. The decision to make the MARAC referral was taken at a professionals' strategy meeting, following the incident in the PAs car, where Scarlett attacked Zac. He was not aware of the referral into Surrey MARAC, and the subsequent transfer to Lincolnshire MARAC, and/or the referral into EDAN Lincs IDVA service that comes as part of the MARAC process.

17.3.8. The gendered nature of domestic abuse means that male victims have different experiences to female victims. Male victims are faced with more feelings of embarrassment and shame, due to society's expectations upon them to behave in a masculine and aggressive way. This toxic masculinity[65] negatively affects men. The model of toxic masculinity expects men to have no emotions and to "man up", which (amongst other impacts, such as high suicide rates) can lead many men to feeling unable to approach domestic abuse services.

17.3.9. During the scoping period for this review, there were no specific service provision for male victims of domestic abuse, in either Surrey or in Lincolnshire. Since then, there has been development of domestic abuse services for men. Now, men are able to access support and intervention and recognise that they are victims of domestic abuse.

17.3.10. In Lincolnshire, EDAN Lincs supports male victims. There are male support workers and specialist IDVAs who are trained to support male victims. There are self-contained refuge spaces in Lincolnshire, which are available to all genders. The DA Matters training for the police and the IDVA service in Lincolnshire includes training on male victims.

17.3.11. In Surrey, Your Sanctuary hosts a dedicated male IDVA; however, all of the other outreach provision is genderless. In January 2022, I Choose Freedom[66] launched a dispersed housing scheme, providing housing for any gender affected by domestic abuse. The domestic abuse training package is genderless.

---

[65] Harrington, C. (2021). What is "Toxic Masculinity" and Why Does it Matter? *Men and Masculinities*, *24*(2), 345–352.

[66] I Choose Freedom - Ending Domestic Abuse | Refuge & Charity

17.4. Specialist Knowledge and Services

17.4.1. This review has shone a light on the need for a more diverse understanding of intimate partner violence. As the sections above detail, the responses to Zac and Scarlett as “classic” victims and/or perpetrators, living within a relationship structured by power and control, was not necessarily suited to their specific needs.

17.4.2. There are gaps in available policies – and knowledge and understanding amongst services and throughout systems – of the possible nuances in different relationship structures, and different dynamics within these relationships, which do not fit within the standard model of domestic abuse.

17.4.3. There follows that there is a lack of suitable assessments for determining the relationship dynamics to identify the best pathway to support those within the relationship and reduce their risks from themselves and one another.

17.4.4. This gap in knowledge and assessment is not specific to the geographical areas pertaining to this review; however, this review has provided the platform to raise this issue with the agencies involved in the review.

17.4.5. The review has identified the need to extend routine enquiry to partners of pregnant women. Particularly, when the pregnant woman is known to be a perpetrator of domestic abuse.

17.4.6. There also remains a gap of specialist services designed for men subjected to domestic abuse, which is to the detriment of current domestic abuse services who are expected to support all genders, but more importantly, it is to the detriment of male victims who do not recognise the services who offer “generic” domestic abuse support as being suitable for their needs.

17.4.7. This review also identifies a gap in assessment and services for female perpetrators of intimate partner violence and abuse.

17.4.8. There also needs to be more understanding around the transition of care leavers when they reach 18. Services need to be aware that there remains many options and services for care leavers, even when they reach 18. Services should also be made aware of the value of including PAs into discussions regarding care leavers. Often, they may have a fuller understanding of the situation than individual agencies dealing with specific aspects of a person’s life.

17.5. Multi-Agency Risk Assessment Conference (MARAC)

17.5.1. There is no legislation underpinning the MARAC process, there are no statutory expectations around MARAC processes, and the SafeLives guidance can be interpreted in various ways. This leads to different practices throughout England and Wales. Whilst Lincolnshire, and more recently Surrey, have restructured their MARAC processes, this review raises questions regarding the limitations of the MARAC process, and particularly the lack of proactive actions stemming from the process.

17.5.2. Surrey's MARAC process review, which had started independently of this DHR, has organically dealt with some of the issues, such as lack of minutes. However, the lack of professionals who were aware of the complexities of Zac and Scarlett's relationship, particularly at the Lincoln MARAC as a transfer in case, alongside the lack of consent for the MARAC referral originality in Surrey, led to lack of actions from the process.

17.5.3. To support a more proactive and impactful MARAC process, all professionals working with an individual, particularly when they are care leavers, should be invited and involved in the MARAC meeting.

17.5.4. There is no evidence that the PA or the Care Leaving Service were invited to any of the MARACs, either in Surrey or in Lincolnshire. It could be argued that Surrey CSC Care Leaving Service, and particularly the couple's PAs, were the only service who had the full picture of the situation.

17.5.5. It was reflected in the IMRs, that the MARAC was one forum that collectively acknowledged the level of violence in the couple's relationships. However, the MARAC did not evidence ways to effectively and collectively address and intervene.

17.5.6. An example of an effective and collective action from the MARAC process, would have been consideration of the DVDS in order to make Zac aware of Scarlett's violent history. This could only have been considered if the MARAC was made aware of the mutuality of violence between Zac and Scarlett and how neither were able to recognise the relationship, or each other, as being harmful.

17.5.7. There is a need for practitioners to be fully trained on the MARAC process. The danger is that otherwise the MARAC process becomes a tick box exercise without any specialist knowledge or understanding involved. This includes an understanding of why consent to refer into the MARAC should be sought, and the limits placed on the process when consent isn't sought.

17.6. Trauma-informed Practices

"Trauma occurs when a sudden, unexpected, overwhelming intense emotional blow, or series of blows assaults a person from outside. Traumatic events are external, but they quickly become incorporated into the mind".[67]

17.6.1. It is not the trauma itself that does the damage, it is how the individual's mind and body react in its own unique way to the traumatic experience, in combination with the unique response of the individual's social group.[68]

17.6.2. As introduced above at 13.15, both Zac and Scarlett had numerous ACEs that shaped their adult lives. Any one of these ACEs could have led to trauma responses, and an amalgamation of traumatic events cumulate to create issues around mental

[67] Terr, L. *Too Scared to Cry: Psychic Trauma in Childhood* (1990) p.8
[68] Bloom, S. "Trauma Theory Abbreviated" *The Final Action Plan: A Coordinated Community- Based Response to Family Violence* (1999)

health, risk taking and self-harming behaviours, and difficulties forming and maintaining healthy relationships. The fact that both parties brought this level of trauma into their relationship is central to their relationship dynamics.

17.6.3. As has been addressed throughout previous sections, Scarlett's life was punctuated by instability. She had numerous placements, with only one being therapeutic. Each placement broke down after a short period of time. This was due to Scarlett's violent behaviours, which were almost definitely, and ironically, due to her early years' trauma, for which a stable therapeutic placement may have remedied.

17.6.4. Scarlett spoke about her emotional wellbeing, emotional regulation, and associated coping strategies as if they were external to her, and that she had little control or understanding of these. Trauma-informed practice and therapeutic support may have helped her to learn emotional regulation and gain an insight into her trauma responses of violence and aggression, including harm to herself.

17.6.5. The Surrey IMR author reflected that, like other young people of their age, romantic relationships are vital, and the PA described how Zac *"absolutely loved Scarlett to bits, you know, in his mind, that was, he was with her forever, and especially after she became pregnant that, you know, he wanted to be a father. He wanted them to be a family".* Their shared experiences bonded Zac and Scarlett together. Similarly, both had broken relationships with their respective families, which served to further bring the couple together. Reflecting upon professional working relationships with the couple at the time, no one professional in Surrey was able to meet Zac's needs in a way that the relationship with Scarlett met his needs.

17.6.6. Both Zac and Scarlett grew up against a backdrop of violence within the home. The theory of intergenerational transmission of abuse[69] explores how witnessing and experiencing intimate partner violence impacts on children and creates a scenario in the mind that is often re-enacted through destructive relationships as adults.

17.6.7. If a person is subjected to enough traumatic experiences, such as violence in the home, or living with a parent with substance misuse issues, or being physically neglected, it may teach them that nothing they do will affect the outcome, and that they should give up trying. This is called "learnt helplessness",[70] and for recovery, an intervention is required, which focuses on mastery and empowerment, whilst also avoiding further experiences of helplessness.

17.6.8. Trauma-informed interventions are designed around the need to empower subjects, whilst concentrating on their strengths and what happened to them, rather than using language of there being something wrong with the subject. It is evidenced that the social worker in Lincolnshire exhibited trauma-informed responses to Zac and Scarlett's needs. When speaking to the Independent Chair, she stated that she had a belief in them succeeding as a couple and that:

[69] Motz, A. *Toxic Couples: The Psychology of Domestic Violence* (2014)
[70] *Ibid. n 58*

> "From reading Scarlett's history, she felt she had been let down by Social Care several times as she was growing up, (and) they had that sense of wanting to improve their lives and succeed. I believe that because I felt belief in them, they also appreciated that belief which spurred them on to succeed, and for a period of time it did".

17.6.9. This strengths-based response is good practice and what is required when responding to adults living with childhood trauma. Lincolnshire CSC also praised the foster placement, which provided boundaries and positive modelling for the couple.

17.6.10. The placement and support from Lincolnshire CSC led to 15 months of relative stability – from late January 2020, when the couple moved to Lincolnshire, until issues between the two families led to the derailment of the relationship, in April 2021. The will to succeed of the professionals may have been a stabilising factor during this time.

17.7. COVID-19 Restrictions

17.7.1. Health Protection (Coronavirus Restrictions) (England) Regulations 2020 came into force on 26th March 2020.

17.7.2. COVID-19 also resulted in the move to virtual Core Group meetings, in line with government guidelines for social distancing and isolation. Core Group meetings were completed virtually; however, attendance of the family and invited professionals was maintained. Furthermore, the social worker and early help worker maintained face-to-face home visits with the family throughout the involvement.

17.7.3. The COVID-19 restrictions did not seem to negatively impact the responses to the couple.

17.7.4. Surrey was able to provide a consistent PA for both Zac and Scarlett. Clearly, the distance between Surrey and Lincolnshire had an impact, and lone working and transportation presented a risk and needed to be managed appropriately. However, COVID-19 restrictions did not have an impact on the support that they were able to offer.

17.7.5. Professionals do consider that the restrictions would have brought additional stress into the home – with them both having to stay in the home with a young baby during the periods of national lockdown measures.

17.7.6. UHLT provided maternity services to Scarlett, and they stated that whilst it was clear that the pandemic had had a considerable impact on the delivery of NHS services, both nationally and locally, Scarlett continued to receive scheduled antenatal care during the period of restrictions.

17.7.7. Visiting restrictions were also in place at this time: this afforded midwifery staff to interact with Scarlett alone, undertaking routine enquiry more readily than if Zac had been present. Professionals' reduced contact with Zac may have resulted in fewer opportunities to seek information relating to his experiences of domestic abuse, or to

witness Zac and Scarlett's interactions as a couple; however, as previously mentioned, no new concerns arose on those occasions when Zac and Scarlett were permitted to present together.

17.7.8. Probation casefiles detail information being provided to Scarlett about managing during COVID-19 restrictions, as a victim of domestic abuse; however, there is no evidence that Zac was provided with the same.

17.7.9. There is evidence that both Zac and Scarlett engaged with remote appointments with their probation officers. Face-to-face probation appointments and home visits resumed with Zac and Scarlett from November 2020.

17.7.10. We Are With You stated that it is best practice to engage with service users face to face, in order to develop a therapeutic relationship between worker and client and to provide psychosocial interventions. Face-to-face working is also necessary to conduct drug screening to confirm abstinence. Due to the COVID-19 restrictions, Zac was provided with telephone appointments and did not receive any drug screening. However, the fact that the sessions were remote, allowed We Are With You to continue support. This was despite Zac entering the foster placement, which took him out of the usual catchment area for the service.

18. Lessons to be Learned

18.1. As the previous section detailed, as well as identifying single agency learning, this review has identified learning across similar broad themes for all agencies.

18.2. One key lesson is the need for agencies and professionals to be aware of the possibility of situations where both partners within a relationship are violent towards one another. It is vital that this does not become the "go to" for all responses towards domestic abuse. Furthermore, in the first instance, professionals should use all available resources to identify a victim, within the relationship, who requires specialist support – in order to reduce their risk of harm from the other party.

18.3. It is important that the most appropriate support is offered to couples and families, and, wherever possible, a specialist domestic abuse service should be utilised to undertake a screening exercise – to safely and accurately assess the dynamics in a relationship where it is not immediately clear who is doing what to whom.

18.4. In order to raise awareness of different "types" of interpersonal violence, training should be made available locally, and organisations should be encouraged to include an element of Johnson's Typologies, or similar, in their domestic abuse policies.

18.5. Another key lesson that cuts across all services, is agencies' ability to identify and respond to male victims of domestic abuse. Men and boys should be asked about domestic abuse when they present with injuries or illnesses that cause

suspicion that they may be a victim of abuse. In the absence of local specialist male services for domestic abuse victims, men and boys should be given the option of a referral into a local generic domestic abuse service or into a national specialist male service.

18.6. The review identified a series of lessons linked to MARAC processes across both Lincolnshire and Surrey: these can be found above in section 16 and are linked to recommendation twenty.

19. Recommendations

19.1. The following section will detail recommendations for individual agencies and will be followed by multi-agency recommendations.

19.2. Surrey Children's Services

19.2.1. To update Surrey Children's Services Group Supervision Guidance and Domestic Abuse Policy to include guidance for Care Leaver Service practitioners who are each supporting one half of where there are concerns that domestic abuse, or mutual couple violence, is present in the relationship. This will call for group supervision to involve the relevant practitioners, and to be undertaken every quarter or more frequently depending on the presenting risks and vulnerabilities. This will ensure closer communication around the challenges and pressures for each young person and enable that knowledge to be shared in order to inform a more complete understanding of the dynamics of the relationship and focus on harmful behaviours of one or both of the parties.

19.3. Surrey Hospital B

19.3.1. Plan to enhance domestic abuse training across key areas of Hospital B Trust, including the Emergency Department. This will be evaluated by collating information regarding training compliance and referral activity.

19.3.2. To review Domestic Abuse Policy to include routine and safe enquiry about domestic abuse, and completion of DASH risk assessments and referral into MARAC where appropriate.

19.4. Surrey and Borders Partnership NHS Trust

19.4.1. To improve Trust employees' understanding of domestic abuse concepts. Domestic abuse awareness is part of the statutory and mandatory safeguarding training for all staff in SaBP; however, during this review, they identified a need to specifically focus on coercion and control, the high-risk factors of domestic abuse, and managing these risks within the context of the victim's life experiences.

19.4.2. To improve awareness of 'Think Family' approach. A 'Think Family' guidance has been developed by the Task and Finish group. The document will be disseminated to all staff across the organisation and promoted on the SaBP's intranet under the Safeguarding section as soon as it is approved.

19.5. Surrey District Council A – Housing

19.5.1. To work with partners, including Surrey County Council, to introduce a protocol for responding to young people who need help and support with accommodation – including care leavers and those who may be considered as a victim of domestic abuse – to help ensure effective case management and information across partners.

19.6. Probation Service (Formerly National Probation Service)

19.6.1. Learning from this review should be highlighted to the East Midlands Probation regional training team to ensure a future focus on the following areas: gender assumptions within domestic abuse cases; working with cases where both parties display abusive behaviour; the importance of timely reviews of OASys; and how to use a more investigative approach in supervising people on probation.

19.6.2. Specific practice development sessions should take place in East and West Lincolnshire Probation delivery unit, with a focus on domestic abuse, women as perpetrators, and cases where both parties are violent to one another.

19.6.3. Guidance will be recirculated to East and West Lincolnshire Probation delivery unit on handling sensitive information, including the recording and storing of MARAC information.

19.6.4. Development of robust processes where both parties are engaged with probation, to promote information sharing and joint supervision.

19.6.5. The recruitment of single point of contact roles within geographical locations – to consistently attend MARAC and to manage the information flow into and out of the MARAC.

19.7. Lincolnshire County Council – Children's Services

19.7.1. Following the publication of the DHR, learning and best practice will be shared via the Children's Services Bulletin.

19.8. Lincolnshire Partnership NHS Foundation Trust

19.8.1. The Trust's safeguarding team will undertake an engagement project with the CJL&D service to explore current processes around safeguarding. The aim being to provide support and guidance on safeguarding responsibilities within an environment (custody) where the police are usually the lead agency for responding to concerns. This will include the use and benefit of Child Protection Enquiries.

19.8.2. The CJL&D's team manager will work with the police to agree a process that enables CJL&D to fully assess service users in the situation where they are imminently to be released from custody.

19.8.3. LPFT will add an alert to their clinical systems to enable a patient's leaving care status to be easily identified.

19.9. We Are With You

19.9.1. Staff to be reminded that when taking a referral over the phone, this must always be followed up by a completed referral form from the referrer. This is to ensure that the relevant and correct information is shared about the client's circumstances, allowing appropriate risk assessments to be carried out and the service's proactive multi-agency involvement throughout the period of the treatment.

19.10. United Lincolnshire Hospital Trust

19.10.1. ULHT maternity services to explore a formal mechanism for initiating and recording the outcome of direct routine enquiry with partners of pregnant women when the pregnant woman is known to be the perpetrator of domestic abuse.

19.11. Lincolnshire Community Health Services

19.11.1. The LCHS safeguarding supervision policy states that a quarterly supervision is provided in Urgent Care settings. Managers will be reminded that all staff are expected to attend these sessions at least twice per year and this should be monitored.

19.12. Lincolnshire Tier 2 Council A and Tier 2 Council B

19.12.1. Review options for improved and appropriate information sharing across teams and systems across all councils within Southeast Lincolnshire and across council borders when appropriate.

19.12.2. Review internal process for appropriate flags on the system for individuals referred to MARAC when there is no direct prior agency involvement or action following the case meeting, including appropriate flags across district borders. This will include reviewing internal systems for checking case files or recording names on case files across all systems to improve clarity on relationships.

19.12.3. Review attendance at MARAC for all cases, to cover cases where there has been no prior direct agency involvement to share**.**

19.13. Multi-agency Recommendations

19.13.1. Learning from this review will be shared across Lincolnshire and Surrey to raise awareness of what makes a good “transfer in” MARAC, including recommended practices of holding a MARAC in both areas, contact with originating area MARAC co-ordinator, and, where it is deemed appropriate, a representative from the originating area attending the MARAC to present the case in the new area.

19.13.2. Learning from this review will be shared with SafeLives to inform best MARAC practice nationally, specifically around transfer in best practice and MARAC referrals where there is no consent, and therefore IDVA referral cannot be included. The Lincolnshire Domestic Abuse Partnership will oversee this recommendation.

19.13.3. Work will be undertaken to raise the profile of care leaver services, including the role of the personal advisor and how they should be included in discussions around safety planning, attendance at MARACs, and utilised by other services to facilitate conversations with the care leavers.

19.13.4. The Lincolnshire Domestic Abuse Partnership will develop a policy template, for multi-agency use, to raise awareness of “typologies” to assist services in identifying and responding safely and appropriately to situational couple violence and violent resistance.

19.13.5. The Home Office and NHS England will be contacted by Safer Lincolnshire Partnership to raise the question of children in care/care leaver status remaining on health records when the child turns 18.

19.13.6. A multi-agency learning briefing tool will be developed to share learning and resources on the following themes:

a) Reminder to all services and professionals to offer option of a referral into a national specialist male domestic abuse service when supporting male victims of domestic abuse.

b) Using the learning from this review to remind professionals of the importance of asking about domestic abuse, either within a routine enquiry process or as part of increased professional curiosity.

Glossary of Terms

Adverse Childhood Experiences (ACEs) – highly stressful and potentially traumatic events or situations that occur during childhood and/or adolescence. They can be a single event or prolonged threats to, and breaches of, the young person's safety. Security, trust, or bodily integrity.

Attention Deficit Hyperactivity Disorder (ADHD) – a condition that affects people's behaviour, making them restless, inattentive, and impulsive.

Autism Spectrum Disorder (ASD) – a neurological and developmental disorder that affects how people interact with others, communicate, learn, and behave.

Care Act s.42 – a legal duty to make enquiries about safeguarding concerns. These duties apply to an adult who has needs for care and support.

Care Proceedings – court proceedings issued by the children's services department, when they have concerns about the welfare of a child and apply for permission to take action to protect the child.

Child and Adolescent Mental Health Services (CAMHs) – assess and treat young people with emotional, behavioural, or mental health difficulties.

Children Act s.47 enquiries – this is a Child Protection Investigation, which is carried out to assess if there is a risk of significant harm to a child.

Children Act 1989 s.20 – giving the local authority the duty to provide a child with somewhere to live if that child needs it.

Child Protection Plan – sets out what action needs to be taken, by when and by whom, to keep the child safe from harm and promote their welfare.

Community Supervision Order – a court order that imposes a duty on the local authority to advise, assist, and befriend the child.

Core Group – a meeting of all the relevant practitioners and family members who work together to create, implement, and review the Child Protection Plan.

Child in Need Plan – a plan that sets out what extra help children's services and other agencies – including health and education – will provide for a Child in Need and their family. The plan should be drawn up in partnership with the family, and child if possible, after a Child in Need assessment.

Criminal Justice Liaison and Diversion Service (CJLDS) – where medical professionals are situated in custody suites to allow them to assess all detained persons as they are booked in, and if they are referred when concerns are identified.

The Domestic Abuse Stalking and Honour Based Abuse Checklist (DASH) – designed and implemented across all police services from March 2009. The questions provide insight into indicators of risk of harm and are now used widespread across all multi-agency partners.

Dyspraxia – a condition that is related to neurological development that impacts how a person understands and copes with a world where they often feel 'different'. It causes difficulties with social interaction and communication. The condition also includes limited and repetitive interests or patterns of behaviour, as well as sensory sensitivities.

Education, Health and Care Plan (EHCP) – a document that sets out the education, healthcare, and social care needs of a child or young person for whom extra support is needed in school, beyond that which the school can provide.

Family Group Conference – a planning meeting led by the family and arranged by an independent person. The process ensures that families are at the centre of decision-making.

Initial Child Protection Conference – a meeting where a multi-agency discussion first takes place, and a decision is made as to whether a child or young person should be placed on a Child Protection Plan. A Review Conference is the term used for subsequent conferences.

Interim Care Order – a short-term court order that means that a child becomes looked after in the care system. It is often made at the start of care proceedings, usually lasting until the court can make a final decision.

Independent Domestic Violence Advisors (IDVAs) – provide a specialist service for males and females, aged 16 and over, who have been referred into a Multi-Agency Risk Assessment Conference.

Multi-Agency Risk Assessment Conference (MARAC) – a meeting where information is shared on the highest risk domestic abuse cases. The primary focus is to safeguard adult victims that are at risk of serious harm.

Multi-Agency Safeguarding Hub (MASH) – bringing together different agencies to enable fast information sharing with the purpose of making an efficient and fast decision to safeguard vulnerable children.

Neighbourhood Patrol Team (NPT) – a highly visible and reassuring presence in the community.

NHS Act 2006 s.75 – allows the NHS and local authorities to jointly fund and commission health and social care services. This allows a local authority to commission health services, and NHS commissioners to commission social care. It enables joint commissioning and integrated services.

NHS Spine – the digital central point, allowing key NHS inline services and allowing the exchange of information across local and national NHS systems.

Offender Assessment System (OASys) – prison and probation services use this tool to complete a risk and needs assessment.

Parenting Assessment – designed to work out what knowledge the parent has about their child's needs and analyses their ability to give the child "good enough" care.

Personal Advisor (PA) – the focal point to ensure a care leaver is provided with the correct level of support.

Pre-Proceedings Process – a phase of work aimed at avoiding care proceedings. It clearly sets children's services' concerns, makes clear what changes the parents need to make, and identifies the extra help required to achieve these changes.

Single Combined Assessment of Risk Form (SCARF) – considers a series of factors specific to the person and in the circumstances. It covers both children and vulnerable adults.

Spousal Assault Risk Assessment (SARA) – a set of guidelines used by criminal justice professionals to assess the risk of domestic violence.

Supervised Placement – a specialist fostering arrangement where a parent and their baby or young child are placed together with a fostering family.

Bibliography

Adley, N. and Jupp Kina, V. “Getting Behind the Closed Doors of Care Leavers: Understanding the Role of Emotional Support for the Young Person Leaving Care” *Child and Family Social Work* (22) (1) (2017)

Atkinson, C. and Hyde, R. “Views About Transition: A Literature Review” *Journal of Children’s Services* (14) (1) (2019)

Bates, E. “Barriers to Men Seeking Help” *Journal of Interpersonal Violence* (37) (7) (2020)

Bichard, H. et al. “The Neurological Outcomes of Non-Fatal Strangulation in Domestic and Sexual Violence: A Systemic Review” *Neurological Rehabilitation: An International Journal* (May 2020) pp.1164-1192

Bloom, S. “Trauma Theory Abbreviated” *The Final Action Plan: A Coordinated Community-Based Response to Family Violence* (1999)

Butterworth S. et al. “Transitioning Care Leavers With Mental Health Needs: ‘they set you up to fail!’ *Child and Adolescent Mental Health* (2016)

Dixon, J. “Young People Leaving Care: Health, Wellbeing and Outcomes” *Child and Family Social Work* (13) (2) (2018)

Domestic Violence Disclosure Scheme Fact Sheet Domestic Violence Disclosure Scheme factsheet - GOV.UK

Friend, D.J. et al. “Typologies of Intimate Partner Violence: Evaluation of a Screening Instrument of Differentiation” *Journal of Family Violence* (2011)

Harrington, C. (2021). What is “Toxic Masculinity” and Why Does it Matter? *Men and Masculinities*, *24*(2), 345–352

Harvard Center ACEsInfographic_080218.pdf

Hope, K. et al. “What we can Learn from DHRs with Male Victims” *Partner Abuse* (2) (4) (2021)

Huntley, A. et al. Help Seeking by Male Victims of Domestic Violence and Abuse: Systemic Review and Qualitative evidence Synthesis” *BMJ Open* (9) (1) (2019)

Johnson, M. P. *A Typology of Domestic Violence: Intimate Terrorism, Violent Resistance, and Situational Couple Violence* (2008)

Kusmierska, G. “Anger and Autism Spectrum Disorders: A Clinician’s Perspective *Autism Spectrum News* (2014)

Motz, A. *Toxic Couples: The Psychology of Domestic Violence* (2014)

NHS *Domestic Violence and Abuse* Getting help for domestic violence and abuse - NHS

Respect Toolkit Respect-Toolkit-for-Work-with-Male-Victims-of-Domestic-Abuse-2019.pdf

Simkiss, D. “The Needs of Looked After Children from an Adverse Childhood Experiences perspective” *Paediatrics and Child Health* (29) (1) (2019)

Taylor, J. et al. “Barriers to Men’s Help Seeking for Intimate Partner Violence” *Journal of Interpersonal Violence* (37) (19) (October 2022)

Terr, L. *Too Scared to Cry: Psychic Trauma in Childhood* (1990) p.8
Womens Aid *Supporting women and Babies After Domestic Violence: A Toolkit for Specialists* (2019) Supporting-women-and-babies-after-domestic-abuse.pdf

World Health Organisation *Global and Regional Estimates of Violence Against Women* (2021) 9789241564625_eng.pdf

Wright, C. “The Absent Voice of Make Domestic Abuse Victims; The Marginalisation of Men in a System Originally Designed for Woman.” *The Plymouth Law and Criminal Justice Review* (2016)