Overview Report

Domestic Homicide and Safeguarding Adults Review following the death in January 2022 of 'Anna'

Independent Reviewers: Fiona Bateman and Sarah Williams

Independent Safeguarding Consultants, Safeguarding Circle

Completed in May 2023

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1. Introduction

1.1 Luton Safeguarding Adults Board and Community Safeguarding Partnership [hereafter referred to as the 'Partnership Boards'] commissioned this joint Domestic Homicide and Safeguarding Adult Review ['DHR/SAR'] following the death of Anna, a white British woman, aged 35. This review will be conducted in line with the statutory guidance under s9(3) of the Domestic Violence, Crime and Victims Act 2004 and the final review report and executive summary will be subject to oversight from the Home Office Quality Assurance Panel. The final report will also be shared with the CSP, LSAB and Local Safeguarding Children's Partnership.

1.2 Throughout this report the pseudonym 'Anna' is used to protect the identity of the individual involved; it was suggested by those who knew her as a name she always liked. This report examines agency responses and support given to Anna, a Luton resident prior to the point of her death. In addition to agency involvement during the review period, 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. By taking a holistic approach the review seeks to identify appropriate solutions to make the future safer for women experiencing similar forms of abuse to Anna.

1.3 As a child Anna had been taken into the care of Luton Borough Council ['the 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. In January 2022, she was accessing psychological and opioid substitution therapy with ResoLUTiONs[1] and was also known to the homeless team at the Council. She had previously requested help from the Community Mental Health Team but had been discharged back to the care of her GP and ResoLUTiONs after she failed to attend appointments. Anna also attended Azalea's drop-in, a charity that works to support and empower people who are experiencing sexual exploitation. On the 03.01.22 Anna had 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 were, however, advised by the 999 call-handler to provide an immediate response, whereupon 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. A subsequent police investigation concluded there was no third-party involvement in her death.

1.4 Those who knew Anna described a likeable and charismatic person who was kind and protective to other women involved in sex work. It was clear to them that she was a very bright, strong person and aspired to change and leave her situation. Equally, they were aware of her very changeable presentation. They explained her behaviour could fluctuate very quickly, explaining that this is common for women experiencing sexual exploitation as disassociation is one coping strategy. Often, she presented with vulnerable, disempowered and tearful behaviour. At other times she could be quite violent, directed usually at sex buyers. It wasn't clear (even to those who knew her) what would trigger the change in her behaviour.

1.5 We wish to express our sincere condolences to all those who knew Anna for their loss. The reviewers are also very grateful to practitioners who worked with Anna for their insight into the challenges in trying to support her stay safe. In particular we would like to thank staff, volunteers and especially clients from Azalea who supported this review by speaking with us and sharing so candidly their thoughts on what could make a meaningful difference to reduce future deaths.

2. Scope of Review

Purpose of a Domestic Homicide or Safeguarding Adult Review

2.1. Luton's Partnership Boards agreed to commission this as a joint review, cognisant that it met the criteria for both a Domestic Homicide Review ['DHR'] and Safeguarding Adult Review ['SAR']. The review will consider agencies' contact or involvement with Anna and perpetrators of exploitation from January

[1] Part of the Change, Grow, Live Charity working in Luton to support people with drug and alcohol dependency.

2020 until her death in January 2022. This period was identified as crucial as it was during this timeframe that she requested assistance from partners agencies and notified practitioners about the abuse and exploitation she experienced.

2.2. The key purpose for undertaking a DHR is to enable lessons to be learned from deaths where a person experienced domestic violence and abuse and their death was linked to that abuse. SAR reports help us to understand how agencies can work more effectively to recognise and respond when an adult with care and support needs is unable to protect themselves from abuse, neglect or exploitation. For these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each death, and most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future.

2.3. There is a strong focus in this report on understanding the underlying issues that informed agency and professionals' actions and what, if anything, prevented them from being able to help and protect Anna from harm.

Themes

2.4. The Domestic Abuse Act 2021 clarified the different relationships within which domestic abuse can occur. It confirmed any abusive behaviour that occurs between two people (16 or over) who are 'personally connected' to each other should now be responded to as domestic abuse. This includes people who are, or have been, in an intimate relationship, shared a parental relationship and any relatives.

2.5. The 2021 Act also introduced new measures designed to '*drive consistency and better performance in the responses to domestic abuse across all local areas, agencies and sectors*'.[2] Section 78 of the 2021 Act amended 189(1)(e) Housing Act 1996 to ensure that '*a person who is homeless as a result of that person being a victim of domestic abuse*' will have a priority need for accommodation. This change was made to reflect the reality that homeless women are particularly vulnerable to being further targeted by perpetrators of both physical and sexual abuse, with 28% of homeless women having formed an unwanted sexual partnership to get a roof over their heads and 20% having engaged in sex work to raise money for accommodation.[3]

2.6. The review will seek to illuminate:

- How well do practitioners from across the health, mental health, housing, social care and criminal justice agencies understand the impact of trauma and coercion on decision making and adapt their usual work practices to ensure that responses and interventions are effective for women at high risk of, or experiencing, sexual exploitation and domestic abuse?
- How confident are practitioners in applying the three-stage test under s42(1) in circumstances where an individual's ability to protect themselves may be impacted by coercion, trauma or the normalisation of violence and/or sexual exploitation?
- Do practitioners know who they can turn to for expert advice and support (including through a trusted assessor approach) in these areas if an adult is at risk but inconsistent in their engagement with statutory assessment processes?
- What are the local pathways to support adults at risk of homelessness who experienced abuse as children?
- How well does commissioning function across the partnership to facilitate identification or creation of accommodation-based support that can meet complex needs, and how responsive is this to periods of crisis?
- How does local availability of resources impact on care planning, prison and hospital discharge and safeguarding?

[2] https://www.gov.uk/government/publications/domestic-abuse-bill-2020-factsheets/domestic-abuse-bill-2020-overarching-factsheet
[3] Domestic Abuse: Draft Statutory Guidance, 2022 Home Office pg177.

Methodology and statement of reviewers' independence

2.7. On the 23.03.22 LSAB completed a 'rapid review' into the circumstances of Anna's death identifying several areas for further investigation. Members of the rapid review panel[4] recognised that there were important lessons for the partnership in respect of assessing and responding to risks for adults experiencing sexual exploitation. Following completion of the actions from that meeting and discussions with the Community Safety Partnership a decision was made to jointly commission this review in September 2022. Unfortunately, the Partnership Boards could not find suitable reviewers to complete this within relevant timescales. A second expression of interest was sent regional leads on the 28.09.22. Applications were reviewed in November 2022.

2.8. In December 2022 the Partnership Boards commissioned Safeguarding Circle LLP as independent reviewers. Fiona Bateman and Sarah Williams are solicitors and safeguarding experts who have considerable experience undertaking statutory practice reviews to identify systems learning and prevent future harm. Both are independent of the Partnership Boards and have no direct association with any of the agencies involved in this review in the past or currently.

2.9. Reviews should be completed, where possible, within six months of the commencement of the review. The Partnership Board agreed to commission this joint review following the conclusion of an Inquest in March 2022. The Coroner provided a narrative verdict, concluding that she died of misadventure. There are no outstanding police investigations or parallel legal proceedings in connection with her death.

2.10. The Reviewers were supported to complete this review by the review panel, the membership of which is listed below. The panel met initially on the 01.12.22 to agree terms of reference, the methodology and panel membership. Panel members confirmed they were independent and had not previously been involved in the case or had responsibility for line managing staff supporting Anna.

Name	Organisation/Title
Beverley McConnell	Strategic business manager for the Luton Safeguarding Adults Board and Luton Safeguarding Children Board ['LSAB/LSCB']
Julie Porter	Development and Improvement Officer, LSAB/LSCB
Armstrong Mvura	Population Wellbeing, ASC MASH Team Manager, Luton Borough Council ['LBC']
Samantha Parker	Adult Social Care Strategic Safeguarding & Integration Manager, LBC
Sancha Thomas	Children's Social Care, Head of Service, Strategic safeguarding, Quality Assurance and Practice Improvement, Principle Social Worker, LBC
Sarah Markham	Head of Housing Operations, LBC
Emma Koroma	Deputy CEO, Azalea
Ruth Robb	Director/Co-founder, Azalea
Jennifer Melrose	Deputy Operational Lead, Luton Sexual Health Services
Katherine Rivers	Detective Inspector, Bedfordshire Police
Marie Gresswell	DCI Lead for Strategic Partnership and Learning, Bedfordshire Police
Lisa Baker	Domestic Abuse Strategic Manager, LBC
Nicholas Dunkley	Deputy service manager and designated safeguarding lead, Resolutions

[4] Namely the LSAB independent chair and board team, Luton Council's strategic leads for safeguarding and integration, Head of housing needs and area projects and involvement officer, Bedfordshire police domestic abuse detective inspector, CCG's named adult safeguarding nurse, Herts Urgent Care- Head of nursing, ELFT adult safeguarding named professional and Head of Safeguarding, ResoLUTiONs deputy service manager.

Joy Leighton	Luton Victim Support,
Dermott Flynn	Named Professional Adult Safeguarding, East London Mental Health Foundation Trust
Patricia Bowles	MASH Nurse Safeguarding BLMK, BLMK H&CP
Toni Nye	Head of Safeguarding, Keystage Housing:
Fiona Bateman	Safeguarding Circle: Independent Reviewer
Vicky Sowah	LBC: Principal Solicitor Social Service and Advisor to the Board

2.11. The review was undertaken in compliance with expectations set out within Statutory Guidance.[5] It also incorporates tools from the Social Care Institute for Excellence Learning Together and SAR In Rapid Time methodology. The learning produced concerns 'systems findings'. Systems findings identify social and organisational factors that make it harder or make it easier for practitioners to proactively safeguard in response to domestic abuse, within and between agencies.

2.12. On the 21.02.23 panel members met again to review information provided by agencies listed in the table below to support the Review. In addition, Luton and Dunstable Hospital Trust, Cambridgeshire Community NHS Trust, HUC (111) NHS Service and NOAH Welfare Centre, who confirmed they had either very little or no contact with Anna or the alleged perpetrators AB and CD. By this time information had been collated into an early analysis report to facilitate a system wide view of activity with Anna. This report identified themes emerging and correlated this to learning from national best practice or learning reviews with similar issues.

Agency	**Documentation provided**
Luton Borough Council	Summary of Agency Information and involvement from Children Social Care, Adult Safeguarding Team and Housing Needs
ResoLUTiONs	Summary of Agency Information and involvement
East London NHS Foundation Trust	Summary of Agency Information and involvement
Bedfordshire Police	Summary of Agency Information and involvement with 'Anna'
Bedfordshire Police	Summary of Agency Information and involvement with 'AB
Bedfordshire Police	Summary of Agency Information and involvement with 'CD
Luton SAB	Rapid Review minutes
Bedfordshire, Luton and Milton Keynes ICB	Summary of Agency Information and involvement, including GP
East Midlands Ambulance Service	Summary of Agency Information and involvement
Azalea	Summary of Agency Information and involvement
HARRP	Summary of Agency Information and involvement

[5] Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews, Home Office, 2016 available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/575273/DHR-Statutory-Guidance-161206.pdf

2.13. In addition, multi-agency learning events took place, both with front-line practitioners who worked with Anna and the leaders who oversaw the services involved in supporting them. Fiona Bateman also accompanied outreach professionals from Azalea to meet with woman who knew and worked alongside Anna in sex work. The reviewers and panel are extremely grateful to those women for their contribution to this review. Their insights into what is needed to keep them safer in Luton is valued and has therefore directly shaped the recommendations detailed below.

2.14. The panel met again on the 12.05.23 to review a draft report. On the 19.05.23 the Partnership Board's Case Review Group reviewed the key findings and provisional recommendations. At this meeting partners agreed to consider how their agencies would respond in order to prevent future harm by providing details of the actions they would take in response to the recommendations.

2.15. The Panel met again on the 31.05.23 to ratify and agree the action plan. This is included within Appendix B.

2.16. The report will be published by the Safeguarding Adults Board in August 2023 and shared with the Community Safety Partnership as well as their constituent partners.

Involvement of Anna's family

2.17. Extensive attempts were made by the Partnership Board teams and panel members to identify Anna's family members and wider social support network. This included reviewing all historic case notes held by the Council and by police dating back to her date of birth. This information identified details of known personal relationships, and the difficulty she experienced in those relationships, which have informed the chronology below. It was not possible, however, to find contact information for any family members or significant personal friendship. Panel members who knew Anna spoke too of how guarded she was of her past childhood experiences and about how attempts to discuss with her family or personal support networks triggered obvious distress.

2.18. Whilst it is acknowledged that throughout this period she resided with AB and CD, given their role in likely perpetrating abuse, it was not felt appropriate to consult with them to ascertain insights into her experiences.

2.19. The partnerships are therefore grateful for the active involvement from Azalea and, specifically, the women they support which enabled the reviewers to ensure her voice has inform this report. The panel were also acutely aware, and wished to draw attention to, how isolated Anna was and how alone she must have felt.

3. Narrative Chronology

3.1. As a child Anna was taken into the care of the local authority,[6] having suffered sexual abuse. It was believed that she had contact from a very young age with AB[7] and therefore is likely to have experienced sexual exploitation or been involved in sex work since she was a teenager.

3.2. It is understood that she left foster care in 2002 and moved around different supported accommodation. She spent some time living with a sibling, but no contact details could be found for her. Throughout this period, Anna was offered but struggled to effectively engage with specialist services including a Foyer placement and Drug and Alcohol support. She turned 18 in 2004, when legal obligations for local authority social care to provide additional support to young adults 'leaving care'[8] were in their nascency. At the time, the Council's children social care department provided on-going support to care experienced children to help prepare them for adulthood through a 16+ team. She remained on the team's case list until 2007, when she turned 21. The team manager (now employed by LBC as an Independent Reviewing Officer for care experienced young people aged 17-25) remembered Anna. He confirmed that whilst support was offered to her throughout her young adulthood, she engaged with their support very sporadically and on her terms. At the time, the team used a 'vulnerable care leavers protocol' to identify vulnerabilities and target support designed to reduce risk and maximise

[6] It is understood that this was in line with duties under s20 Children Act 1989, rather than through court proceedings under s31 Children Act.
[7] Her father was arrested in 2011 for assaulting AB and accusing him of paedophilia.
[8] Leaving Care obligations are owed to all care experienced young people aged 16 and 17 who have been looked after for at least 13 weeks after they reached the age of 14. Responsibilities for planning continuing support applies to all care leavers at least until they reach the age of 21. These are set out in s23A- 24D Children Act 1989.

independence. This was completed with Anna. Having reviewed her case file, he explained that social care staff had suspicions she was misusing drugs and engaged in sex work. They had put in place some risk mitigation (for example, offering financial support by purchasing necessary items rather than providing her with cash), but accepted that this had not ended the exploitation. Historically, until the publication of the Independent Inquiry into Child Sexual Exploitation in Rotherham in 2014 professional knowledge of and response to sexual exploitation across the UK was limited to relatively small pockets of good practice. The team manager, whilst rightly proud of the work of the 16+ team at that time, recognised a system-wide response to child sexual exploitation was not well established in Luton by 2007.

3.3. Between 2011 and 2018 Anna moved out of the area. It is understood that she was known to High Wycombe's Azalea team as someone engaged in sex work in that area. However, on her return she reported she had worked as a live-in carer. She explained she had returned to the area as her own medical needs meant she was unable to continue to work as a carer. At the time she was suffering depression and was in receipt of methadone to address a long-standing heroine and crack cocaine addiction. In 2018 she moved to reside with 'AB' who she had described as her 'former sugar daddy'. She remained living with him until the period under review and she was known to engage with sex work and continued to misuse heroin and crack cocaine. She was also known to the ResoLUTiONs outreach and recovery workers.[9]

3.4. Between 2018 and 2020 Azalea staff explained she would sometimes disappear for long periods and wouldn't be seen or attend their drop in. They understood she was involved with gangs and international and national sex trafficking. Those who supplied her with drugs also organised her sex buyers: she later reported they would lock her in rooms where she experienced numerous rapes. It was believed that she may also have been involving in grooming other women into sex work for those gangs.

3.5. At the start of this period Anna had positive engagement with ResoLUTiONs outreach and recovery workers (e.g. agreeing in January 2020 to attend the Women's Clinic). She was also supported by ResoLUTiONs to request housing assistance on the 06.02.20 and advised by the Council's Housing department to return on the 07.02.20. However, there was a delay until the 26.02.20 when she attended the housing department reporting she had left AB's address following sexual harassment. She advised she had been rough sleeping since the 23.02.20 and that she suffered from anxiety, depression and was on a methadone script for addiction. She gave a detailed account of where she was sleeping, but could not evidence she had been seen by the SoS Street Chaplin. She was informed she had not been deemed in priority need and so she was advised there was no duty to provide interim accommodation under s188 Housing Act 1996[10]. At this time, Anna was informed about the cold weather shelter, which was open at the time for 2 nights. The Council referral made to HARRP[11] and Squared Housing, though the following day Squared Housing confirmed they would not progress the referral, so Anna returned to reside with AB.

3.6. Over the next few months, she reported he frequently requested sex and that her refusal caused friction between them. She reported having to leave after a fight in March 2020, but again when she approached Housing services on the 05.05.20 (because he was no longer willing to accommodate her), she was advised she did not meet priority need test and was referred to a hostel. Her ResoLUTiONs recovery worker reported in May that she had engaged with Luton's sexual health service and wished to find a safe place to live. At that time, she was open about engaging in street sex work. Bedfordshire police also had a record her as a victim of common assault on the 07.05.20 linked to sex working. It was noted that, whilst Police responded to this assault by referring her to Azalea, this was not progressed as she did not engage with the service. The Police did not raise a safeguarding concern to the Council or any other notification of a vulnerable person coming to notice.

3.7. She was reported to have some positive interactions with Azalea's Outreach and Drop-In services. They reported Anna had engaged with their Outreach services or attended the drop-in services on the 24.02.20, 14.04.20, 28.04.20, 26.05.20, 14.07.20, 12.08.20, 21.10.20 and 16.12.20 where she would sometimes engage for a brief chat and be signposted information. They reported '*Anna was well cared*

[9] ResoLUTiONs model works within the framework of Engagement, Assessing, Early Behaviour Change, Early Recovery. Clients are usually more stable by the time they get to the Early Recovery Stage and can start accessing less specialist workers – low numbers get to this point. There is a High Intensity Assertive Outreach Team that goes into the community to promote engagement with the service.

[10] The Council found she was 'not significantly more vulnerable than the ordinary person' as defined in the housing act 1996; Homelessness code of guidance for local authorities and *Hotak **v** London Borough of Southwark'*

[11] Homeless Assessment Rapid Resettlement Pathway

for by the Outreach team and Drop-In team, she received safety measures – condoms and a rape alarm, homemade cakes and hot drinks, and contact details to encourage connecting with our Build team [daytime practical and relational support]. *Anna did not take steps toward or show a desire to engage with further support from Azalea's Build team, but she was regularly made aware of our services and encouraged to connect.'*[12]

3.8. In early June her ResoLUTiONs recovery worker reported she had lost weight and was looking pale. She reported she had moved in with CD who was known to services as someone who exploited '*female sex workers through provision of a place to stay and providing £100 daily for their drug use. Anna reports that CD has not asked her for any sexual favours yet, but she is taking his money daily and as such is expecting to have to repay this through sexual favours. Anna advised she would like her own place to live and not be indebted to a man such as CD or AB*.'[13] Her recovery worker provided her with the telephone number of the Housing department and Signpost hotel. She, CD and a third person were also trained on the 09.06.20 to use Naloxone by ResoLUTiONS recovery worker, during which Anna again requested help to find an alternative to living with CD. However, the following day (during a discussion with police involved in 'Operation Inwood')[14] she denied being a sex worker or that where she was living with CD was a brothel. On the same day she met (via telephone) the ResoLUTiONs doctor and stated she wished to work towards rehab rather than increase her methadone script. She denied any physical or mental health concerns, history of self-harm or suicide attempts.

3.9. Over the course of the next few months (until December 2020) she continued to engage with her ResoLUTiONs recovery worker who noted she continued to misuse heroin and crack cocaine daily, was losing weight and continued to 'sofa-surf' between AB and CD's houses. She also came into contact with the police on 4 occasions as a victim of burglary, theft (of her methadone), assault (threats from two men who had engaged her as an escort) and criminal damage following an altercation outside CD's house.

3.10. In February 2021 Anna reported to her recovery worker that she had moved to Bushmead and that she was no longer injecting. The following month she appeared pale, but with good eye contact, and happy to engage with her recovery worker. On the 22.03.21 she was referred to East London NHS Foundation Trust ['ELFT'] mental health services by her GP. She reported having low mood, anxiety, paranoid thoughts and having poor sleep and appetite for the preceding 18 months, but had not previously requested support. The referral was screened by Early Intervention Service (EIS). There is evidence from case notes of good cross agency communication; the EIS psychosis team liaised with the ResoLUTiONs recovery worker, advising them that she was hearing voices, and seeking to work with her recovery worker to engage Anna with ELFT. An assessment was arranged for the 1st and 12th April 2021. However, she failed to attend either assessment appointment so was discharged back to the care of her GP and to ResoLUTiONs on the 15.04.21. Her recovery worker then offered further appointments between then and the 17.05.21. Although Anna continued to access the needle exchange (attending 5 times during 01.04.21-17.05.21), she did not attend appointments or her medical review with the ResoLUTiONs doctor on the 25.05.21. She did request assistance on the 25.05.21 regarding her benefit claim and reported on the 23.06.21 that her prescription had been voided after she had missed 3+ days. She was offered a restart appointment on the 24.06.21 but did not attend. She was re-allocated a new recovery worker on the 29.06.21 and, although she continued to access the needle exchange (attending 6 times between 29.06.21-08.09.21) she did not respond positively to attempts to reengage her in treatment during that period.

3.11. On the 01.07.21 she witnessed CD being assaulted and forced to transfer money by individuals known to police. The police also visited CD's home on the 19.08.21 to investigate if the address was being used as a brothel. She refuted this.

3.12. In August 2021 Anna contacted her new recovery worker and left a message indicating she wished to discuss a safeguarding concern; this was not escalated by the worker to ReSoLUTiONs designated safeguarding lead. The following day Anna met face-to-face with a non-medical prescriber and her recovery worker. She confirmed she was using £70 heroin and £60 crack cocaine daily which she smoked and was not injecting. She was re-started on methadone and the case notes recorded no concerns regarding her mental capacity, no visual or auditory hallucinations or mental health concerns.

[12] Taken from the agencies combined chronology submitted for this review
[13] Taken from the agencies combined chronology submitted for this review
[14] investigating recent reports of attacks against sex workers by a group of eastern European men who were believed to be taking women to a house on Fredrick Street

On the 19.09.21 she attended the NOAH welfare centre asking for assistance with accommodation and on the 23.09.21 was placed in emergency accommodation.

3.13. On the 24.09.21 Anna attended Housing Solutions service requesting assistance and disclosed she had been sleeping rough for four months after fleeing domestic abuse. She reported her previous partner (AB) had been abusive and that, since his death, his brother (CJ) was stalking her. She also reported she had been chased and kidnapped by a well-known 'Somali gang'. She was accommodated at Rutland Hall, Crawley Green Road by Housing Solutions Team. On the 27th and 28th September the police communicated to the Council that Anna had not reported abuse or stalking by CJ and, based on the information available to them, she was not at risk if accommodated at Eaton Green Road Hostel and she was at low risk of gang violence. She was offered accommodation at Eaton Green Hostel. This is a specialist unit with low level support for women who have experienced sexual exploitation. After a referral by her recovery worker to HARRP she accepted an offer in their supported accommodation at Studley Road so withdrew her homeless application. She requested further assistance from the Housing Solutions team on the 17.10.21, but when they called her back they were unable to speak with Anna.

3.14. Housing Solutions noted she remained at HARRP support accommodation until the 08.11.21. However, ResoLUTiONs' records report that on the 19.10.21 she advised her recovery worker that she would be attending a privately funded residential rehabilitation placement at Oasis Recovery between 27.10.21-05.01.22. Case records suggest she was back in contact with AB, as he had made contact with services requesting information about her support options to facilitate the move to Oasis. It is understood, from the subsequent police investigation following her death, that CD paid for the private rehab placement. Anna asked for ongoing support with accommodation after the rehab placement and counselling support but declined relapse prevention programmes or groups. There is evidence of consultation between ResoLUTiONs (including the consultant psychiatrist and recovery worker) and Oasis Recovery before they took the decision to discharge Anna from the Luton service after she move into the rehab Oasis placement. ResoLUTiONs also notified her GP of their closure and her rehab placement.

3.15. Anna returned to Luton by the 04.11.21 but returned to live with AB as she was fearful that CD would be angry she had lost the rehab placement. As part of a high risk missing person enquiry, police requested information from the MASH to consider if she was known to mental health teams. On the 25.11.21 she attended ResoLUTiONS and met with a new recovery worker; she informed them she was asked to leave Oasis after two days because she was found in possession of a mobile phone. She was restarted on opiate substitute therapy (methadone). Information submitted to this review identified that whilst it was good practice that a prescription assessment was completed to enable her to access methadone and reduce harm from illicit drug use, she should have received (as part of the ResoLUTiONs Entry into Services process) a personalised assessment of current risks and needs. At this time there were significant pressures on the service due to staff vacancies, worsened by the upsurge in Covid infections at this time, but within their submission to this review the service noted this was a missed opportunity to explore with Anna her perception of the risks she faced and her ability, given her drug dependency, to stay safe.

3.16. She continued to engage with the prescription and needle exchange. She also attended the Woman's evening clinic on the 09.12.21. On the 20.12.21 her recovery worker contacted the pharmacy and was advised she had not collected her methadone for 3+ days. Anna was contacted and attended the offices but was unable to provide a urine sample for a drug screen. She was asked to return later to restart her prescription and became upset, stating she did not want to restart her prescription if she could not take it then. Her recovery worker attempted to get Anna to attend the women's clinic on the 23.12.21 and it was noted that she accessed the needles exchange on the 30.12.21.

3.17. On the 03.01.22 Anna called 999 to report domestic abuse by CD. She explained that the previous day he had been going through her stuff and taking photos on his phone of her whilst she was asleep. She argued with him, during which he grabbed her by the neck leaving a bruise.[15] She reported he also had assaulted her friend and that they had argued again earlier that day. She indicated she was concerned about becoming homeless and leaving her cat at the property. Police reported she became very angry and irate when officers were dispatched prior to CD leaving for work. She threatened to withdraw her

[15] The Domestic Abuse Act 2021 had, by this time, introduced a specific offence of non-fatal strangulation in recognition of the significant increase in risk and long-term harm caused by such an assault.

statement and called two further times stating she did not want officers attending as she was worried about becoming homeless. She was advised that as she had alleged domestic abuse, officers would need to attend. Police records report '*She was not very happy saying she won't call the police for help in the future.*' Officers who attended tried to speak with Anna but she was extremely distressed and presented as very angry. In conversation with the reviewer the officer explained he understood that her denials may have been to protect herself from recriminations so had also interviewed CD in his car whilst a colleagued tried to speak with Anna alone in the house. CD denied he was in a relationship with Anna, claiming they were currently house sharing at the moment; he stated that Anna was a self-harmer and the marks on her neck are from sucking on her skin from a pen. Officers felt unable to identify this as domestic abuse, so no DASH[16] or DARA [17] was completed. They also reported it was not possible to verify if there was bruising as Anna refused to speak with them. This is explored in more detail below, given prior intelligence that CD was known to exploit women by requiring sex for the provision of drugs and accommodation. As such, despite his denials of a relationship, this would have fallen within the definition of domestic abuse under the 2021 Act. She subsequently sent a text message to AB indicating she intended to self-harm. He found her unresponsive in the garden of CD's home and called an ambulance. She was pronounced dead by ambulance staff who also notified police. A subsequent police enquiry concluded there was no suspicion of third-party involvement in the death.

4. Overview

4.1. Anna had very little control over her life for most of her life. In common with findings from many DHRs and SARs, practitioners involved in assessing or providing support to Anna reported they did not have a full understanding of the whole picture, including wider legal duties owed by partners until this was bought together by this review. Historic social care records that had identified high risks of sexual exploitation and a long history of serious sexual abuse were not available to support assessments when she requested help between 2020-22.

4.2. She was known to Azalea to be actively engaged in sex work, often under duress and that this was adversely impacting on her wellbeing and safety. Police records identified she was at high risk of sexual exploitation, but this information was not shared externally with partner agencies or even with officers responding to the 999 call on the day of her death.

4.3. Throughout this review period she was open about the impact for her of the exploitation when speaking with trusted professionals, including ResoLUTiONs and Azalea staff. Whilst those practitioners were aware of the level of violence she had experienced and the continued coercion exercised over her by AB and then CD, this was not considered in the context of statutory assessments for housing, and no-one identified that she may have benefitted from a social care assessment under the Care Act 2014. When Anna reported she had slept rough following a flight, professionals did not enquire if this involved physical violence or explored if this might meet the definition of domestic abuse. Multi-agency protection planning duties (under s42 Care Act or via MARAC process) were not triggered despite her notifying safeguarding partners (LBC's housing staff and her ResoLUTiONs worker) that she was under pressure to provide AB and CD with sex in exchange for accommodation and that she had experienced domestic abuse on at least two occasions, resulting in periods of rough sleeping. The concerns regarding sexual exploitation and domestic abuse were not raised with the ResoLUTiONs designated safeguarding lead, and a safeguarding concern/multi-agency intelligence form was not submitted to the Council, despite guidance to this effect in the ResoLuTiONs' safeguarding policy and LSAB's multi-agency safeguarding policy.

4.4. Practitioners involved in this review confirmed they understood Anna had care and support needs arising from poor mental health, substance dependency, homelessness and the exploitation she had endured throughout her life. These were not circumstantial factors to be disregarded. These all directly impeded her ability to keep safe.

4.5. Agencies had very little knowledge or involvement with AB. It was lawful for ResoLUTiONs staff to refuse to share information with him regarding planning for her admission into a private rehab, as they had not had Anna's permission to share personal information. However, this offered an opportunity to explore with him (and her) the basis of their relationship and thereafter share with a wider professional

[16] Domestic Abuse, Stalking, Honour Based Violence
[17] Domestic Abuse Risk Assessment

network any information that would help her to access support to protect herself from ongoing exploitation.

4.6. CD was suspected of exploiting women. Anna denied his home was a brothel when questioned by police, but this was in the context of questioning by officers conducting criminal (not welfare) enquiries. Police attending CD's home on the day of her death did not complete domestic abuse risk assessments. They explained this was because she would not answer any questions or engage with their assessment and CD denied they were in an intimate relationship. They had not been informed that she had asked officers to attend only after CD had left for work, that the address was a suspected brothel or that CD was known by partner agencies to sexually exploit women.

5. Analysis of Agencies' Actions

5.1. This section examines how and why events occurred, information that was shared, the decisions that were made, and the actions that were taken or not taken. We have grouped these according to the key lines of enquiry, highlighting good practice as well as opportunities to improve practice.

How well do practitioners from across the health, mental health, housing, social care and criminal justice agencies understand the impact of trauma and coercion on decision making and adapt their usual work practices to ensure that responses and interventions are effective for women at high risk of, or experiencing, sexual exploitation and domestic abuse?

5.2. LSAB's adult safeguarding policy[18] highlights obligations to protect adults at risk. It explains multi-agency responses to risk should be shaped by the 'making safeguarding personal' approach and provides guidance on practical tasks to collate necessary information (including information on how to engage with adults at risk of exploitation). Luton Borough Council's webpages regarding adult safeguarding also provide a brief guide to responding to sexual exploitation but does not contain a link to the LSAB's more comprehensive policy. This policy requires practitioners to work with the adult at risk to better understand how to reduce the risk of abuse in a way that is meaningful to them. This policy and subsequent practitioners' good practice briefings[19] have made clear that neither the Mental Capacity Act or making safeguarding personal principles absolve practitioners of statutory or professional responsibilities if an adult says they do not want an enquiry to be undertaken. Rather, careful consideration is needed of the circumstances and any inability or coercion that impacts on the person's ability to understand the risk or freely decide to refuse support must be acted on.

5.3. NICE guidance[20] advises assessments of capacity should take into account observations of the person's ability to execute decisions in real life situations, thereby reflecting the long-standing impact of trauma and adverse childhood experiences on the development of the brain. It recommends, where previous case history indicates that outside of an assessment environment the person is not able to understand or weigh up information to enact a decision, this should be thoroughly explored as it should trigger further duties to ensure an adult is safe from abuse or exploitation.

5.4. NHS England and NHS Improvement ['NHSE/I'] published guidance on commissioning effective trauma informed care for women, which includes examples of commissioned services,[21] recommending services are commissioned to enable flexibility for practitioners, so they adapt their 'usual offer' to take into account the prevalence of trauma and likely long-term effects on survivors. In particular, services should be aware that survivors of childhood trauma and multiple adversities are at greatly increased risk of substance misuse and poor mental health (including self-harming and suicide). It is also much more likely that their ability to form healthy, supported relationships will have been damaged.[22]

5.5. Within the information from agencies submitted to this review, there were very few references to assessments of Anna's ability to protect herself or her capacity to engage with necessary care or treatment. Where this was commented on, agencies noted no concerns regarding her capacity. This

[18] Available at: http://lutonsab.org.uk/wp-content/uploads/2018/04/BBC-CBC-LBC-SA-Policy-and-Procedures-2017-2018.docx-1.pdf
[19] See 'Myths and Realities' about Making Safeguarding Personal available at https://www.local.gov.uk/sites/default/files/documents/25.144%20MSP%20Myths_04%20WEB.pdf and LGA/ADASS 'Making decision on the duty to carry out safeguarding adults enquiries' advice note [July 2019} available at: https://www.adass.org.uk/media/7326/adass-advice-note.pdf
[20] NICE (2018) *Decision Making and Mental Capacity*. London: National Institute for Health and Clinical Excellence.
[21] See 'Engaging with Complexity: Providing effective trauma-informed care for women' by the Centre for Mental Health available at: https://www.mentalhealth.org.uk/sites/default/files/Engaging_With_Complexity.pdf
[22] Lewis, S.J.; Arseneault, L.; Caspi, A.; Fisher, H.L.; Matthews, T.; Mo_tt, T.E.; Odgers, C.L.; Stahl, D.; Teng, J.Y.; Danese, A. The epidemiology of trauma and post-traumatic stress disorder in a representative cohort of young people in England and Wales. Lancet Psychiatry 2019, 6, 247–256.

was often a generic statement, without reference to the issue under consideration. The subjective nature of capacity assessments, particularly in respect to a person's perceived reluctance to accept (or sustain engagement with) support, can obscure statutory welfare responsibilities including under the Care Act. Where there is a suspicion of coercion and/or addiction, this can add significant layers of complexity because the person's ability to weigh up and act on information affects relevant legal powers to respond to identified safeguarding concerns. For example, had Anna been assessed as lacking capacity in respect of her application for housing, this would have frustrated the Council's legal powers under the Housing Act 1996, but not their safeguarding responsibilities. Similarly, offers to support someone to reduce harm associated with drug dependencies or for rehabilitation are predicated on their ability (and willingness) to engage with treatment programmes. There is, however, still an expectation, in national and local policy, for practitioners to recognise and respond to safeguarding concerns for those in contact or known to their services.

5.6. The wellbeing principle and safeguarding obligation to adults with care and support needs was deliberately widely defined in the Care Act 2014 by Parliament. It goes beyond the issue of mental capacity as defined by the Mental Capacity Act 2005. Since April 2015, s1 Care Act requires local authorities to promote an individual's wellbeing whenever it is carrying out any care and support function. Section 2 obligates local authorities and relevant partners[23] to provide services or take other steps it considers will prevent or delay the development of care and support needs by adults in its area. The Care and Support Guidance, which accompanies the Care Act, dictates an early response to emerging harm is essential to stop risks from escalating. It also clarifies that local authorities have duties when the adult's needs for care and support are due to a physical or mental impairment or illness and that they are not caused by other circumstantial factors. This includes '*physical, mental, sensory, learning or cognitive disabilities or illnesses, substance misuse or brain injury. The authority should base their judgment on the assessment of the adult and a formal diagnosis of the condition should not be required*.' [24] Section 11(2) provides an enduring duty to offer an assessment when an adult with care and support needs has experienced, or is at risk of abuse or neglect, including sexual exploitation. Finally, s.42 of the Care Act 2014 requires that each local authority must make (or cause others to make) enquiries, decide what must be done and by whom whenever an adult with care and support needs is at risk of, or experiencing, abuse or neglect.

5.7. Those who knew Anna well spoke of an articulate, bright woman who had a survival instinct. Outreach staff explained some sex buyers scout women intending violence and Anna was identified within that cohort meaning she experienced significant abuse alongside years of exploitation. They recognised that she had suffered substantial trauma and would have undoubtedly experienced poor mental health. Whilst they did not believe she had previously presented with suicidal ideation, they believed she would have benefitted if mental health specialists had been able to input into an assessment of her needs so that she (and agencies working to support her) could better understand how the abuse she had suffered impacted on her cognitive, psychological and behavioural needs.

5.8. Practitioners and senior leaders believed, however, that as a consequence of Anna's apparent 'street smart' she was often perceived to be much more capable than she really was. They accepted her ability to stay safe was not fully explored. This was most acutely felt when in February and May 2020 when she was assessed as not in priority need by LBC's housing department and again in April 2021 when she was discharged by ELFT's CMHT for non-attendance at appointments with little consideration to how the increased risks to her mental health could be managed by her, or by the practitioners she did have sporadic engagement with, most notably her GP, ResoLUTiONs staff and Azalea.

5.9. The Domestic Abuse Act 2021 included controlling and coercive behaviours and economic abuse within the statutory definition of domestic abuse, reflecting the clear evidence of victim survivors' experiences. 95% of those who suffer psychological, sexual or physical abuse are also subject to debilitating control of their finances preventing their acquisition or use of money and property or the ability to obtain goods or services.[25] There was widespread recognition within discussions in this review of the need for a greater understanding of the long-term impact of domestic abuse. There were examples of good practice to support frontline police staff and encourage a system-wide understanding of coercion and controlling behaviours, specifically in respect of heightened risks to those involved in sex work. Senior

[23] Section 6 and 7 of the Care Act 2014 obligates relevant partners (police, NHS, district or county councils, prison, probation, department of work and pensions and providers of health or social care services) to cooperate in the delivery of respective functions to adults with care and support needs and their carers.
[24] Paragraph 6.104 Care and Support guidance, DHSC
[25] https://survivingeconomicabuse.org/what-is-economic-abuse/

police colleagues recognised that the current high levels of newly qualified police officers[26] make it more likely that those responding to urgent calls may not have wider life experiences or expertise to recognise or respond in a way that reflects wider 'think family' and person-centred, trauma-informed approaches now advocated within safeguarding best practice guidance. They have therefore secured additional funding and used this to commission a 2-day bespoke training programme to support 64 officers from across different teams to become subject leaders for their units in trauma-informed responses (due to commence in July 2023). This training will explore unconscious bias, the impact of adverse childhood experiences and will be aimed at those likely and wanting to remain in frontline positions so that this influences the whole culture of frontline policing. In addition, Bedfordshire police have developed case studies and a 3-minute video exploring survivor stories. It forms part of the mandatory training for all officers on capturing the voice of the adult at risk, or child in any enquiry, and is targeted to ensure officers remain professionally curious and empathetic. They also have forums with survivors so that the police can hear directly from victim survivors about how to change practice to safeguard those at risk. This is structured as an informal chat between local police and survivors. The feedback from survivors and police staff is that this is a very productive, useful learning environment. Police staff have also commented that it protects against burnout at the frontline.

5.10. Azalea have also run workshops with frontline police on recognising signs of sexual exploitation and sex trafficking. Two specialist police officers work closely with Azalea and attend drop-in sessions to build trusted relationships with women using their services so they can act as a point of contact or referral to assist women to report crime and get access to justice. Azalea offered opportunities to develop similar approaches for partner agencies, particularly those responsible for primary care and mental health, adult social care and housing.

5.11. East London NHS Foundation Trust [ELFT'] who run secondary mental health provision in Luton have started to roll out a training programme for all staff regarding trauma-informed practice, but accepted this is still in its infancy. They have also run workshops and a conference to raise awareness of long-term impacts of domestic abuse. This conference included presentations from organisations working with women who were exiting sex work, and early intervention services. They also provide regular workshops thorough the year for staff to sustain awareness.

5.12. ResoLUTiONs reported that they currently run a women only clinic weekly until 8pm and thereafter provide outreach between 9pm- 2am specifically targeting women involved in street sex work. They recognise high levels of exploitation and trauma means many of the women at highest risk have undiagnosed mental health conditions, including personality disorders. Most present with challenging behaviours, likely as coping mechanisms or learned behaviour minimising risk or avoiding services. They explain they carefully consider allocation of specialist workers, but that there is always a risk that even skilled workers can experience 'burn out' so they recognise the importance of smaller caseloads, quality supervision and training, though this isn't always possible with current resource constraints. They intend to commission bespoke training to assist specialist staff to better understand how to successfully engage with women with personality disorders to protect against any 'normalisation of risk' for this cohort. They report there is now much greater awareness of the level of coercion and exploitation trafficked women experience. Staff are also alert to trauma, so appreciate they need to be ready to respond positively rather than wait for the women to 'use the right language'. As a consequence, they have seen a rise in their staff submitting safeguarding referrals.

How confident are practitioners in applying the three-stage test under s42(1) in circumstances where an individual's ability to protect themselves may be impacted by coercion, trauma or the normalisation of violence and/or sexual exploitation?

5.13. Karl Mason[27] highlights that, whilst responsibilities under s42 Care Act 2014 to work collectively to address safeguarding risks is relatively new, it conceals shadows still present in wider welfare policy frameworks that influence how practitioners interpret their organisational duties. Different approaches within legislation to vulnerability and limitations to statutory legal powers (which are directly attributable to different legislative eligibility criteria that practitioners must apply) frustrate a shared understanding, particularly where addiction and adult abuse are features in a case. Mason[28] identifies that the '*stretching of safeguarding responses …has not elided the powerful and persistent discourse of 'sin*

[26] Currently 60% of frontline responding officers have less than 5 years' experience. Basic domestic abuse training is included as part of the initial training programme.

[27] 'Adult Safeguarding and Homelessness, Understanding Good Practice' [2022] Jessica Kingsley publishers

[28] Op Cit. at p34

talk'.[29] He points to research which has identified the conditionality of statutory agencies responses, necessitated by chronic resource issues, results in agencies normalising risk or look for ways in which individuals fall outside of eligibility criteria.[30] Practitioners within this review recognised this and, whilst they commented they were lucky to have so many committed practitioners, felt too often pressures for resources meant there was an impasse in supporting people to make meaningful change away from their exploitative circumstances.

5.14. There was concern that the level of risk for Anna had become normalised as forming part of a 'lifestyle choice'. There were some examples of staff assessing her ability to protect herself against some risk, for example she and members of her household were trained to use Naloxone to reduce the risk of accidental drug overdose. However, it is notable, given the indicators of sexual exploitation and domestic abuse, that her ability to protect herself from those known risks was not considered or recorded in any agencies case records. This is important in the context of safeguarding functions because it is an adult's ability to protect themselves rather than the capacity to make decisions that is the basis for safeguarding legal duties under s42 Care Act 2014. This duty sits alongside the 'wellbeing principle' and though it includes a focus on personal dignity, choice and control, there '*is no hierarchy, and all should be considered of equal importance when considering 'wellbeing' in the round*'.[31] As such, equal weight should be attributed to duties to protect against abuse or neglect. Ultimately, the duty to protect life (protected under article 2, Human Rights Act 1998) requires all public bodies to do whatever is within their legal powers where risk is real and imminent to act to reduce risk.

5.15. Prior to the 999 call on the day of her death, Anna had disclosed she was pressured for sex by AB and CD in exchange for accommodation and drugs on a number of occasions, but this was not identified as a form of sexual exploitation or domestic abuse warranting a safeguarding response. Currently, Luton SAB's multi-agency safeguarding adults policy does not include domestic abuse as a distinct form of adult abuse, despite statutory guidance identifying this as a specific form of abuse since 2019.[32]

5.16. The local policy does, however, contain a definition of sexual exploitation, namely:

> *Sexual exploitation is the sexual abuse of children, young people or vulnerable adults in exchange for food, drugs, shelter, protection, other basic necessities and/or money. Sexual exploitation could be part of a seemingly consensual relationship, or be used for 'payment' for attention, affection, money, drugs, alcohol or somewhere to stay. The person being exploited may believe their abuser is their friend, boyfriend or girlfriend. The abuser may physically or verbally threaten the victim, take indecent photographs of them and circulate to others, be violent towards them, try to isolate them from friends and family.*

5.17. Newcastle's Joint Case Review into sexual exploitation[33] identified the lack of a national definition of adult sexual exploitation undermines safeguarding practice because partner agencies have '*little scope for proactively looking for abuse. Sexual exploitation occurs in locations not usually frequented by safeguarding professionals and victims may not attract concerns of welfare agencies for any other reason. Sophisticated grooming means victims may not recognise they are being abused and believe they are in control, in healthy consensual relationships. Apparent close relationships may develop to involve intimidation, threats and coercion. Victims may have mild cognitive difficulties that do not impact significantly on ability to cope with education or functioning as an adult. However, involvement with perpetrators, use of drugs and alcohol and the abuse itself may increase vulnerability*.'

5.18. This report warned of the need to remain alert to grooming and coercive behaviours, stating *'perpetrators demand extreme loyalties and create dependence so victims maintain links even after attempts to protect them and resent inquiry by agencies, actively mislead or avoid professional contacts. Victims may, while needing protection themselves, become involved in recruiting other victims and facilitating abuse. They will have been separated from friends and family and peer groups so that offering alternatives that do not leave them isolated may be difficult*.' It also highlights that *'bad*

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[29] This occurs where legislation emphasises the person's responsibility for their situation leading to punitive state response, e.g. the requirement under the Housing Act 1996 to consider if a person is intentionally homeless and, if so, determine they are ineligible for on-going support

[30] Whiteford and Simpson 2015, p.130; Cornes et al. 2011; Mason et al. 2018

[31] Section 1.6 Care and Support Guidance, DHSC available at: https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance#general-responsibilities-and-universal-services

[32] 14.17 Care and Support guidance warns '*Local authorities should not limit their view of what constitutes abuse or neglect, as they can take many forms and the circumstances of the individual case should always be considered… Exploitation, in particular, is a common theme in the following list of the types of abuse and neglect*'. It goes on to list different forms of domestic violence.

[33] Available at: https://www.newcastle.gov.uk/sites/default/files/Final%20JSCR%20Report%20160218%20PW.PDF (accessed 05.05.23)

experiences of the criminal justice system deter victims from coming forward or persisting with complaints. Perpetrators will adopt cruel tactics and, being aware of agencies' processes, become skilled at undermining attempts to safeguard victims.' The review also acknowledged '*the application of the law and professional standards of practice relating to consent, capacity and the right to choose is complicated and uncertain. The presence of some form of exchange or benefit complicates assessments. Working with challenging adolescents and adults requires particular skills. Lack of progress may be frustrating and time limited interventions may not have a significant impact. Progress might be limited to keeping a victim as safe as possible while continuing to be abused*.'

5.19. In conversation with the reviewers, practitioners and senior managers confirmed these were all factors in why agencies were unable to support Anna escape abuse. They spoke of a presumption that adults, even when reported as high-risk missing people, were perceived to be able to manage their own risk. Those with expertise explained they always sought to support frontline staff to recognise and disrupt exploitation. As in this case, they were not always made aware of those at highest risk and could not confidently provide assurance that their advice was acted on by other agencies.

5.20. Similarly, specialist services (such as the Council's adult safeguarding team) explained that too often referrals contained too little information so they were unable to take further action, for example vital contact information for the adult was not included. This is most acute for women at risk of sexual exploitation because any known address or contact details may be subject to a high level of surveillance by those exploiting them. Whilst some officers were aware of the Herbert protocol and spoke about how that has helped to support a more effective response if a vulnerable adult absconds or is missing from care, it required adaptation to take into account different nature of risk associated with adult sexual exploitation.

5.21. Risk mitigation is made more difficult for single women as risks within DASH matrix are heavily weighted to families with children. If police have insufficient evidence to pursue perpetrators at the scene, they need clear guidance on how to refer safeguarding concerns for more detailed follow up. The CSPR Panel's analysis identified multi-agency work in response to domestic abuse was only in evidence after cases had been identified as high risk (i.e. meeting MARAC threshold). It warned of too great a focus was on parents rather than involving specialist domestic abuse services in risks to children. The briefing identified 5 cases involving adolescent children taking their own life. Co-occurring issues for those children (and pertinent to this review[34]) included gang involvement, sexual abuse and exploitation and criminal exploitation. Whilst there is a well-established evidential basis demonstrating the impact that trauma and adverse childhood experiences have on the development of the brain, the CSPR Panel's research concluded that the lasting impact of domestic abuse in childhood is less well understood. Commonly, case reviews involving adolescence categorised domestic abuse, as in the past, without proper consideration of the continued impact and the person's ability for recovery and to keep themselves safe. Again, this is pertinent to Anna's case as neither she, nor either perpetrator AB and CD were known to Luton MARAC. During the initial rapid review Luton's MARAC Coordinator identified numerous high risks indicators, including that she was frightened and refusing to support police, that she had visible injuries (bruises and reported she'd been grabbed by the throat, she had limited friends, was feeling low in mood, concerns of homelessness, sex working and known drug user). They recognised that forum could have facilitated information sharing from agencies to have enabled a more detailed risk assessment.

5.22. Practitioners and senior managers understood that locally the MARAC and s42 safeguarding processes could no longer run concurrently. They also highlighted their alternative multi-agency risks process (the VARAC) is also unavailable if the adult at risk is subject to a s42 enquiry.

5.23. Safeguarding professionals accepted long-backlogs within their team, during this review period, meant delays in responding with the flexibility required by adults subject to coercion. They explained processes had improved with firm (and reportable) timescales to triage referrals within 48 hours according to a screening tool. Those cases deemed to be high risk are reviewed by the team manager and the team are expected to speak with the referrer before screening and provide feedback on the outcome. Sometimes this is not possible, for example if the referral is submitted without contact details or anonymously, but all involved in this case accepted it was also the responsibility of the referrer to follow up the concern to ensure it had been received and actioned appropriately. Whilst high risks are prioritised, cases are flagged to managers if the s42 enquiry is not completed within 28 days. They

[34] At the time of her death, Suzanne was in her 30s but had experienced domestic abuse and sexual abuse throughout her childhood, adolescence and adult life.

explained there was flexibility across social care so that if another team had an established relationship with the adult at risk, someone from that team would usually lead the enquiry, but that the safeguarding team remained responsible for oversight of the quality of that assessment. They were keen for this review to highlight that they welcome notification of safeguarding concerns, provided these are properly completed with relevant information to enable them to assess risk. They explained their process require gathering for information where the source of the referral has provided sufficient personal details, but will always check to ascertain if the adult is known to adult social care. Even where the referral is not progressed in the first instance, where there are three concerns raised within a six-month period this will trigger a s42 enquiry so would advocate for those in doubt to submit a concern as this allows them to draw up a picture of risk or need over time and improves their ability to provide a proportionate response.

5.24. Prior to her death, the safeguarding team confirmed they received only one concern in respect of Anna. This related to her being missing and did not specify she had care and support needs or was experiencing exploitation. Ultimately this was explored by the police and closed when she was located. There was recognition that more safeguarding concerns should have been made in respect of Anna and that these should have detailed the risks of sexual exploitation and domestic abuse. They should also have detailed why it was practitioners believed her care and support needs would mean she would be unable to protect herself. Practitioners and senior managers explained that too often she interacted with practitioners from different agencies for very episodic, transactional based needs. She was also very focused on the immediate need and could appear avoidant (or was perhaps unable) to disclose the risks faced at the time of an incident. They also did not know to seek her permission to access records held by other agencies or historic social care records. This made it very difficult to piece the jigsaw together. They believed there is now greater recognition of sexual exploitation indicators within outreach teams and those supporting women engaged in sex work. They accepted it would be helpful for agencies to know the right questions or to have prompts or descriptors to help provide objectively the level of detail required to trigger safeguarding enquiries. There are also opportunities to learn from multi-agency activity to disrupt and pursue perpetrators of criminal and sexual exploitation of children and young people so that similar responses become the norm for adults who are exploited.

5.25. As noted above, police did respond with immediate concern to her reporting domestic abuse on the day of her death. It was not possible to retrieve the transcript of the call or speak with call handlers, but it is understood that they did not pass on crucial information to officers responding. Of particular concern was their insistence to send out officers despite further calls from her when she had identified the perpetrator would still be at the address. Officers involved in this review understood her response in this context. They confirmed they had received training warning them of that aggressive, adverse reactions by domestic abuse victims in front of perpetrators should be understood and responded to with compassion. They had not been informed of police intelligence that the address was suspected to be a brothel or that women within it may be subject to coercion.

5.26. Independent domestic abuse advocates involved in this review explained that they often speak with police officers to verify if there are shared concerns. They explained the importance of following principles of safe enquiry[35] and were surprised that this practice wasn't followed with Anna. They highlight that it is not uncommon, particularly where there is coercive control and/or exploitation for victims not to want police involvement in the first instance or to be frightened of retribution. They work with frontline practitioners and wider professional networks to secure safe opportunities for victims to open up about the abuse they are experiencing and support them to thereafter access support.

5.27. Locally there has been an increase in funding from the Police and Crime Commissioner to co-locate three Independent Domestic Violence Advocates within the hospital and adult social care teams, including the safeguarding adults team. The DASH risk assessment has also been adapted to incorporate the eight stages of a homicide timeline into a matrix, rather than a checklist so that practitioners might more accurately record risk. This also prompts for the consideration of exploitation. LSAB and Adult Social Care also reported they are commissioning an accessible on-line policy framework that will include guidance for practitioners on recognising risks associated with sexual exploitation.

[35] Guidance on principles of safe enquiry about domestic abuse within a virtual setting are set out at: https://safelives.org.uk/sites/default/files/resources/Domestic%20abuse%20guidance%20for%20virtual%20health%20settings-%20C19.pdf

Do practitioners know who they can turn to for expert advice and support (including through a trusted assessor approach) in these areas if an adult is at risk, but inconsistent in their engagement with statutory assessment processes?

5.28. Practitioners involved in this review explained that working with adults who have experienced significant trauma, exploitation and abuse requires time and persistence to gain trust and build a relationship. Often practitioners must be able to offer something of value to adults at risk or adapt their practice to facilitate engagement for those who are likely coerced into night-time work or prevented from freely accessing statutory support during normal office hours. Azalea and ResoLUTiONs both have female only evening drop-in sessions to enable those engaged with sex work to access advice, prescriptions, harm minimisation support (rape alarms, needle exchanges, condoms etc) and basic needs such as food, warm clothing and a hot drink. These services have been set up deliberately to enable the attendance of women who are working at night and under pressure to prioritise sex work over their own wellbeing. They therefore have a crucial role to play to support holistic assessments and protection planning obligations. From the 30.05.23 Women's Aid in Luton will also host a monthly 'pop-up hub'.

5.29. Anna attended evening drop-in sessions and responded to practical assistance offered by ResoLUTiONs and Azalea to minimise harms associated with drug misuse and sex working. She also approached services asking for help to so that she could reduce her drug use, address her poor mental health and find safe accommodation away from the gangs she was involved with and from CD and AB. As trusted persons, Anna notified her ResoLUTiONs worker of the abuse she experienced and her ongoing fear following threats by gangs involved in sexual exploitation and stalking by her former partner's sibling.

5.30. Practitioners also recognised that she knew what to say within professional assessments to access support on what she believed to be her terms, but had very little insight into the long-term impact of exploitation. Practitioners and senior managers commented on her use of language to minimise risks. They questioned, for example, whether her use of the term 'sugar daddy' to describe AB or his persistent demands as 'sexual harassment' downplayed the control he had over her and the power imbalance created by her long-term dependency on him for accommodation and drugs. The Newcastle review findings articulate the well-established legal principles that coercion and undue influence can have such a significant impact on someone that their capacity to act freely is compromised. In such situations there are legal powers and remedies that partner agencies should explore, including with the adult at risk. It is notable that, despite high risks, agencies did not refer Anna to any multi-agency forum for consideration of how to reduce risk including when referrals to partners for specialist support did not successfully mitigate those risks or address her needs. Even where there was evidence of cross agency communication, responses by agencies were not joined up to have in place a holistic plan to support Anna safely move away. As a consequence, she became more reliant (increasing their control over her life) on AB and CD.

5.31. Research, including through thematic safeguarding adults reviews, identify best practice when working with those who have co-occurring conditions, such as addiction and poor mental or physical health and are at risk of abuse, is to adopt a 'team around the person' approach. This enables a service with an established relationship to lead on direct work with the adult, but ensures that lead agency or worker is supported organisationally and by all other relevant services to develop and deliver a robust plan addressing each distinct need in a holistic plan. Practitioners and senior managers involved in this review commented that they felt lucky that in Luton there were a lot of services, but commented that it wasn't always clear which referral pathway (e.g. MARAC, VARAC or adult safeguarding) would assist with setting up such an approach.

5.32. It was understood Anna was not in a position to engage directly with CMHT when referred by her GP. During discussions with the reviewer practitioners questioned whether she would have been permitted by those exploiting her to attend appointments or if, because she worked at night, the timing of appointments needed to be considered to facilitate her engagement. ELFT's Early Intervention Service has been designed to support those presenting with psychosis. This was not how Anna presented, however members of that team commented on how difficult it can be to get a formal diagnosis for someone, like Anna, who isn't able to comply with usual referral pathways and expectations set out within currently commissioned specialist mental health teams. ELFT staff explained they do have flexibility to attend evening or drop-in sessions and will now work with trusted persons to try to facilitate engagement, but that during this period they were restricted to on-line contact due to the Covid Pandemic and necessary restrictions to prevent cross infection. There was widespread agreement that

it would be preferable for adults experiencing exploitation (and so unable to engage directly with therapeutic support), if flexibility could be 'written into the system' by facilitating trusted practitioners to access specialist mental health advice as part of a team around the person, even prior to a formal diagnosis, so that protection plans can be tailored to specific risk, understand likely mental health presentation and what this might mean for the delivery of care and support, so that protection plans are trauma informed.

5.33. Other practitioners and senior leaders spoke of an urgent need to improve support for mental health, particularly to those at high risk of sexual exploitation. Presently, the safeguarding adults team meet weekly with police and mental health colleagues to review safeguarding concerns. But other teams involved in this review commented that it can be extremely difficult to get meaningful engagement from secondary mental health teams for preventative protection planning, including where there are high safeguarding risks associated with poor mental health.

5.34. During this period Noah and Signpost were providing outreach to establish a profile of people who were known to be rough sleeping or engaged in street sex work in the area. As noted above, Anna was initially turned down for support because she was unable to evidence she was rough sleeping and during review discussions practitioners commented that access into accommodation based support is easier if people are verified by those agencies. Azalea staff explained, however, that this approach could discriminate against those at the highest level of risk, particularly those who, because of their vulnerabilities, choose (as Anna did) to sleep in discreet locations. It also makes it much harder for those (as Anna was on occasions) forced to carry out sex work behind locked doors. They would like to extend their awareness raising training offer to staff working in mental health specialist teams, primary care and housing. They would also welcome partners contacting them for verification as to whether someone is known to them and, where a women discloses that she attends their drop-in, would like this to trigger increased professional curiosity and, where appropriate, their inclusion within a 'team around the person' approach so that they (as a service trusted by women), can act as a conduit of information between the women and statutory services and support multi-agency risks analysis and protection planning. They explained the importance for women they work with to have a single point of contact so that they were not always having to re-tell their story or attend frequent office based appointments.

5.35. Many of the agencies reported they had adopted this practice and were more comfortable to work as a team around the person with a single contact to make it more accessible for the adult at risk. ResoLUTiONs explained their recovery workers were able to visit people outside of an office setting; it is also usual practice for the recovery workers to accompany their clients to appointments with other agencies to facilitate access to support and that they did this on two occasions with Anna. Independent Domestic Violence Advocacy [IDVA'] services explained they also work with Azalea and other providers to collate information about risks and will make referrals to VARAC. There was recognition that sharing personal information about adults at risks without their consent could undermine trust so careful thought had to be given about how to do this in a sensitive, proportionate way whenever safeguarding concerns arise. HARRP and members of the Key Stage Housing Team are also looking to offer assertive outreach with other agencies so that they can identify those most in need of their support.

5.36. As was demonstrated by responses to Anna's requests for help, any team around the person will need input from teams resourced to provide accommodation-based support. Often this is the local authority's housing need team but, given the complexities of her health, mental health, substance misuse and on-going exploitation, any offer is likely to require significant wrap around support. This is explored below in response to the fourth line of enquiry.

5.37. The safeguarding team accepted they had concluded, because of paucity of information in the referral, that her circumstances did not meet the criteria under s42 Care Act. They explained that practice has improved since this period as they now have access to advice from an IDVA embedded within their team. If domestic abuse is reported, even if the notification doesn't specify concerns about an adult with care and support needs, enquires are conducted. Unfortunately, because the concern raised in respect of Anna identified her as a missing person and did not identify domestic abuse, this did not happen in this instance.

5.38. Improving awareness across partner agencies so that Luton has a domestic abuse-informed workforce should go some way to prevent future harm. However, the Child Safeguarding Review Panel briefing (published in September 2002) identified this may require more than simply alerting staff to domestic

abuse. This review found '*most practitioners use the term 'domestic abuse' without full exploration, assessment or understanding of the nature of the abuse and its impact.*'[36] The briefing warned this led to optimistic and dangerous assumptions that simply naming domestic abuse was enough for practitioners to understand the situation and respond appropriately. This means knowing how to make safe enquiries, consider wellbeing beyond appearances and go beyond incident-based approaches to focus on continuous patterns of behaviour by the person causing harm. It also means recognising the different presentations of domestic abuse, including coercive and controlling behaviours, how older victims experiencing abuse may present[37], and abuse behaviours linked to grooming.

What are the local pathways to support adults at risk of homelessness who experienced abuse as children?

5.39. The legislative framework to support those with an appearance of care and support needs and experiencing homelessness can be complex as it includes duties owed by health, social care, housing and, in some instances, prison and probation services. But it is designed to ensure that agencies with statutory responsibilities carry out their functions in partnership to prevent needs escalating. Statutory criteria for services should be approached as fluid and facilitative, as opposed to creating artificial barriers. The roll-out of Integrated Care Systems is an ideal opportunity to outcome barriers between agencies. The Chief Social Worker's Transitional Safeguarding Knowledge briefing[38] sets out the case and expectations for working in partnership to address contextual safeguarding risks for young people transitioning to adulthood, including examples of innovation to overcome common barriers to preventative pro-active disruption of abuse that can have consequences long into adulthood.

5.40. The risk of homelessness was clearly a serious concern for Anna. She had requested assistance on a number of occasions, including on her return to the area. Given her age at the time of her return to Luton, leaving care duties would not have applied. However, some practitioners felt it would be prudent for housing needs staff to have the ability to search previous records held by the local authority to verify if they had care experience as a child. As noted above, this is an important marker of possible enduring need and would then prompt further consideration of risks or indicators of priority need. Practitioners spoke of the importance of building trust if they are able to demonstrate informed, empathetic questioning. Saying to a victim of exploitation 'we know what you might be going through' breaks down barriers and empowers adults to take steps away from abusive, coercive situations.

5.41. Presently, the IDVA service has two staff members to offer floating support across the local authority's housing, children and adults' social case caseload. Anna was offered accommodation within a specialist unit with low level support for women who have experienced sexual exploitation and was accommodated by HARRP in September 2021. She resided there for only a short time, before moving to a private rehab. Staff commented that placement would have further indentured her to CD, and it also frustrated their ability to form a trusting relationship. There was recognition that more specialist resources are needed to enable a higher level of support, in recognition of the continued risk for women who have moved away from their exploiters (but not necessarily out of their reach) and still require significant support to address ongoing mental health, substance misuse and past trauma.

5.42. Anna also raised her fear of homelessness on the day of her death during the 999 call. Officers did not have an opportunity to provide advice in respect of options to secure alternative, safe housing for her, given her distress. Police recognised that where the threshold is met, they will arrest and charge perpetrators of domestic abuse, imposing bail conditions preventing them from returning to the property. If there isn't sufficient evidence to charge, but the victim survivor requires preventative support, they can also issue a Domestic Abuse Protection Notice and apply to have this converted to an Order. However, remaining in the home of a perpetrator, at an address likely known by sex buyers was far from ideal.

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[36] Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1107448/14.149_DFE_Child_safeguarding_Domestic_PB2_v4a.pdf

[37] See for example, Pathak et al '*The experience of intimate partner violence among older women*' (2018) available at: https://doi.org/10.1016/j.maturitas.2018.12.011; Meyer SR Lasater ME, Garcı́a-Moreno C (2020) '*Violence against older women: A systematic review of qualitative literature*.' PLoS ONE 15(9): e0239560. https://doi.org/10.1371/ journal.pone.0239560 and '*Domestic abuse and older people: factors influencing help-seeking*' Wydall, Sarah;Zerk, Rebecca *The journal of adult protection,* 09 Oct 2017, Vol. 19, Issue 5, pages 247 - 260

[38] Published by the DHSC in June 2021 and available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/990426/dhsc_transitional_safeguarding_report_bridging_the_gap_web.pdf

How well does commissioning function across the partnership to facilitate identification or creation of accommodation-based support that can meet complex needs, and how responsive is this to periods of crisis?

5.43. There isn't always a clear distinction in complex cases between safeguarding responsibilities and partners statutory functions, including the provision of suitable accommodation or safe and appropriate treatment, care and support. Within the Care and Support guidance there is a clear statement that safeguarding is not a substitute for agencies complying with their own legal obligations. The Care Act also imposed clear legal duties on local authorities and 'relevant partners' to ensure cooperation[39] and elucidated this was not limited to s42 duties; rather the importance of inter-departmental cooperation across disciplines (e.g. housing and social care) and between functions (e.g. between commissioning and care management teams or third sector providers) is reinforced within accompanying statutory guidance and regulations. Where an adult has complex needs, local authorities are required to have in place '*arrangements to ensure co-operation between their officers, particularly between housing and social care, given that housing and suitability of living accommodation play a significant role in supporting a person to meet their needs and can help to delay that person's deterioration*'[40]

5.44. Those involved in this review spoke of several accommodation providers and pathways to support different needs across Luton. Anna did engage, albeit temporarily with HARRP. This is a rapid resettlement service designed around a 'housing first' model to support rough sleepers into accommodation, often responding to adults in crisis. They have a 24-hour staffed hostel and offered Anna accommodation the day after receiving the first referral from her ResoLUTiONs worker. Despite this, she remained hesitant to trust staff, possibly as a consequence of initial refusals by Housing need staff to identify her as in priority need. HARRP reported, whilst this was understandable given her experiences and on-housing needs, it was much more difficult for them to engage her in any meaningful programme. They acknowledged that she didn't often stay at the address, but that they intended to keep her placement open until she felt ready to engage. They accepted that often adults with ongoing care needs, particularly those looking to abstain or reduce substance misuse, are initially reluctant to accept support from their project. But, after a week Anna did open up and explain she wanted to arrange rehab. They would usually look to step up a multi-disciplinary team, including registration with a local GP, but that this was made more difficult as Anna engaged only sporadically and then moved away from the accommodation to take up the private rehab placement.

5.45. There is evidence of good practice in this case, including the availability of different accommodation options. Also, HARRP demonstrated trauma-informed, flexible approach working at Anna's pace. However, it is also crucial to ensure systems work well together to identify and respond at the earliest opportunity, and with consistency, so that those who have been or continue to be subject to sexual exploitation and violence feel validated by responses from statutory agencies. The National SAR analysis[41] identified that case responsibility can be diluted in the context of multi-agency working: too often adults at risk involved in SARs were signposted to other agencies with no follow up and insufficient checks to ensure those agencies could meet the needs/ risks identified. That analysis also found a lack of managerial oversight for case closure was a causative factor in numerous reviews. Closer managerial supervision of decision making within the Housing Needs team should have prevented Anna from being turned away as not in priority need.

5.46. Whilst ResoLUTiONs staff were proactive in ensuring Anna had continuity of care before closing her to their services when she moved to a private rehabilitative placement, more pro-active managerial oversight may have identified the missed opportunity to complete a personalized assessment on her return to the service. ResoLUTiONs reported they carry out regular audits to examine case records, recovery plans, and risk assessments. They also intend to explore within these audits if appropriate referrals into adult safeguarding have been made and acted on by partner agencies. ResoLUTiONs are undertaking a specific piece of work to ensure that re-engagement strategies are employed during Needle and Syringe Exchange interventions and that case records are crossed referenced with next appointments issued where appropriate.

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[39] See s6-7 Care Act and 'Revisiting safeguarding practice' published by DHSC in March 2022
[40] 15.24 Care and Support guidance
[41] Published by ADASS/LGA in 2020 and available at:
https://www.local.gov.uk/sites/default/files/documents/National%20SAR%20Analysis%20Final%20Report%20WEB.pdf

5.47. As noted above, Mason's research evidences practitioners can become desensitised to high levels of risk when working adults with complex presentations that do not neatly fit ideals of 'priority need' within housing legislation or 'eligibility' for care and support services. One young woman[42] who spoke with the reviewer during outreach explained the level of fear she experienced at all times as a result of her experiences, including rape, physical assault and sexual exploitation. Often for her this results in extreme distress even if people pass her unexpectedly. She told us she engaged with sex work to afford nightly accommodation but often couldn't sleep even within hotels due to the anxiety she always felt. If she is unable to earn sufficient money, she sleeps rough irrespective of the weather. Like Anna, she had asked for help. She had reported being raped by two men in Luton town centre and reporting this at the time of the offence. She had undergone forensic examination, but was later advised that it would unlikely meet the criteria for prosecution because 'it was her word against theirs'. She had also attended NOAH and the housing department, completing referral forms many months ago but still hadn't been able to secure a referral to accommodation. She spoke of how hard it was for her, and how unjust the system felt, that prioritised other less vulnerable people for support over her. Almost all the women encountered during outreach confirmed that, despite obvious vulnerabilities, including signs of physical assault, clothing unsuitable for the weather conditions and (for some) signs of cognitive impairment, they were '*safe for tonight'*.

5.48. All those involved in this review accepted there had been a lack of coordinated, holistic assessment and protection planning. There were pockets of good practice, for example when she moved from Luton to a private rehabilitative provider out of area, staff within the supported living placement, unaware of the placement, raised a high risk missing person alert to the police who contacted ResoLUTiONs and thereafter only closed the alert when they were satisfied she was safe. However, failure by the private provider to notify ResoLUTiONs she had failed to complete the programme (despite contact with the services a few days prior to support their initial assessment) meant she returned to the area without arrangements in place to access suitable, safe accommodation or opiate substitute services. As a consequence, she moved back in with AB, placing her at ongoing risk of exploitation and drug misuse. To ensure that everyone attending the Women's Clinic going forward is offered a personalised assessment, a new reporting measure has been implemented whereby service users who attend the Women's Clinic will be contacted within 48 hours of their clinic visit by a High Intensity Recovery Worker, and offered the opportunity to participate in a personalised assessment.

5.49. Practitioners explained normal post-rehab planning wasn't possible for Anna because of the late notification of her placement. It is also notable that ResoLUTiONs did not receive contact from the private rehab provider to confirm that Anna had been asked to leave. There was an opportunity for better communication to have been in place. ResoLUTiONs report they have since updated the residential rehabilitation pathway to support Recovery Workers whose service users who are asked to leave or self-discharge early from a residential rehabilitation, but questioned why the private provider was not accountable for poor safeguarding or risk mitigation practice. It is notable that they will be a CQC registered provider and whilst this failure is unlikely to meet the strict criteria for enforcement action, LSAB and CSP may wish to make enquiries with the relevant provider and local SAB as to what action they take to ensure continuity of care where someone exits their services in an unplanned way before completing the rehab programme, and there is reasonable cause to suspect they are at risk of abuse, exploitation or neglect.

5.50. Partners also reported a shortage of specialist accommodation for people with complex needs,[43] in particular for women who have been or are being sexually exploited. We understand that a complex needs panel has been developed focused on supporting the top 10 vulnerable rough sleepers in Luton. A multi-agency approach is used, including voluntary and charitable providers, to secure accommodation-based support. Senior leaders report good working relationships between HARRP, ELFT and the Rough Sleepers Team, but also noted that in Anna's case (as with Adult Abdullah) their complex needs were not deemed as a high risk so neither were identified as needing support and slipped through the net. Other teams spoke of high risk panels or multi-agency meetings to seek to provide holistic care planning and problem solving, such as the Rough Sleeping High Risk meeting which takes place monthly to review care plans for the 10 highest risk individuals on that list. However, in common with many national reviews, partners identified gaps in commissioned services for those

[42] At the time of the conversation she was clearly distressed, the reviewer therefore did not ask her age but estimates she was in her late teens or early twenties.
[43] LSAB safeguarding adult review into Adult D

with co-occurring conditions arising from poor mental health and substance misuse, with adults at high risk often being 'ping-ponged' across services.

How does local availability of resources impact on care planning, prison and hospital discharge and safeguarding?

5.51. Anna's death highlighted issues of staffing related to the Omicron Covid-19 virus and the impact that had on available resources. ResoLUTiONs report that since this period, they have successfully filled 9 vacancies and are currently inducting staff, cognisant that it will likely take between 2-3 months before staff feel confident of local support pathways. In addition, they have 10 remaining live vacancies. They are liaising with substance misuse specialist agencies, supported by a designated specialist recruitment role who is reviewing ResoLUTiONs secondment opportunities and are also liaising with external organisations such as Luton Borough Council, partners and stakeholders to find suitable candidates.

5.52. The Council's safeguarding team also reported increasing workloads placed pressure on the team, such that annual leave was sometimes hard to cover.

6. System learning and recommendations emerging from this review

System Finding: 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.

Recommendation 1: Working with experts by experience and partner agencies, the Partnership Boards should revise the local policy framework for responding to adult sexual exploitation so that this aligns with good practice and is fully integrated into the multi-agency risks management processes. Regard should be had for supporting agencies most likely to have specialist skills or opportunities for engagement with women involved in sex work (police, housing, mental health, substance misuse services and Azalea) to identify those at risk of trafficking and experiencing sexual exploitation and violence. Clarity is also needed regarding the most appropriate risk management process to use depending on the level of risk, so that robust plans can be agreed and agencies are accountable for actions to mitigate abuse. The Partnership Boards should agree reporting arrangements so that they are able to monitor how effective agencies work together to reduce risk.

Recommendation 2: Local Authority (social care, housing and public health) and ICB commissioners should liaise with regional NHS leads and specialist providers in the area to arrange bespoke trauma-informed cross disciplinary training for staff working with adults experiencing sexual exploitation and abuse.

System finding: 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. Opportunities to use existing processes for multi-agency risks management (under s42 Care Act or MARAC) were not explored, nor were known concerns used to inform statutory assessments and service provision. Responses to safeguarding concerns she raised, including on the day of her death, were not in line with best practice or local policy.

Recommendation 3: In preparation for the launch of the on-line policy, the Partnership Boards should develop a local protocol which will support the early identification of adults subject to sexual exploitation and domestic abuse. This should include descriptors or indicators of high, medium and low risk and clear pathways for early intervention support, multi-agency risk mitigation and immediate responses to those at high risk. It should also contain clear instructions for involving relevant agencies in proactive protective planning meetings, including how to safely make contact with anyone suspected of being trafficked or exploited (adapted from the Herbert protocol). It should also provide prompts to ensure referrals include sufficient information to evidence eligibility criteria for emergency accommodation and trauma-informed support is met. This will enable 'reachable moments' (e.g. when a woman is accessing outreach support, or requests assistance from statutory safeguarding partners) can be properly harnessed to effect a change in circumstance.

Recommendation 4: The Partnership Boards should also have a protocol and procedures for multi-agency involvement and legal powers to disrupt sexual exploitation and hold to account perpetrators. This should

include measures for relevant partner agencies to demonstrate domestic abuse crimes and sexual exploitation and abuse results in sanctions against the perpetrator and safety for the victim survivor.

Recommendation 5: Police call handlers should receive further training and guidance on principles of safe enquiry and of ensuring all intelligence held by the police is used to grade the response to a call. Where a victim survivor of domestic abuse requests support is provided away from the perpetrator, police call handlers should have agreed local mechanisms to arrange for the victim survivor to attend a 'safe haven' to report their concerns and seek support.

System findings: 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.

Recommendation 6: Partner agencies should report, as part of any protocol development work, what steps they have taken to identify adults at risk of sexual exploitation within their current caseloads and support a 'team around the person' approach.

Recommendation 7: The Partnership Boards to jointly write to relevant strategic leads for the housing allocations policy with a copy of this report to request the allocation policy makes clear that priority need criteria includes those who experience sexual exploitation within their current accommodation. This is in line with the Homelessness (Priority Need for Accommodation) (England Order) 2002 as a 'special reason' see pg8.14 (f) and (g) of the Homelessness Code of Guidance. The Partnership Boards, working with the Domestic Abuse placed based programme board ensure access to safe accommodation for anyone experiencing sexual exploitation is incorporated into the Safe Accommodation Needs Assessment.[44] The Partnership Boards to raise awareness across partner agencies and wider stakeholders of this requirement so that they can advocate on behalf of anyone experiencing exploitation.

Recommendation 8: The Partnership Boards to explore with partners the development of physical safe havens in Luton, for example GP surgeries and existing women only drop-in) so that anyone at risk is able to access all emergency support, including safe accommodation without having to re-tell their experiences or wait until office hours or attend numerous appointments to exit safely from exploitation.

System findings: 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. This gap in support for emotional dysregulation presentations, restricts partner agencies' ability to respond holistically and therapeutically. Furthermore, the lack of awareness of the psychological impact of high levels of trauma increases the risk of malignant alienation.[45]

Recommendation 9: The Council, ICB and mental health trust to provide an assurance to the Partnership Boards that, in light of the findings in this review, they have explored current assessment and care pathways for emotional dysregulation. They should provide assurance there is sufficient access to therapeutic support for those experiencing high levels of emotional dysregulation. In addition, that within current risk management processes there is sufficient mental health professional support to the team around the person so responses are trauma informed and adhere to best clinical practice so as to reduce inequalities of access for those who have experienced sexual exploitation, adverse childhood experiences or trauma.

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[44] As required by s57 Domestic Abuse Act 2021 and sB3 statutory guidance issued by the DLUHC 'delivery of support to victims of domestic abuse in domestic abuse safe accommodation services.'

[45] atts, D., & Morgan, G. (1994). Malignant Alienation: Dangers for patients who are hard to like. The British Journal of Psychiatry, 164(1), 11-15. doi:10.1192/bjp.164.1.11 available at: https://www.cambridge.org/core/journals/the-british-journal-of-psychiatry/article/malignant-alienation/EEA2DE69F88E8C636BD470528398264F and https://www.rcpsych.ac.uk/docs/default-source/events/congress/2021/speaker-presentations-thursday/thomso-1.pdf?sfvrsn=d8028fa8_2