1 'Anna' Review

Luton Safeguarding Adults Board and Community Safeguarding Partnership commissioned this joint Domestic Homicide and Safeguarding Adult Review following the death of Anna, a white British woman, aged 35.
The report examines agency responses and support given to Anna, a Luton resident prior to the point of her death. The report includes relevant details from her past to understand the trail of abuse she experienced before her death, whether support was accessed within the community and whether there were any barriers to accessing support.

2 Background to the Review

As a child Anna had been taken into the care of Luton Borough Council having suffered sexual abuse. She was known to be at high risk of sexual exploitation and suspected of being involved in sex work since she was a teenager. In the two years preceding her death Anna had told professionals that she did not feel safe residing with two known associates ('AB' and, later, 'CD') as they pressured her for sex. She had also complained of threats of violence and intimidation from a previous partner's family, and gang related violence linked to sex working. Anna was accessing psychological and opioid substitution therapy with ResoLUTiONs and was also known to the homeless team at the Council.

3 What happened?

Anna contacted the police to report she was the victim of domestic abuse. She advised that she was frightened as she didn't want to become homeless. She asked that the police attend later in the day when CD would have gone to work. Police provided an immediate response, and she refused to speak with them, and CD denied they were in a relationship. Later that day Anna was found by AB unresponsive in the garden of CD's house. She died at the scene by suspected suicide.

4

System Finding 1: Currently there are pockets of good practice to recognise harm caused by sexual exploitation, but this is not routinely applied to adults. Practitioners from across public health, housing and criminal justice agencies are not always able to provide trauma-informed responses or formulate holistic protection plans informed by the wider welfare duties.

5

System Finding 2: Understanding on the risks of domestic abuse and sexual exploitation for women involved in sex work is currently limited to small pockets of specialist teams. Those involved in completing statutory assessments in respect of Anna's needs did not act on indicators of adult sexual exploitation and domestic abuse and there were inadequate opportunities to draw together what was known or reasonably suspected across partner agencies.

6

System Finding 3 Whilst there is recognition that a 'team around the person' approach is good practice, this is developing in a piecemeal fashion and dependent on individual agencies to make arrangements. Developing this as a strategic system-wide approach would enable more consistency of practice to develop, support more effective protection planning and better manage demand across the system.

7

System Finding 4 The primary focus of the current structure of mental health services is on people presenting with psychosis and there are serious gaps in service for those experiencing emotional dysregulation often associated with adverse childhood experience and trauma, a key factor in Anna's case.

Further information on the practice improvements and practice resources can be found here: here:

Information on other Safeguarding Adults Reviews can also be found on the LSAB website here:

Luton Safeguarding LSAB Adult Board
Working in partnership to protect adults at risk