SETDAB | Southend, Essex & Thurrock Domestic Abuse Board

Domestic Homicide Review
Executive Summary

Under s9 of the Domestic Violence, Crime and Victims Act 2004

Basildon Community Safety Partnership

A Review into the death of Angel in April 2018

Report Author: Christine Graham
April 2021

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Preface

Basildon Community Safety Partnership and the Domestic Homicide Review Panel wish at the outset to express their deepest sympathy to Angel's family and friends. This review has been undertaken in order that lessons can be learned. We wish to place on record our thanks to the family for their engagement and challenge with the review; it has helped us form a deeper understanding of those involved and the issues they faced.

The review has been carried out in an open and constructive manner with all the agencies, both voluntary and statutory, engaging positively. This has ensured that we have been able to consider the circumstances that ultimately culminated in Angel's murder in a meaningful way and address, with candour, the issues that it has raised.

The review was commissioned by Basildon Community Safety Partnership on receiving notification of the death of Angel in circumstances which appeared to meet the criteria of Section 9 (3)(a) of the Domestic Violence, Crime and Victims Act 2004.

Contents

1 The Review Process

1.1 This summary outlines the process undertaken by Basildon Community Safety Partnership Domestic Homicide Review Panel in reviewing the murder of Angel who was ordinarily a resident in their area.

1.2 The pseudonym Angel has been used for the victim to protect her and her family's identity. The perpetrator will be known as 'Steven'.

1.3 At the time of her death Angel had just turned 18 years of age. She had been in the care of the local authority since she was a small child. She had, at the time of her death, been allocated supported accommodation in Basildon but was spending significant time with Steven at an address in the London Borough of Greenwich. She had been the subject of Multi-Agency Child Exploitation (MACE) meetings and Multi-Agency Risk Assessment Conferences (MARAC) in relation to Steven.

1.4 They had been in a relationship for approximately 13 months. He was significantly older than her; he was in his early 30s at the time of her murder. For most of their relationship Angel was still in the care of the local authority.

1.5 She was murdered in London, in April 2018. Steven asserted that her injuries had been caused by her falling down the stairs but was found guilty of her murder. A post-mortem showed that Angel died from a head injury and noted multiple other injuries to her body. Steven was also found guilty of two counts of causing Actual Bodily Harm and one of Common Assault, relating to incidents that occurred in the weeks prior to her murder. In August 2019 he was sentenced to life imprisonment with a minimum term of 18 years to be served before he will be eligible to apply for parole.

1.6 Steven had an extensive criminal background with most of his offences relating to assaults, including significant domestic abuse with a previous partner. At the time of Angel's murder, he was being managed under MAPPA[1] due to the level of risk that he posed to others. He had been subject to previous Child Abduction Warning Notices in relation to Angel and was also 'wanted' by police for reported assaults upon her. There is evidence to suggest that shortly before she was murdered, she had made the decision to leave him.

1.7 Basildon Community Safety Partnership was notified of the death immediately after it occurred. This demonstrated a good understanding by the police of the need for a referral at the earliest possible opportunity.

1.8 Given the complexity of the criminal investigation, Steven was not charged until January 2019. A core group meeting was held on 21st March 2019. The meeting was chaired by the Southend, Essex, and Thurrock Domestic Abuse Partnership Co-ordinator. At this meeting, the police provided a summary of the incident, and it was agreed, unanimously, that the criteria had been met and that a Domestic Homicide Review would be undertaken.

1.9 Once the decision to hold the review had been taken, the Home Office was advised of the decision on 8th April 2019.

[1] Multi-Agency Public Protection Arrangements

1.10 An Independent Chair and Author were appointed to carry out the review in April 2019. A planning meeting had been held on 25th April 2019. At this meeting, the Chair and the police's Senior Investigating Officer (SIO) ensured that Section 9 of the statutory guidance was adhered to in relation to disclosure and criminal proceedings.

1.11 The first review panel meeting took place on 5th June 2019. The meeting was used to set out the purpose of a Domestic Homicide Review, the standards and ethos by which it would be undertaken, and to discuss the information known to that date. The meeting was advised that criminal proceedings had been established in this case and that a trial was set for 24th July 2019. As a result of this, the Chair of this review had previously discussed the issue of disclosure with the senior police investigator, and it was agreed that the review would continue in limited scope until the conclusion of those proceedings. Agencies were, however, asked to ensure that all records were secured in preparation for a chronology and Individual Management Reviews (IMR).

1.12 The Terms of Reference were agreed, subject to being reviewed by Angel's family.

2 Contributors to the Review

2.1 A large number of agencies contributed to the Review.

2.2 An initial chronology was prepared with the information known by the different agencies and subsequently IMRs[2] were commissioned from:

- Basildon and Thurrock University Hospital
- Broomfield Hospital
- Chelmsford College
- East Suffolk and North Essex Foundation Trust (Colchester Hospital)
- Essex Child and Family Wellbeing Service (ECFWS)
- Essex Community Rehabilitation Company (CRC)
- Essex County Council – Children's Social Care
- Essex Multi-Agency Public Protection Arrangements (MAPPA)
- Essex Partnership University Foundation Trust (EPUT)
- Essex Police
- Metropolitan Police Service (MPS)
- NHS Greenwich on behalf of Angel's GP surgery
- National Probation Service (NPS)
- North East London Foundation Trust (NELFT)
- Oxleas Mental Health Service
- Virgin Care on behalf of Sutherland Lodge Surgery

2.3 Summary reports were provided by:

- East of England Ambulance Service Trust (EEAST)
- Essex Multi-Agency Risk Assessment Conference (MARAC)
- Essex Partnership University Trust (EPUT)
- Safer Places
- Youth Offending Service (YOS)

[2] Individual Management Review

2.4 The review panel confirmed that each of the IMR/Summary reports were independently authored and had appropriate organisational governance 'sign-off'.

3 The Review Panel

3.1 The review panel met seven times, including a two-day event when the IMRs and reports were discussed in depth, and the review panel agreed a draft overview report concluded in April 2021. Thereafter, the report was shared with the family for their comments and changes made to reflect those comments. In addition, the panel met, virtually, with the victim's sister and her advocate.

3.2 Steven was interviewed in prison after his conviction for the purposes of this review.

3.3 The members of the Review Panel were:

Name	Organisation	Job title
Gary Goose	Independent Chair	
Christine Graham	Independent Report Author	
David Landy	Basildon & Thurrock Hospital	Lead Nurse Adult Safeguarding & Learning Disabilities
Greer Phillips	Basildon Clinical Commissioning Group	Quality & Patient Safety Manager
Paula Mason	Basildon County Council	Community Safety Partnership Manager
Alison Bird	Changing Pathways	Interim Service Director
Stuart Smith	Essex Police	Child Sexual Exploitation Manager
Katie Castle	Community Rehabilitation Company	Manager – Quality and Operational Investigations
Caroline Sexby	East of England Ambulance Service Trust	Safeguarding Specialist Practitioner for Adults
Maria Barnett	Essex County Council	Service Manager (C&F) Children's Social Care
Louise McSpadden	Essex County Council	Service Manager (C&F) Children's Social Care
Paula Gregory	Essex Child and Family Wellbeing Service	Named Nurse LAC
Ines Paris	Essex Emotional Child and Family Wellbeing Service	Safeguarding Specialist Nurse
D/Supt Elliot Judge	Essex Police	Detective Superintendent
Liz Newns	Probation Service	Essex MAPPA Manager
Andrew Coombe	Greenwich Clinical Commissioning Group	Safeguarding Lead
Charlotte E Gaunt	MET Police	Detective Inspector, Specialist Crime Review Group (SCRG)
Sam Brenkley	National Probation Service	Senior Probation Officer

Jenny Harris	North East London Foundation Trust (NELFT)	Named Professional Safeguarding Children EWMHS
Annette Hines	Royal Borough of Greenwich	Senior Community Safety Officer, Greenwich Community Safety Partnership
Michelle Williams	SETDAB	Domestic Abuse Coordinator
Jacob Nurdan	SETDAB	Domestic Abuse Support Officer

3.4 It was not possible to complete the review within the six months set out within the Home Office Statutory Guidance for the following reasons:

- The review could only proceed in limited scope until the conclusion of the criminal trial.
- The complexity of the case, and the number of agencies involved, meant more time was taken.
- The review was further delayed by the Covid-19 lockdown as its timing frustrated initial efforts to progress meetings with the victim's family and during 'lockdown 1', it was agreed to have a short pause in the process to allow organisations to adjust to the new requirements and focus on covid delivery.

4 Involvement of Angel's Family and Friends

4.1 At the point that the Independent Chair and Report Author were appointed, Angel's sister was already being supported by an advocate from AAFDA[3] and, therefore, contact was made via the advocate.

4.2 The Independent Chair met with Angel's sister and her AAFDA representative at the end of May 2019. As the criminal process was not yet complete, this was an introductory meeting to explain the review.

4.3 The Report Author then met Angel's sister and mother at the criminal trial.

4.4 Following the conclusion of the trial, the Report Author met with Angel's sister and her AAFDA representative in February 2020. This was a much more in-depth meeting and Angel's sister was able to ask questions about the review, as well as talk about her sister. She confirmed that her mother was not able to meet but that she was keeping her informed about the review. She agreed to make her brother aware of the review and offer him the opportunity to meet with the Independent Chair or Report Author.

4.5 A number of Angel's family and friends released their statement (made for the murder investigation) to the review, and these have enhanced our understanding of Angel and her life. Their contributions have been included in such a way as not to reveal their identity.

4.6 Angel's sister met with the panel virtually on 2nd September 2020, supported by her AAFDA advocate.

[3] Advocacy After Fatal Domestic Abuse

4.7 Angel's sister had a copy of the draft report to review in her own time with her AAFDA advocate and has contributed to the final version.

5 Domestic Homicide Review Chair and Overview Report Author

5.1 Christine Graham undertook the role of Overview Author on this Review. She previously worked for the Safer Peterborough Partnership for 13 years managing all aspects of community safety, including domestic abuse services. During this time, Christine's specific area of expertise was partnership working – facilitating the partnership work within Peterborough. Since setting up her own company, Christine has worked with a number of organisations and partnerships to review their practices and policies in relation to community safety and anti-social behaviour. As well as delivering training in relation to tackling anti-social behaviour, Christine has worked with a number of organisations to review their approach to community safety. Christine served for seven years as a Lay Advisor to Cambridgeshire and Peterborough MAPPA, which involves her in observing and auditing Level 2 and 3 meetings as well as engagement in Serious Case Reviews. Christine chairs her local Safer off the Streets Partnership.

5.2 Gary Goose undertook the role of Independent Chair on this Review. He had previously served with Cambridgeshire Constabulary rising to the rank of Detective Chief Inspector: his policing career concluded in 2011. During this time, as well as leading high- profile investigations, Gary led the police response to the families of the Soham murder victims. From 2011, Gary was employed by Peterborough City Council as Head of Community Safety and latterly as Assistant Director for Community Services. The city's domestic abuse support services were amongst the area of Gary's responsibility as well as substance misuse and housing services. Gary concluded his employment with the local authority in October 2016. He was also employed for six months by Cambridgeshire's Police and Crime Commissioner developing a performance framework.

5.3 Christine and Gary have completed, or are currently engaged upon, a number of Domestic Homicide Reviews across the country in the capacity of Chair and Overview Author. Previous Domestic Homicide Reviews have included a variety of different scenarios: male victims; suicide; murder/suicide; familial domestic homicide; a number which involve mental ill health on the part of the offender and/or victim; and reviews involving foreign nationals. In several reviews, they have developed good working relationships with parallel investigations/inquiries such as those undertaken by the Independent Office for Police Conduct (IOPC), NHS England and Adult Care Reviews.

5.4 Neither Gary Goose nor Christine Graham are associated with any of the agencies involved in the review nor have, at any point in the past, been associated with any of the agencies.[4]

[4] Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (para 36), Home Office, Dec 2016

6 Terms of Reference

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Terms of Reference for a joint
Domestic Homicide Review and MAPPA Serious Case Review
into the death of Angel

6.1 **Introduction**

6.1.1 This Domestic Homicide Review (DHR) is commissioned by Basildon Community Safety Partnership (BCSP) in response to the death of Angel, which occurred in April 2018.

6.1.2 The review is commissioned in accordance with Section 9, The Domestic Violence, Crime and Victims Act 2004.

6.1.3 The MAPPA Serious Case Review is commissioned by Essex MAPPA Strategic Management Board (SMB), as Steven was a MAPPA nominal at the time of Angel's death.

6.1.4 The Chair of the BCSP and Essex MAPPA SMB has appointed Gary Goose MBE to undertake the role of Independent Chair for this Review. Gary Goose will be supported by Christine Graham who will be the Overview Author in this case. Neither Christine Graham nor Gary Goose are employed by, nor otherwise directly associated with, any of the statutory or voluntary agencies involved in the review.

6.2 **Purpose of the Review**

The purpose of the review is to:

6.2.1 Consider the circumstances surrounding the death of Angel and whether there are any lessons to be learned from the case about the way in which local professionals and agencies worked together to safeguard Angel. (DHR)

6.2.2 Identify what those lessons are, how they will be acted upon, and what is expected to change as a result. (DHR)

6.2.3 Establish whether the agencies or inter agency responses were appropriate leading up to and at the time of her death: suggesting changes and/or identifying good practice where appropriate. (DHR)

6.2.4 Establish if his MAPPA arrangements were effectively applied (MAPPA SCR) specifically, but not exclusively, to establish if Steven was:

- Identified as a MAPPA offender at the correct time
- Referred to Level 2 or 3 management as appropriate

- Managed effectively via MAPPA meetings

6.2.5 Establish whether agencies have appropriate policies and procedures to respond to domestic abuse, and to recommend any changes as a result of the review process. (DHR)

6.2.6 Contribute to a better understanding of the nature of domestic violence and abuse; (DHR) and

6.2.7 Highlight good practice. (DHR)

6.3 **The Review Process**

6.3.1 The review will follow the Statutory Guidance for Domestic Homicide Reviews under the Domestic Violence, Crime and Victims Act 2004 (revised 2016).

6.3.2 This review will be cognisant of, and consult with, the criminal investigation being undertaken by Essex Police into the death of Angel.

6.3.3 Domestic Homicide Reviews are not inquiries into how the victim died or who is culpable: that is a matter for coroners and criminal courts.

6.4 **Scope of the Review**

The review will:

6.4.1 Consider the period from 1st January 2016.

6.4.2 Request Individual Management Reviews by each of the agencies defined in Section 9 of The Act and invite responses from any other relevant agencies, groups or individuals identified through the process of the review.

6.4.3 Request Individual Management Reviews from those agencies involved through the MAPPA process.

6.4.4 Examine recent MAPPA records for the case, including meeting minutes and VISOR record, where one exists.

6.4.5 Seek the involvement of family, employers, neighbours & friends to provide a robust analysis of the events.

6.4.6 Produce a report which summarises the chronology of the events, including the actions of involved agencies, analyses and comments on the actions taken, and makes any required recommendations regarding safeguarding where domestic abuse is a feature.

6.4.7 Aim to produce the report within the timescales suggested by the Statutory Guidance subject to:

- guidance from the police as to any sub-judice issues,
- sensitivity in relation to the concerns of the family, particularly in relation to parallel enquiries, the inquest process, and any other emerging issues.

6.4.8 Seek to answer any questions asked by Angel's family.

6.5 **Family Involvement**

6.5.1 The review will seek to involve the family in the review process, taking account of who the family may wish to have involved as lead members and to identify other people they think relevant to the review process.

6.5.2 We will seek to agree a communication strategy that keeps the families informed, if they so wish, throughout the process. We will be sensitive to their wishes, their need for support, and any existing arrangements that are in place to do this.

6.5.3 We will work with the police and coroner to ensure that the family are able to respond effectively to the various parallel enquiries and reviews, thereby avoiding duplication of effort and minimising their levels of anxiety and stress.

6.6 **Legal Advice and Costs**

6.6.1 Each statutory agency will be expected and reminded to inform their legal departments that the review is taking place. The costs of their legal advice and involvement of their legal teams is at their discretion.

6.6.2 Should the Independent Chair, Chair of the CSP or the Review Panel require legal advice then BCSP will be the first point of contact.

6.7 **Media and Communication**

6.7.1 The management of all media and communication matters will be through the Review Panel.

7 Summary Chronology

7.1 Angel had been in the care of the local authority since she was six years old. After initial foster placements with her siblings, it was felt that she needed a placement on her own. A number of unsettled and eventually disrupted foster placements followed (through no fault of her own) with services struggling to provide the level of therapeutic support needed to reduce her outbursts of violence and therefore, better meet her needs. One of these episodes (Angel now being in her teens) led to her being convicted of criminal damage and assault at a foster carer's home. Over the following years, Angel had several placements. Police were called by the foster carers as they were not able to manage her behaviour. There were multiple times when she was reported as missing from home and multiple episodes of self-harm.

7.2 From 2014 onwards, Angel arranged her own contact with her family. She had unsupervised contact with her mother and supervised contact with her father. In June 2014, concerns for Angel's mental health escalated and it was recorded that she struggled to understand the consequences of her actions, she would stay out without telling her carers where she was, she was being bullied at school, and she was becoming more violent.

7.3 Child and Adolescent Mental Health Service (CAMHS) and other support services found it difficult to engage with her.

7.4 From late 2015 until late in December 2016, Angel was placed in a residential unit. Whilst there were still some episodes of 'missing from home' and self-harm (described within the overview report), this was seen as a settled placement, and she also had a period of consistent schooling. She completed her Year 11 exams during the summer term and in September moved to a local college to continue her education: she studied for a Diploma in Travel and Tourism. During a Looked After Child (LAC) review held in July 2016, the placement was willing for her to stay until she reached her 18th birthday, however Angel said she wished to leave and move into supported accommodation. It was identified that she needed to develop several skills before moving to a more independent placement. Between April and July, Angel attended Colchester Hospital on four occasions, having taken overdoses of over-the-counter medication (for example 16 aspirin tablets on one occasion). On each occasion, she was referred to the mental health Crisis Team and Children's Social Care (CSC). She was assessed as being at medium risk of self-harm when under the influence of alcohol. She did, however, move to a more independent living arrangement in December 2016. Her care was transferred from the Children in Care Team (of CSC) to the Leaving and After Care Team.

7.5 On moving to the new arrangements, she soon began to struggle. Her college attendance tailed off and her 'missing from home' episodes increased significantly during 2017. She was finding it hard to manage on her own and it is reported that she said she was 'lonely'.

7.6 During 2017, she was reported as missing from home 31 times.

7.7 In early 2017, she met another young woman resident of the placement who subsequently introduced her to Steven. Whilst the date of this remains unclear, it is believed that he was one of two men Angel and her friend met at the placement in early March. Within a few days of this, Angel had an episode of self-harm – cutting her forearms after drinking significant quantities of alcohol and ending up in a local Emergency Department.

7.8 The first formal identification of her with Steven was in early April when she was found with another young woman and Steven by police. The police had been called by the landlord of a property who said Steven had let himself in and was threatening other tenants. Angel was made subject of Police Protection and returned to the placement. After this, it is clear that their relationship had begun in earnest.

7.9 Steven was a man with a number of previous criminal convictions. These included a number of violent offences some of which were physical assaults on ex-partners. One assault was so severe that the victim had lost sight in one eye. He had received a prison sentence for that assault. He had a diagnosis of Emotionally Unstable Personality Disorder (EUPD) and deemed to be of high risk to others as he had a history of violence. He said that the assaults he had committed had been impulsive and he had no thoughts of harming anyone.

7.10 He used a number of aliases and had a number of warning markers for violence, mental health (Borderline Personality Disorder), mental health (severe depression and anxiety) and mental health (PTSD).

7.11 When subsequently sentencing him for Angel's murder, the judge referred to him as a man with a volatile and violent temper which he was unable and/or unwilling to control. The judge said he was possessive, jealous and isolating, and prone to outbursts of serious violence, especially when he had been drinking.

7.12 During their time together a Child Abduction Warning Notice (CAWN) was issued to Steven which advised him he was not permitted to have contact with Angel. There is not an offence of breach of CAWN but, for ease of reading, this, and the overview report will refer to breach of CAWN. If arrested in these circumstances, Steven would be charged under Section 49 of the Children's Act 1989 – commonly known as 'abduction of a child in care'. He continued to see her and was arrested twice for abduction, under Section 49 of the Children Act 1989, after the placement had reported her missing and she was found with him.

7.13 Angel's college had noted that she attended in March with heavy make-up covering what looked like a swollen eye injury.

7.14 In the year before her death, Angel was reported missing again by the placement, having been overheard making plans to meet a man (believed to be Steven). She attended a local police station in the early hours of the morning and reported that Steven had assaulted her causing her to black out. She described several incidents of physical abuse and controlling behaviour. She said that she now knew the risks and wanted to be away from him. The Independent Domestic Violence Advocate (IDVA) service became involved, but the case was closed because of subsequent 'non-engagement ' (the term recorded by the service, by Angel.)

7.15 Angel had several further incidents of self-harm including overdoses and cuts to her arms, resulting in hospital attendance.

7.16 Angel was subject of MARAC and MACE meetings.

7.17 By the end of the June before she died, Steven had been arrested three times under Section 49 of the Children Act 1989, after he had failed to take notice of the CAWN: he was sentenced to 12 week's imprisonment. During his time in prison, Angel reported that she was concerned for her mother's safety as he was threatening her from prison. He was in prison during July and August.

7.18 In July, Steven was adopted by MAPPA as a level 2 nominal. Police considered applying for a Violent Offender Order but were advised that he did not meet the qualifying conditions.

7.19 Steven was released in the August, being given a placement at an Approved Premises in Essex. He met with Angel on the day of release. This triggered several reports of Angel being reported missing. Steven was recalled to prison one week after release. Angel said she had been with him.

7.20 Angel had been spoken to by staff from various agencies in readiness for Steven's pending release from prison in September.

7.21 Police took steps to try and prevent Steven re-establishing the relationship with Angel post release. In October, they were found together in a hotel in Exeter. He was arrested but bailed by court.

7.22 There continued to be numerous incidents of Angel being reported missing by her placement, self-harm, and evidence that their relationship continued throughout the remainder of 2017 and into 2018. They were found in various places around the country with Essex Police attempting to co-ordinate activity and work jointly, in particular with the Metropolitan Police Service, to safeguard her.

7.23 In January 2018, Angel turned 18 and thus the CAWN expired. In March 2018, Angel reported being severely assaulted by Steven and efforts were made to arrest him by both Essex and the Metropolitan Police. He was still wanted by police for these assaults at the time he murdered her.

8 Key issues arising from the Review

8.1 This was a very complex review; the overview report running to nearly 150 pages plus appendices. The review panel make no apology for the level of scrutiny around this case, Angel's life and the circumstances surrounding her death deserved that level of attention.

8.2 It is clear that a number of individuals within a range of agencies worked hard to care for, protect and ultimately safeguard Angel from the clear risk that Steven posed. Other members of staff worked similarly hard to prevent Steven from reoffending. Despite all those efforts, Angel still died at his hands. This review has sought to understand how that happened.

8.3 There is clear evidence that Angel suffered domestic abuse at the hands of Steven before being killed by him. The various aspects of domestic abuse present in this case are discussed within the overview report. She lived in fear of him, suffered physical and sexual abuse and there is clear evidence of misogynistic and controlling behaviour by him towards her.

8.4 Angel was a subject of Multi-Agency Risk Assessment Conferences (MARAC) in relation to Steven. She also featured in Missing And Child Exploitation (MACE) meetings, again in relation to Steven and a group of associates.

8.5 Steven was subject to Multi Agency Public Protection (MAPPA) meetings because of the risk he posed to the public and in particular to females with whom he became involved.

8.6 There is little evidence of any of these meetings being joined up, with each identifying actions without sight of each other's.

8.7 The fact that Angel was spending much of her time across two different police force boundaries and across various local authority boundaries hindered efforts to arrest Steven and support her at times.

8.8 Those supporting and caring for Angel were not always consistently invited to meetings about her care, resulting in important information that may have helped them support her simply not being known by their staff.

8.9 On the occasions when Steven was arrested for abducting Angel it was identified that this was a time to maximise efforts to support her to break away from him. There is little evidence that those efforts actually materialised. There was also patchy understanding of the tools and powers available to protect her whilst she was in the care of the local authority.

8.10 This review has looked in depth at a range of issues present in this case, namely:

- Did Angel's background contribute towards her vulnerability?
- The support offered to Angel during the scope of the review.
- Was Angel considered a child or an adult?

- Adverse Childhood Experiences and Trauma-Informed Care/Practice.
- Child Sexual Exploitation (CSE).
- Safeguarding of Angel.
- Liaison between Essex Police and Metropolitan Police Service.
- Steven, his background, offending and efforts to prevent his offending.
- Preventative Orders.
- Why did Angel not feel able to leave the relationship?
- Southend, Essex and Thurrock's approach to tackling domestic abuse.

8.11 The review makes recommendations across a range of agencies that we believe will make the future safer for others.

9 Conclusions

9.1 This case relates to the murder of a young woman, Angel, whose life was viciously taken shortly after her 18th birthday.

9.2 Angel was a much-loved sister and daughter. Although she was not able to live with her family, they were very important to her, and she had regular contact with them over the years. She would always attend family parties and functions.

9.3 Angel was described as a young lady who was funny and scatty. Her sister talked with great love and affection of her. She said Angel did not care what she said, or what she looked like. She was a free spirit. She and Angel would speak often on Facebook video calls and were very close. She said Angel was a happy person and fun to be around. There is one expression that almost everyone used to describe Angel which was 'bubbly'. She was full of life and sociable. She was very caring.

9.4 She was murdered by a man, significantly older than her, who demonstrated considerable manipulation, power, control, and violence towards her for almost all their relationship. A relationship that began just after her 17th birthday.

9.5 All involved in this review have been touched by Angel's story, and this has fortified their efforts to learn from this review and make a difference.

9.6 There had been substantial prior involvement across a range of agencies with both Angel and Steven, individually, before they met. Once it became known that they were in a relationship, efforts were made across agencies to protect her. Sadly, those efforts failed.

9.7 Angel had been a looked after child in the care of the local authority since she was 6 years old. She had suffered significant trauma in her young life and grew up in foster placements and care facilities. She moved to semi-independent living around her 17th birthday. It is through other residents in that placement that she met Steven.

9.8 Angel's murderer was known to the authorities as a violent man. He had previously served terms of imprisonment, which included a sentence for a serious assault on a previous partner who lost the sight in one eye.

9.9 This review does not doubt the individual efforts made by staff from various organisations who recognised the danger that was posed to Angel by Steven and attempted to protect her. The fact that risk was identified, a range of mechanisms were used to try and mitigate it, and

yet still she was murdered, is a sad reflection that those mechanisms did not work in this case. The system in place to safeguard a young woman such as Angel, simply failed. This review has sought to identify why.

9.10 This case, and the issues identified, must be used to learn from to protect others who find themselves in a similar position to Angel. In particular, by understanding the effect of childhood trauma and how it may manifest itself in behaviour as children grow. It must improve information sharing across agencies about those who are most vulnerable. It must also be used to ensure that efforts to intervene with perpetrators similar to Steven who present a clear risk of serious harm are joined-up across areas, and that the tools available are used more effectively.

9.11 We believe the recommendations contained within this review will better protect others in the future.

10 Lessons Identified

10.1 **CHILDREN'S SOCIAL CARE**

10.1.1 All those in CSC who had worked with Angel spoke warmly of her and all felt that the move from the residential unit was too soon for her, and that it is possible that this would not happen now. Having said that, at some point she would have needed to move from a residential placement and many young people move to semi-independent accommodation successfully. For example, when she moved from the residential placement, she could not cook more than beans on toast which, at the age of 17, is concerning.

10.1.2 A formal joint review of the history of Steven, with all services involved with Angel and Steven, may have enabled a more effective disruption plan for Steven to be developed and implemented. While the focus of CSC led forums, such as MACE, traditionally focuses on the young person referred, it would have been a useful exercise to have mapped out how Steven had previously behaved and was arguably likely to continue to behave.

10.2 **ESSEX POLICE**

10.2.1 The review is aware that the time covered by this review was one of significant organisational change within Essex Police. In 2015 and 2016, Her Majesty's Inspector of Constabulary (HMIC) published two reports following inspections of Essex Police. These are mentioned here within the lessons learned as, although the lessons arise from those inspections rather than this review, they cover issues highlighted in this review and therefore are pertinent.

10.2.2 In December 2015, the HMIC inspection rated Essex Police as 'inadequate' at protecting from harm those who were vulnerable, and for supporting victims. The report highlighted weaknesses in the force's approach to victims of domestic abuse, its response to missing and absent children, and its preparedness to tackle CSE.

10.2.3 The second report in March 2016, recognised that whilst protecting vulnerable people was a priority for Essex Police and that there was a strong commitment to improvement, with significant embryonic change underway, the force was still not adequately protecting all children who were at risk, due to widespread, serious, and systemic failings. The report

made several recommendations, some of which it recognised were already being implemented within the force.

10.2.4 The review notes that these reports led to significant change to the structure of the Crime and Public Protection Command, including the introduction of the Operations Centre and incorporating the Assessment Team and CSE Triage Team. Equally significant, work was undertaken to bring about cultural change within the organisation, aimed at ensuring frontline operational officers and staff were able to recognise vulnerability in its various forms, including where it may result in domestic abuse and CSE. Increased emphasis was placed on effective recording, information-sharing and risk assessment, and all officers were required to undergo mandatory training.

10.2.5 The changes made in force were recognised in a statement released by the HMIC's Lead Inspector to coincide with the March 2016 report. This statement highlighted a sea change in approach, with the protection of vulnerable people, especially children, being the force's top priority. The statement recognised the changes that had been made and the additional investment in the number of staff working to protect children.

The review notes that subsequent HMIC PEEL Effectiveness Inspections have recognised the improvements undertaken and have rated the force as good at keeping people safe and reducing crime. For this reason, recommendations have not been made to all the missed opportunities, acknowledging that significant changes have been made.

The review has highlighted several learning opportunities for the force, but it is acknowledged that there were examples of good work and a genuine desire by individual officers and staff to support and help Angel.

10.2.6 Key to the learning for Essex Police is how the force can more effectively and proactively manage Violent Offenders (category 2 and 3 MAPPA nominals), how the force can ensure that relevant intelligence is shared with other forces when a child at risk of exploitation and/or domestic abuse moves, and how the force investigates and manages outstanding high-risk offenders to ensure suspects are arrested.

The review considers that despite the involvement of several specialist teams, there remained a lack of strategic oversight and thinking. Each missing episode, CAWN breach, or assault was investigated as a standalone offence and, whilst information was shared with CSC and referrals were made to MACE and MARAC, there was not at any point a step change in how the force viewed and then managed the cumulative risk which developed during 2017 and 2018.

10.2.7 Whilst the ability that Essex Police had to work directly with Angel and address the underlying factors which may have caused her to go missing and to place herself in high-risk situations and relationships might be considered to be limited, the opportunity to disrupt Steven's offending was there. Opportunities were not taken to deploy additional investigative resources, to ensure all potential offences were pursued with vigour and to secure protective orders. All these disruption methods had the potential to impact on Steven's offending behaviour and reduce the risk posed to Angel.

10.3 BASILDON AND THURROCK UNIVERSITY HOSPITAL

10.3.1 This case highlights the importance of CSC notifying the hospitals of all Looked After Children (LAC), as this impacts on future care and onward referral.

10.3.2 The review also notes that Basildon Hospital ensures that, when a child discloses that they are LAC, checks are made with the hospital systems and if they do not have this registered, contact should be made with CSC to verify this and gain all relevant information.

10.3.3 It is imperative that safeguarding referrals are completed in a timely way, especially when the patient leaves before they are seen.

10.3.4 It is important that a safeguarding referral is completed, even if another agency has documented that they have done this.

10.3.5 The importance of referring patients to other specialist services.

10.4 EAST SUFFOLK AND NORTH ESSEX FOUNDATION TRUST (COLCHESTER HOSPITAL)

10.4.1 It was noted, by the IMR author who examined the individual records for Angel's attendances, that it was difficult to identify the practitioners who treated Angel due to the illegibility of the signatures and designation against some of the record entries. The review is satisfied that on this occasion there was no need to speak to those involved in Angel's care, and that these issues have already been addressed within the hospital. Therefore, no recommendation was made in respect of this.

10.5 GP SURGERY IN ESSEX

10.5.1 All out-of-hours letters, A&E attendances, and letters from secondary care should be reviewed by a clinician, and any safeguarding concerns should be shared with the safeguarding Lead within the practice.

10.5.2 Patients who have documented risk factors/safeguarding concerns should always be offered new patient clinical assessments after their records are reviewed by a clinician.

10.5.3 When a child with safeguarding concerns leaves a practice, carers and social workers should be notified when reregistration at another practice does not take place in a timely manner.

10.5.4 Patients with safeguarding concerns should be appropriately flagged on the clinical system.

10.6 GP SURGERY IN LONDON

10.6.1 It is accepted that, as Angel had not long been registered at the practice, it was highly likely that her medical records had not yet been received from her previous GP. However, it appears from the GP records that when Angel saw the GP on 5th March, an opportunity was not taken to explore and discuss some of the riskier behaviours that Angel had been engaging in since her previous appointment. This would suggest that either:

- The GP did not access the information available prior to, or during, the consultation or
- The GP was aware of the information available and, for some reason, elected not to discuss this with Angel.

10.6.2 Had the GP discussed these issues with Angel, the most likely outcome would have been signposting Angel to local services such as domestic abuse services or substance misuse services.

11 Recommendations

11.1 Agencies are responsible for completing the actions agreed through the DHR: this includes providing updates to Basildon CSP and the SET DA Team. Basildon CSP is responsible for ensuring the action plan is implemented and the SET DA team will be responsible for monitoring and updating the action plan with updates provided to the SET Strategic Development Group (SETSDG). This will include flagging where actions are not completed.

11.2 **BASILDON THURROCK UNIVERSITY HOSPITAL**

11.2.1 That Basildon Hospital reviews its flagging alert system to consider domestic abuse.

11.2.2 The review is aware that work is ongoing to identify long-term funding for an IDVA service in hospital settings. It is recommended that Basildon Hospital continues to explore how this service, which the review considers to be a crucial safeguarding role, will be funded in the future.

11.2.3 That Basildon Hospital use this case to further enhance education around domestic abuse, mental health, and the importance of correct and adequate referrals.

11.2.4 That Basildon Hospital reviews all its training to bring it into line with the Inter Collegiate Document for Adults to ensure that up-to-date training is provided to staff in relation to safeguarding.

11.2.5 That the Named Nurse for children's safeguarding facilitates an audit of Child Protection Information Sharing (CP-IS). This would ensure that the system is running effectively.

11.2.6 That Basildon Hospital and the wider Mid and South Essex (MSE) group review its current audit programme to ensure that any learning recommendations from this DHR are implemented.

11.3 **EAST OF ENGLAND AMBULANCE SERVICE TRUST (EEAST)**

11.3.1 That those responsible for implementing access to CIPS within the service are made aware of this review and the implications.

11.4 **ESSEX CHILD AND FAMILY WELLBEING SERVICE (ECFWS)**

11.4.1 That LAC Nursing Teams/Lead Health Professionals for ECFWS should escalate concerns to allocated SWs when health recommendations are not followed (for example, when advice is given to LAC to attend A&E and this does not happen).

11.4.2 That ECFWS has an internal process of escalation when practitioners are not able to make contact with partner agencies in relation to safeguarding/LAC concerns.

11.5 **ESSEX COUNTY COUNCIL – CHILDREN'S SOCIAL CARE**

11.5.1 That the existing practice guidance is enhanced to ensure that the role of Independent Reviewing Officer (IRO) is strengthened specifically with reference to MACE and MARAC. This should include an expectation that the plans made will be shared with the IRO and that the most appropriate representative from CSC will attend multi-agency meetings.

11.5.2 The review is aware that Leaving and Aftercare Staff have access to a full training package regarding domestic abuse, but it is recommended that further training is provided to Leaving Care practitioners on the impact of domestic abuse on teenagers, and to refresh their knowledge on the range of legal powers available to disrupt Steven.

11.5.3 That guidance is developed for practitioners to raise awareness of the impact of domestic abuse and having a disability, such as a hearing impairment.

11.5.4 That services commissioned by Essex County Council to provide semi-independent accommodation, include a requirement for all staff to be trained in domestic abuse, emotional wellbeing, and trauma.

11.6 **ESSEX MAPPA**

11.6.1 That consideration is given to Core Groups being developed to manage those individuals (both victims and perpetrators) who are being considered at multiple safeguarding meetings, such as MARAC, MAPPA and MACE, to allow these individuals to be jointly case-managed.

11.7 **ESSEX POLICE**

11.7.1 That Force Missing Persons Procedure should be reviewed to reflect the requirement to consider the use of specialist staff, including Missing Person Liaison Officers (MPLOs) and Children and Young People Officers (CYPOs), to conduct vulnerability interviews with frequent missing children. Additional emphasis should be placed on the need to conduct interviews not only in a timely fashion, but also by appropriately trained specialist staff, in the right circumstances, so as to maximise the opportunities to support the child, gather relevant information, and prevent further missing episodes.

11.7.2 That guidance is reissued to ensure that officers are aware of the requirement to complete the Police Information Report (PIR) in respect of all found high-risk missing persons and children under 18.

11.7.3 That Force Child Abuse Investigation Procedures are reviewed to include the requirement of a standardised CSE risk assessment recording process, which provides a full audit of the assessment. It is recommended that this is used in all cases where a CSE risk assessment is conducted, and thereafter uploaded to Athena.

11.7.4 That where an offender is within MAPPA, responsibility for applications for Violent Offender Orders (VOO), and similar civil protective orders, should sit with specialist staff within Management of Sexual and Violent Offenders (MOSOVO). MOSOVO staff should take the lead in liaising with Essex Police Legal Department and applying for such orders.

11.7.5 That a dedicated cohort of staff should be identified and provided with training in the management of violent offenders and legislation relating to protective orders: they should then lead in this area.

11.7.6 That the use of emails to disseminate MARAC initiated actions should cease, with the Task function in the crime recording system being utilised. The actions should be added to the system by officers upon receipt of the minutes.

11.7.7 That further guidance is issued to ensure that all investigative and safeguarding tasks passed between Commands, Departments and Teams are made subject to Athena Tasks.

11.7.8 That staff working within Crime and Public Protection, as well as MPLOs and CYPOs, should receive additional awareness training regarding the use of Domestic Violence Protection Notices (DVPN), Domestic Violence Protection Orders (DVPO), VOO, and other protective orders, to ensure awareness of the circumstances in which these orders can be obtained.

11.7.9 That Essex Police should review existing procedures for the completion, management and storage of Trigger Plans.

11.7.10 That Essex Police review staff levels within the MOSOVO teams in order to ensure that these teams adopt an effective, proactive and investigative approach to the management of dangerous offenders, in line with authorised professional practice (APP).

11.7.11 That a review is undertaken of the existing force procedure MOSOVO (B1410), with a view to clarifying which aspects of offender management fall within the remit of MOSOVO and which should be managed elsewhere. This should include clearly defining roles and responsibilities for staff working in MOSOVO, and the inclusion of guidance on tactical options for the management of Violent Offenders.

11.7.12 That the Force lead reviews existing working practices to ensure that appropriate structures, procedures and processes are in place, to enable effective information sharing and working between forces regarding CSE and Child Abuse investigations. It is also recommended that a new procedure should be developed for the handover of relevant information when a child at risk of CSE, or criminal exploitation, is known to have moved to another force area.

11.7.13 That Essex Police and Essex CSC use the circumstances of this review to consider how best to safeguard a LAC when they are known to have moved to another geographical area outside of the Essex services boundaries.

11.7.14 That the force reviews the existing procedures for the management of outstanding high-risk domestic abuse offenders, and other high-risk offenders, to ensure effective oversight. It is recommended that the force ensures that investigators managing such investigations have awareness of the full range of investigative tactics, including specialist support from within the Serious Crime Directorate.

11.8 ESSEX YOUTH OFFENDING SERVICE (YOS)

11.8.1 The review is advised that Essex YOS now follows a more strength-based approach so that this positive factor would now have more focus. It is recommended that a dip sample of recent cases is undertaken by Essex YOS to reassure SETDAB that the expected changes have been achieved.

11.8.2 That dip sampling of more recent cases is undertaken by Essex YOS to reassure the SETDAB that these changes have resulted in the expected improvements to the recording of 1-1 contact.

11.9 **METROPOLITAN POLICE SERVICE**

11.9.1 BCU Level – EA BCU Senior Leadership Team (SLT)
That EA BCU SLT remind officers and supervisors, concerned with this case, of the need to ensure that a MERLIN report is created in all safeguarding children cases to document a full record of information shared with partner agencies and county forces.

11.9.2 BCU Level – EA BCU Senior Leadership Team (SLT)
That officers are reminded of their responsibilities for crime recording of domestic abuse incidents.

11.9.3 BCU Level – SE BCU Senior Leadership Team (SLT)
That officers are reminded of the importance of thorough intelligence checks in addition to their responsibilities in relation to the assessment of VAF criteria.

11.9.4 BCU Level – SE BCU Senior Leadership (SLT)
That all officers are reminded of the MPS DA Policy and VAF policies.

11.9.5 MPS Lead Responsible Officer (LRO) for CSE
That staff have a clear understanding that any CSE subject residing within MPS requires an active CSE report for assessment and monitoring of SET.

11.9.6 MPS Learning and Training – MPS Lead Responsible Officer (LRO) for CSE – Central Specialist Command (CSC)
That the process for transferring CSE subjects from area to area, as well as in and out of MPS, is clarified and delivered to all staff. Understanding must be clear for all staff that any CSE subjects residing in the MPS, requires an active CSE report for assessment and monitoring by CSC.

11.10 **NATIONAL GOVERNMENT**

11.10.1 That the Government introduces national standards for provision for 16 and 17-year-olds.

11.10.2 That the Home Office work with the College of Policing to ensure that all Forces have a shared understanding of protocols in place when children at risk of CSE are moved across local authority and policing areas.

11.11 **NATIONAL PROBATION SERVICE – SEE DIVISION**

11.11.1 That NPS reminds all authors of Pre-Sentence Reports (PSR) of the need to consider Building Better Relationships (BBR) when making recommendations for those who have past offences related to intimate partner violence and/or present a high risk of violence to partners.

11.11.2 That Essex CRC assures itself that all staff have read and can demonstrate a working knowledge of the policies and guidance relevant to their role, and notes that a number of workshops and briefings have already taken place around professional curiosity and an

investigative approach. (Following reunification of the services in June 2021, this will be taken forward by NPS).

11.12 **NORTH EAST LONDON FOUNDATION TRUST (NELFT)**

11.12.1 That consideration of referral to specialist services needs to form part of every assessment where there are identified concerns about substance misuse.

11.12.2 That the Service Manager investigates the missing notes and takes the necessary action with the staff involved.

11.12.3 That practitioners are reminded of the need to complete contemporaneous notes.

11.13 **NORTH GREENWICH CCG ON BEHALF OF GP SURGERY**

11.13.1 That the GP surgery reflects on this case to ensure that GPs are aware of any significant risks with their patients that have been reported by other agencies.

11.13.2 That NHS Greenwich CCG delivers training to all GPs within the borough on domestic abuse. This should be actioned through the implementation of the IRIS[5] programme in Greenwich, which is planned for the second half of 2020/2021.

11.14 **SETDAB**

11.14.1 That SETDAB ensures that all commissioning bodies are aware of this review's recommendation that when services move from one provider to another, the commissioner ensures that a copy of policies and SOPs, along with all staff training records, is transferred to the new provider.

[5] Identification and Referral to Improve Safety