SAFER SOMERSET PARTNERSHIP

DOMESTIC HOMICIDE REVIEW

Report into the death of Libby

November 2021

Contents

Safer Somerset Partnership

Feel Safe, Be Safe

OVERVIEW REPORT

of the

Domestic Homicide Review

relating to the death of Libby in 2021

on behalf of:

The Safer Somerset Partnership

Report Author: **Liz Cooper- Borthwick**

Independent Chair

Report submitted to Home Office: October 2024

Report updated: June 2025 following feedback from the Home Office

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GLOSSARY

ABBREVIATION	DEFINITION
CCG	NHS Clinical Commissioning Group, now the NHS Integrated Care Board from July 2022.
CMHT	Community Mental Health Team
CRC	Community Rehabilitation Company privatised arm of Probation Service unified into Probation Service in 2021.
DASH	Domestic Abuse, Stalking, and "honour" based violence check list
DAT	Police Domestic Abuse Triage meeting
DHR	Domestic Homicide Review
HIS	Hospital Interface Service (adult social care)
ICB	NHS Somerset Integrated Care Board July 2022, previously the CCG
IDVA	Independent Domestic Violence Advisor
IOPC	Independent Office for Police Conduct
KPE	Key Practice Episode
LSU	Lighthouse Safeguarding Unit Lighthouse Victim Care
MARAC	Multi-Agency Risk Assessment Conference
NPS	National Probation Service(reunified to Probation Service June 2021
OASys	Offender Assessment System
OCG	Organised Crime Groups

OIC	Police officer in charge of Investigation
OM	Offender Manager
PLO	Public Law Outline
PLT	Psychiatric Liaison Team (SomFT)
SASC	Somerset Adult Social Care
SCSC	Somerset Children Social Care
SDAS	Somerset Drug and Alcohol Service provided by Turning Point
SIDAS	Somerset Integrated Domestic Abuse Service
SomFT	Somerset NHS Foundation Trust
SSP	Safer Somerset Partnership
TNT	The Nelson Trust

Pen Portrait

Libby was like a whirlwind ⋯sometimes chaotic ⋯she would turn up somewhere and dominate the room and people's attention. People loved to be around her as she was fun and always looked on the brightside.

Her best friend said that if you make one friend in life like Libby ⋯then you were blessed and lucky. She was infectious with her laughter and had sense of humour⋯. she was beautiful inside and out.

She was also outspoken but with the best intentions.

Libby was our only child and was educated at a private school. She passed her GCSE exams but decided she wanted to work with horses and not do A Levels.

She became a riding instructor at a very young age of 17. She passed her exams at Gleneagles in Scotland.

She taught riding at a private school which she loved ⋯ it also meant she could have her own horse stabled there.

Her ambition was to compete in the Horse of the Year Show which she did.

Libby's first child was born in 2007 and is also educated at the same school as Libby. loves sport as well.

She was so proud of her child achieving a Sports scholarship.

Libby used to shout out cheering the child playing rugby ⋯. half time you would see her running across the pitch with a bottle of Lucozade for her child!

Her youngest child was born in 2015 and now in the same school⋯.The youngest child is also very sporty.

She was running from one rugby match to the other at weekends.

Both children are so much like their mother in their ways ⋯ we will always talk about her and keep her memory alive.

She will always be with us and looking out to her two children. We all miss you so much.

You were tragically taken from us ⋯ but you will live on in your two children⋯ Hopefully they will grow up to be fine young adults and for her to be proud of.

If every single person who has liked you in your lifetime, were to light up on a map, it would create the most glittering beautiful network you can imagine. Throw in the

strangers you have been kind to; the people you've made laugh or inspired along the way and that star -bright network of you would be an impressive sight to behold. You're so much more than you think you are. You have done so much more than you realise. You're trailing a bright pathway that you don't even know about …. what a thing.

Mum.

The Somerset Community Safety Partnership wish to express their sincere condolences to the family and friends of Libby.

1.0 PREFACE

1.1 This Domestic Homicide Review (DHR) examines agency responses and support given to Libby and her family before Libby's death in **November 2021**. The Safer Somerset Partnership determined that the criteria for a DHR had been met under DHR Statutory Guidance 2016, in particular paras 5(1), 18 and 27(c).[1]
The review will identify any agency involvement and will also seek to understand the family dynamics in the build up to Libby's death, whether support was accessed within the community, whether there are identified gaps in provision and whether there were any barriers to accessing support. By taking a comprehensive approach the review seeks to identify appropriate solutions to make the future safer for those accessing services.

1.2 DHR: Domestic Homicide Reviews became statutory under Section 9 of the Domestic Violence, Crime and Victims Act 2004 and came into force on 13 April 2011. The Act requires a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by a person to whom they were either related, in an intimate personal relationship with or living with in the same household.

1.2.1 The Domestic Abuse Act 2021 defines domestic abuse as:

Behaviour of a person ("A") towards another person ("B") is "domestic abuse" if—

(a) A and B are each aged 16 or over and are personally connected to each other, and

(b) the behaviour is abusive.

(3) Behaviour is "abusive" if it consists of any of the following—

(a) physical or sexual abuse;

(b) violent or threatening behaviour;

(c) controlling or coercive behaviour;

(d) economic abuse (see subsection (4));

(e) psychological, emotional or other abuse;

[1] DHR-Statutory-Guidance-161206.pdf(publishing.service.gov.uk)

and it does not matter whether the behaviour consists of a single incident or a course of conduct.

(4)"Economic abuse" means any behaviour that has a substantial adverse effect on B's ability to—

(a)acquire, use or maintain money or other property, or

(b) obtain goods or services.

(5) For the purposes of this Act A's behaviour may be behaviour "towards" B even though it consists of conduct directed at another person (for example, B's child).

(6) References in this Act to being abusive towards another person are to be read in accordance with this section.

(7) For the meaning of "personally connected," see section 2.

1.2.2 Definition of "personally connected"

(1) For the purposes of this Act, two people are "personally connected" to each other if any of the following applies—

(a) they are, or have been, married to each other;

(b) they are, or have been, civil partners of each other;

(c) they have agreed to marry one another (whether or not the agreement has been terminated);

(d) they have entered into a civil partnership agreement (whether or not the agreement has been terminated);

(e) they are, or have been, in an intimate personal relationship with each other;

(f) they each have, or there has been a time when they each have had, a parental relationship in relation to the same child (see subsection (2));

(g) they are relatives.[2]

This definition includes so called 'honour' based violence, female genital mutilation (FGM) and forced marriage, and is clear that victims are not confined to one gender or ethnic group.

This was expanded to include apparent suicides / unexpected deaths within abusive relationships in subsequent guidance. [3]

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[2] Domestic Abuse Act 2021 www.legislation.gov.uk

[3] Controlling or Coercive behaviour HO guidancehttps://www.gov.uk/government/publications/statutory-guidance-framework-controlling-or-coercive-behaviour-in-an-intimate-or-family-relationship

1.3 The key purpose for undertaking a DHR is to enable lessons to be learned from homicides where a person is killed because of domestic violence and abuse. For these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each homicide, and most importantly, what needs to change to reduce the risk of such tragedies happening in the future.

1.4 Time scales: The review began April 2022 and concluded with submission to the Home Office in October 2024

The Home Office guidance states that a DHR should be completed within six months of the initial decision to establish a DHR. This period was extended for several reasons-;

a. To allow the family sufficient time to review the DHR overview report and to meet with the DHR Panel

b. Independent Office for Police Conduct (IOPC) Review

c. Ill health of the Independent Chair and family

d. Due to retirement and capacity within the police, a delay in receiving comments on draft copies of the DHR

e. The criminal justice process

The DHR was commissioned by SSP in accordance with the revised Statutory Guidance for the conduct of Domestic Homicide Review[4] published by the Home Office in March 2016.

1.5 Confidentiality: The detailed findings of each review are confidential. Information is available only to participating officers / professionals and their line managers. A confidentiality agreement has been signed by DHR Panel members at the commencement of the DHR.

1.5.1 This DHR has been anonymised in accordance with the statutory guidance. The specific date of the homicide has been removed, with only the Independent Chair and Review Panel members being named.

1.5.2 The following pseudonyms have been used to protect the identity of the victims, other parties, those of family members and the perpetrator. The family requested that the DHR Panel chose the pseudonyms and they agreed to the following names as none had family connections. The names are as follows;

[4] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/575273/DHR-Statutory-Guidance-161206.pdf

	Pseudonym
Victim	Libby
Perpetrator	Benas
Eldest child of the victim	Sam
Youngest child of the victim	Alex
Victim's husband and father of Sam	Gerry
Victim's partner and father Alex	Peter

Details of the relationships and equality information are provided in paragraph 2.2.1. It should be noted that the villages and the towns in Somerset are named as Town A, Town B etc to also provide anonymity for the victim and the family.

1.6 TERMS OF REFERENCE

Terms of Reference were agreed by the DHR Panel in **April 2022** and were regularly reviewed and amended as further details of events in Libby's life emerged. The full TOR is included in Appendix One. The DHR aims to identify the learning from this case and for actions to be taken from that learning, with a view to preventing homicides and ensuring families are better supported.

The DHR Review Panel (Review Panel) comprised of agencies from Somerset as this was the area that the victim and the perpetrator were living at the time of the homicide. Agencies were contacted as soon as the DHR was established to inform them that a DHR was taking place and that their participation was required and there was a need to secure their records.

At the first meeting, the Review Panel considered the initial scoping exercise by the SSP about agency contact with Libby, Libby's family and Benas. This included significant contact with Libby and the family over several years and it was agreed that the review would cover the period **1 January 2015** up until **Autumn 2021** unless there were significant events of relevance prior to this. (This date range has been chosen because of Somerset Adult Social Care (SASC) and Somerset Integrated Domestic Abuse Service (SIDAS) both receiving information about domestic abuse in 2015 and the birth of Alex).

Key lines of enquiry ; The Review Panel considered both the generic issues as set out in the DHR statutory guidance and identified the following case specific issues;

- Consider how (and if knowledge of) all forms of domestic abuse (including the non-physical types) are understood by the local community at large – including family, friends and statutory and voluntary organisations. This is to also ensure that the dynamics of coercive control are also fully explored.

- To discover if all relevant civil or criminal interventions were considered and/or used.

- Determine if there were any barriers Libby or her family/friends faced in both reporting domestic abuse and accessing services. This should also be explored against the Equality Act 2010's protected characteristics.

- Examine the events leading up to the incident, including a chronology of the events in question.

- Review the interventions, care and treatment and or support provided. Consider whether the work undertaken by services in this case was consistent with each organisation's professional standards and domestic abuse policy, procedures and protocols including Safeguarding Adults and Safeguarding Children.

- Review the communication between agencies, services, friends and family including the transfer of relevant information to inform risk assessment and management and the care and service delivery of all the agencies involved.

- Identify any care or service delivery issues, alongside factors that might have contributed to the incident.

- Examine how organisations adhered to their own local policies and procedures and ensure adherence to national good practice.

- Review documentation and recording of key information, including assessments, risk assessments, care plans and management plans.

- Examine whether agencies considered and understood all Libby's vulnerabilities including substance misuse, potential exploitation/sexual coercion, the intersecting of those vulnerabilities and their impact on her accessing support, and what support was provided (or not) to Libby.

- Are agencies sufficiently understanding of unconditional bias, and the impact of such bias on providing the support to Libby.

- Examine whether services and agencies ensured the welfare of any adults at risk, whether services took account of the wishes and views of members of the family in decision making and how this was done and if criteria for intervention were appropriately set and correctly applied in this case.

- Whether practices by all agencies were sensitive to the gender, age, disability, ethnic, cultural, linguistic and religious identity of both the individuals who are subjects of the review and whether any additional needs on the part of either were explored, shared appropriately and recorded.

- To acknowledge the ethnicity of the perpetrator and whether this impacted on any help he might or should have received including availability of services/recourse to public funds?

- Whether organisations were subject to organisational change and if so, did it have any impact over the period covered by the DHR. Had it been communicated well enough between partners and whether that impacted in any way on partnership agencies' ability to respond effectively (including the Covid pandemic).

1.7 METHODOLOGY

Contributors to the Review

1.7.1 *Statutory and Voluntary Agencies:*

Each involved agency submitted an Individual Management Review (IMR) in accordance with the statutory guidance. Authors were independent of the incident and the reports were Quality Assured by the organisation. As the review progressed, additional agencies were identified who had contact with the family members and further information was requested. IMRs were received from:

i. Avon and Somerset Constabulary (the Police)
ii. Probation Service (Although both Libby and Benas were historically supervised by the privatised provider of probation services, Bristol, Gloucestershire, Somerset and Wiltshire Community Rehabilitation Company BGSW CRC)
iii. Somerset Clinical Commissioning Group (CCG) now NHS Somerset Integrated Care Board (ICB) (on behalf of the GP)
iv. Somerset NHS Foundation Trust (SomFT)
v. Somerset Public Health Nursing Team
vi. Somerset Adult Social Care (SASC)
vii. Somerset Children Social Care (SCSC)

viii. Somerset Integrated Domestic Abuse Service (SIDAS)
ix. Somerset Drug and Alcohol Service (Turning Point)(SDAS)

To note that this report will refer to the CCG as Libby's death was prior to the NHS Somerset Integrated Care Board in July 2022. BGSW CRC ceased operating in June 2021 when the Ministry of Justice withdrew the contracts of the 21 privately run CRC's and created the National Probation Service. The service is referred to as the Probation service throughout the report.

Following receipt of the IMR's and contact with Libby's family it was identified that Libby did have contact with housing services at Mendip District Council and Somerset West and Taunton District Council. Information was requested from both organisations but due to the migration of housing information to a new system, historical data was not available for this review. Homelessness was a significant issue for Libby and therefore it is disappointing that the DHR Panel have not been unable to review the contacts that Libby had with any housing support.
A recommendation relating to the retention of data by housing services is detailed within section eight of this report.

The Independent Chair invited IMR authors to a Panel meeting where the panel gave detailed consideration and professional challenge to the IMRs submitted by these agencies and the final documents have contributed significantly to this report.

1.7.2 Involvement of Family and Friends

The Independent Chair met with Libby's parents on three occasions (face to face) and Libby's parents had a virtual meeting with the DHR Panel prior to the report being sent to the Home Office. A Victim Support advocate supported the parents, and the parents were provided with a copy of the draft overview report to make contributions as appropriate and they received a final copy of the DHR Overview Report, Executive Summary and Action Plan. The Independent Chair kept the family updated on progress of the DHR via the Victim Support advocate, as this was their preferred method.

Libby's parents had parental guardianship for Alex for five years preceding Libby's death. The Independent Chair spoke with Libby's parents about their views on a specialist advocate speaking with Alex. Libby's parents felt that he was very young and did not wish for Alex to be traumatised further by discussing the loss of Libby.

The Independent Chair also wrote to Gerry to explain about the DHR and whether he or Sam would be willing to speak about Libby. No contact was received from Gerry or Sam.

(To note that Gerry has automatic parental responsibility as he is named on a birth certificate. Following their divorce, Libby and Gerry agreed fifty-fifty joint custody for the eldest child).

Two friends of Libby contributed to the DHR which added further context as to what issues Libby was experiencing. The contacts were provided by Libby's family.

1.7.3 Contact with the Perpetrator

The Independent Chair wrote to Benas via the prison governor. Benas agreed to meet with the Independent Chair. Details of the discussion are included in section four of this report.

1.7.4 Further contact with agencies

To support this DHR, the Independent Chair spoke twice with senior managers at The Nelson Trust[5] (TNT), an organisation based in the Southwest providing a trauma informed approach to support women who have experienced abuse and trauma which is often masked with substance dependency meaning that the women have multiple complex needs.

The services offered by TNT includes Women's Centres, advocacy and support, custody liaison and diversion, prison in-reach and residential rehabilitation treatment. TNT has a collaborative approach which views the women as a human being first, not someone with needs and risks. This approach includes asking a woman "what has happened to you," instead of "what is wrong with you." This has meant that there appears to be a better "take up" of services from women who were normally perceived as non-engagers.

Although TNT started in 2014, there was no provision in Somerset until 2016. The initial provision was limited as there were only three workers who managed an outreach service. In 2018 and 2019, when Libby was referred to TNT by the Probation Service and SDAS, the provision of services was still limited due to funding, but the service came into full operation just prior to the Covid Pandemic in 2020, with a Women's Centre based in one of the larger town in Somerset, although Libby was not living in the town where the Women's Centre is located. TNT did identify

[5] www.nelsontrust.com

that Libby was referred to the organisation and although originally stating that there was no contact from Libby, following a request for further details which have been provided, it was reported that there was some contact with Libby via text messaging, and phone calls, although there were no face-to-face meetings despite TNT trying to arrange several meetings. TNT have highlighted that if Libby was referred to the service today and was not engaging then they would be "going to places that Libby would go to" to try to engage with her.

The services offered by TNT today could have benefitted Libby. An advocate would have supported Libby, in a non-judgemental way and this may have helped Libby navigate the issues she was experiencing and receive support that may have achieved a different outcome.

TNT did identify that it would be beneficial to remind the Probation Service that women in the justice system should be referred to TNT.

1.7.5 ACRO Criminal Check[6]

As Benas (the perpetrator) was from Eastern Europe and following information provided by a contributor to this review, a ACRO criminal check was requested by the Police on behalf of the Independent Chair. The ACRO check stated that Benas had no criminal convictions from his home country.

1.7.6 Multi Agency Risk Assessment Conference (MARAC)[7]

The IMR's identified that a MARAC process was established in 2015 and Libby stated to SIDAS that there had been a MARAC referral in 2018/19. The Independent Chair contacted the Somerset MARAC to get confirmation that Libby was discussed at a MARAC. The Somerset MARAC coordinator confirmed that it was not possible to confirm whether there was a discussion at a MARAC in 2015 as no records were available prior to 2019. It was also confirmed that there were no MARAC referrals for Libby from 2019 up until her death.

1.7.8 Documents Reviews

[6] ACRO criminal check is provided by the ACRO Criminal Records Office which is a national police unit working for safer communities. www.acro.police.uk

[7] Multi Agency Risk Assessment Conference - A meeting to share information on highest risk domestic abuse cases between police, probation, health, social care, specialist domestic abuse services, other relevant agencies to discuss increasing safety options for a victim of domestic abuse. www.safelifes.org.uk

In addition to the IMR's and interviews with family other documents were reviewed including SSP DHR protocol, other completed Somerset DHR's and Somerset County Lines Action Plan.

1.8 PANEL MEMBERSHIP AND REPRESENTATIVES

The Panel consisted of senior representatives from the following agencies.

NAMED OFFICER	ORGANISATION	ROLE
Liz Cooper-Borthwick	LCB Consulting	Independent Chair
Suzanne Harris	Somerset County Council and Safer Somerset Partnership	Senior Commissioning Officer (Interpersonal Violence) Somerset County Council
Su Parker /Dave Marchant	Avon and Somerset Police	DI- Major and Statutory Crime Review Team
Liz Spencer	Probation Service	Head of Somerset Probation Delivery Unit (Unified in June 2021)
Julia Mason	NHS Somerset Integrated Care Board	Designated Nurse for Safeguarding Adults NHS Somerset Safeguarding Team
Louise White	Somerset Adult Social Care (ASC)	Adult Safeguarding Service Manager Somerset County Council
Kelly Brewer	Somerset Children Social Care	Head of Service Help and Protect
Heather Sparks	Somerset NHS Foundation Trust	Named Professional for Safeguarding Adults
Melanie Thomson	Live West (Housing Association) providing SIDAS until 2020	Safeguarding Lead
Tonia Redvers	The You Trust (Current SIDAS Providers)	Director of Paragon, Counselling and Young Lives

Jane Harvey Hill	Somerset Drug and Alcohol Service (provided by Turning Point)	Safeguarding Manager
Patricia Ashfield	Mendip District Council to 2023 and Somerset Council from 2023	Strategic Housing Manager

The panel met 7 times during the period April 2022 to September 2024 including the final meeting with Libby's family in September 2024. All the meetings were virtual, and this method made no difference to the commitment of the Independent Chair or the DHR Panel and it was felt that attendance at the Panel meetings were enhanced due to the participation in virtual meetings.

1.9 Statement of Independence

The Chair and Author of the review is Liz Cooper- Borthwick, formerly Assistant Chief Executive at Spelthorne Borough Council in Surrey. Liz has a wide range of expertise including Services for Vulnerable Adults and Children, housing and domestic violence. She has conducted partnership Domestic Homicide Reviews for the Home Office and has attended the Home Office Independent Chair training for DHRs and further DHR Chair training with Advocacy after Fatal Domestic Abuse (AAFDA). Liz is a member of the AAFDA DHR Chair Network and participates in training to support her continuous professional development (CPD). Liz has also been involved with several Serious Case Reviews (children and adults). Liz has no connection with any of the agencies in this case.

1.10 PARALLEL INVESTIGATIONS AND RELATED PROCESSES

1.10.1 Criminal Investigation

Following the criminal investigation, Benas admitted killing Libby. Benas was sentenced to life in prison with a minimum term of fourteen years and ten months.

1.10.2 Independent Office for Police Conduct (IOPC) Investigation.

The Police made a mandatory referral to the IOPC as they had had recent contact with Libby before her death. The DHR Independent Chair contacted the IOPC lead investigator to share TOR's and ensure any joint learning. The IOPC report has been completed with the following conclusion;

- There were some missed opportunities to safeguard Libby but there were also significant efforts by individual police officers to try and support Libby. The IOPC report concluded the police had implemented further training on the DASH risk assessment which has developed into a force wide vulnerability training days and the IOPC felt that this approach should continue.

Where appropriate, the IOPC findings have been included and referenced within the DHR.

1.10.3 Inquest

Following the outcome of the criminal trial and a murder conviction, the coroner issued Libby's death certificate and the inquest was closed.

1.11 . EQUALITIES

1.11.1 Libby was a heterosexual white British woman, age 47, with no known disabilities, but Libby suffered from substance misuse and some mental health issues including anxiety and depression. Libby's religion was Church of England.

1.11.2 Benas was a heterosexual, eastern European man, age 38, with no known disability and religion not known.

1.11.3 The nine protected characteristics of the Equality Act 2010 were considered (age, disability, gender re-assignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, sexual orientation). Two of these characteristics are considered in this review to have had an impact–sex/gender and pregnancy/maternity. The characteristics are considered later within this report.

1.11 DISSEMINATION

The Overview Report, Recommendations and Executive Summary have been redacted to ensure confidentiality, with pseudonyms used for the victim, children and family. The report has been disseminated to the following groups;

I. Safer Somerset Partnership
II. Somerset Safeguarding Adults Board
III. Somerset Safeguarding Children's Partnership
IV. Somerset Domestic Abuse Board
V. Avon and Somerset Police Crime Commissioner
VI. Domestic Abuse Commissioner for England and Wales
VII. Libby's family

2.0 Background Information -The Facts

2.1 The Homicide

2.1.1 The police and ambulance service were called to Libby's house in **November 2021**. Libby was found dead with lacerations to her neck and the paramedics tried to resuscitate Libby but the attempts to revive Libby were unsuccessful.

2.1.2 Following an extensive investigation by the Police, Benas was arrested and charged with Libby's murder. Benas admitted to the murder of Libby and therefore the case did not go before a jury, and he was sentenced to life with a minimum term of fourteen years and ten months.

2.2 Post-mortem: A post-mortem was carried out the following day.

2.2.1 Main Subjects of the Review are;

DHR Subject	Relationship to the Victim	Age at Death	Ethnic Origin	Disability
Libby (victim of domestic abuse)		47	White British	None
Benas (perpetrator)	Partner	38	White Eastern European	None
Sam	child		White British	N/A
Alex	child		White British	N/A
Mother of Libby	Mother		White British	N/A
Father of Libby	Father		White British	N/A
Gerry	Ex- Husband		White British	N/A
Peter	Ex-Partner of Libby		White British	N/A
Ann	Long term friend		White British	N/A
Lucy	Friend in later life		White British	N/A

2.3 Background information on Victim and Perpetrator.

Libby (Victim)

2.3.1 Libby was the only child and was brought up in Somerset. In her twenties she started to attend raves, and, from information provided by the family, this is when

Libby started to experiment with drugs. Libby engaged in drug rehabilitation on a number of occasions.

2.3.2 Libby met Gerry, were married in 2005 and the marriage broke up in 2012. Gerry was in the armed forces and Libby and Gerry had a child together called Sam. Following the breakup of the marriage, Libby met Peter in 2013. Peter was known to agencies as involved in drugs and other criminal activities.

2.3.3 Libby and Peter had Alex and for a while Libby and Peter were living in a different county and another country. Following reports of domestic abuse, the relationship between Libby and Peter started to break down and they both returned to England with Libby returning to Somerset to be near her family. Libby and Peter did stay in contact with each other following the breakdown of the relationship.

2.3.4 Libby and the children became known to agencies in Somerset due to concerns around Libby's own wellbeing and the impact this had on her ability to care for the children. Alex spent a period in foster care following his birth and then went to live with Libby's parents and Sam went to live with Gerry.

2.3.5 Despite the wellbeing issues that Libby was experiencing she worked throughout her 20's, 30's and 40's including working in travel and setting up her own website and pod cast in the last few years of her life. Libby supported her children and attended sports matches, collected her children from school/nursery, attended school meetings and was proactive in family life. Gerry did not provide any financial support for Libby and Peter provided no financial support for Libby or Alex.

2.3.6 However, Libby continued to struggle with substance misuse, and this seemed to increase when she was no longer able to care for her children. Libby became involved in county lines and the sex trade to fund her drug use but also to protect herself from organised criminal gangs.

Benas – The Perpetrator

2.3.6 Benas informed the Independent Chair that he came to live in the United Kingdom (UK) in 2010 from Eastern Europe. This date cannot be verified as at that time there was freedom of movement for European citizens to live and work in the UK. Benas had a family in Eastern Europe, including three children ranging from 14 years to 22 years. Benas was separated from his children's mother and Benas did manual roles whilst in the United Kingdom, which included gardening.

Libby and Benas-The relationship

2.3.7 It is not clear how long Libby knew Benas, but the family became aware of the relationship in early 2021 when Libby took him to the family home. Benas moved into Libby's home and the relationship was violent with Libby reporting several domestic abuse incidents to the police in May and October 2021. Libby was in fear of her life and predicted her own death to friends and Libby stated that she was trying to end the relationship when she died.

3 THE CHRONOLOGY

3.1 The information below has been drawn from a range of sources; including the IMRs submitted by agencies (referenced where appropriate). IMR authors were requested to review agency contact with Libby, her family and Benas from the period **1 January 2015 up until Libby's death November 2021**. The reason for the time frame has already been described in section 1.6 of this report. The IMRs have been reviewed and robustly challenged by the DHR Panel.

3.2 The DHR Independent Chair has used the SCIE model "Learning together"[8] to identify the key episodes in the lives of Libby and her family leading up to Libby's murder.

3.3 The Key Practice Episodes (KPE) are identified below and will be referred to throughout the report.

- **KPE One: Libby pregnant with her youngest child, child safeguarding concerns and Libby experiencing Domestic Abuse**
- **KPE Two: Birth of the Alex and safeguarding concerns for Alex**
- **KPE Three: Removal of Alex from Libby**
- **KPE Four: Increased concerns for Libby's mental health and substance misuse**
- **KPE Five: Increased concerns for Libby's mental health and substance misuse and alleged involvement with County Lines**
- **KPE Six: Libby's arrest and a Community Order and safeguarding concerns for Libby**
- **KPE Seven: Homelessness and Libby operating as a Sex Worker**

[8] www.scie.org.uk/children/learningtogether/

- **KPE Eight: Libby identified as being an instigator of cuckooing[9]**
- **KPE Nine: Libby's increased involvement with County Lines and cuckooing**
- **KPE Ten: Libby being cuckooed and in fear of County Lines Organised Crime Groups**
- **KPR Eleven: Known relationship between Libby and Benas and first contact relating to domestic abuse in the relationship**
- **KPE Twelve: Escalation of domestic abuse by Benas**
- **KPE Thirteen: Death of Libby**

3.4 Family Life pre-2015.

3.4.1 Libby had lived in Somerset for many years and started taking heroin when she was in her early twenties. Libby met Gerry and they married and had Sam, in **2007**. The relationship ended and Libby then met Peter around **2013**.

3.4.2 Libby left Somerset with Peter and spent time living in Ireland and Oxfordshire prior to their return to Somerset in **2015** when Libby was pregnant with Alex. *(Source; various IMR's and family)*

It is important to note that on Libby's return to Somerset, she resided in, a rural area comprising of small towns and villages with many of the services that Libby needed for support being located in larger towns elsewhere in the county and therefore not always easily accessible for her.

3.5 Key Practice Episode One- Libby pregnant with Alex, child safeguarding concerns and Libby experiencing domestic abuse.

3.5.1 **Spring 2015**, Libby was pregnant with Alex and came to the attention of Somerset Children Social Care (SCSC). A referral was made by Public Health Nursing as there were concerns about Libby's unborn child, due to domestic abuse and parental substance misuse. At the same time, Gerry began private law proceedings in respect of the Sam. The court agreed that Libby would care for Sam with support from her mother and father.

3.5.2 During Libby's assessment with SCSC, it was acknowledged that Libby had difficulties with drug use (heroin) for the past twenty years. Prior to her pregnancy,

[9] Cuckooing – a type of exploitation by criminal gangs which involves befriending a person, then taking over their home and using it to deal drugs. The name comes from the cuckoo bird, which is known for laying eggs in other birds' nests. www.catalystsupport.org.uk

Libby reported that she was using an herbal legal high, known as Kratom[10]. During Libby's pregnancy she had relapsed to taking heroin and Peter had tried to "help" her to withdraw by taking her to his parents' house and also keeping her locked in the house for days forcing her to go through withdrawal. *The motivation for Peter to act in this way is not known, he may have been trying to help Libby or he may have been trying to control her.*

3.5.3 Libby claimed that if she did try to leave, Peter would restrain her by pulling her hair, an example of physical abuse. Libby explained that Peter would not allow her to use Kratom, but that he gave her Valium[11] which he controlled, a further example of controlling behaviour.

3.5.4 Libby told professionals that Peter was controlling and would not allow her to have access to any money. Peter claimed he was trying to stop Libby spending money on drugs and again it is not clear as to the motivation for Peter's actions was it out of concern or economic abuse.

3.5.5 Professionals recorded that Libby was minimising the action of Peter and blaming herself. *A behaviour by victims of domestic abuse often seen. The victim blames themselves for the actions of a perpetrator.* [12]

3.5.6 Following an assessment, a Strategy Discussion was held by SCSC and due to the safety concerns for Alex, an initial child protection meeting was convened. [13]

3.5.7 Libby contacted the police on **6 April 2015** to state that she had moved back into the area (town A) having lived in Ireland and Oxfordshire and was reporting that she was suffering domestic abuse. On reviewing the information shared by Libby, only one matter was identified by the police and that related to the ownership of a property and was therefore seen by the police as a civil matter. *(Source; CSC, PHNT and Police IMR)*

3.5.8 **7 April 2015**, it was noted on Libby's GP records that Libby had admitted herself to a hospital as she had had acute withdrawal symptoms and was unable to administer her herbal supplement of Kratom due to being locked out of her home by Peter. Oramorph[14], Chlordiazepoxide[15] and diclofenac[16] were prescribed for Libby in

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[10] Kratom - Tropical tree native to Southeast Asia, leaves produce stimulant effects (low dose) and sedative effects (high dose). www.dea.gov Kratom drug fact sheet.
[11] Valium – Valium is a Benzodiazepines prescribed for anxiety. Nhsinform.england
[12] www.broxtowewomensproject.org.uk It's not your fault .Self Blame and domestic abuse
[13] Child Protection Meeting – A meeting to consider id a child needs a Child Protection Plan and a named key worker. www.saferchildrenyork.org.uk
[14] Oramorph-liquid morphine used in small doses to kill pain.
[15] Chlordiazepoxide-sedative to treat anxiety
[16] Diclofenac-medicine to treat muscle and joint pain

hospital. On returning home from hospital, Libby found she had been burgled and her debit/credit cards had been stolen. Libby stated that the police were aware, but she did not feel at risk as Peter was still living in Oxfordshire. *(Source; CCG IMR)*

A referral was made to SDAS by the hospital and on **8 April 2015**, Libby completed an assessment with SDAS and was provided with a prescribing clinic appointment the following day. *(Source ; SDAS IMR)*

3.5.9 **9 April 2015**, at the prescribing clinic, Libby disclosed abuse from Peter which included being forced to use drugs. *The IMR author stated that in 2015, SDAS did not have a clear DA process, and therefore this disclosure was not followed up. Around 2015/2016 a DA process was introduced as part of Somerset County Council public health contract specification for SDAS. It would have taken some time for the DA process to be implemented as SDAS staff would have needed to be trained.*

3.5.10 Somerset Adult Social Care (SASC) received an email from SDAS wishing to share concerns for Libby. The information stated that Libby was twenty-eight weeks pregnant and was misusing substances (alcohol and drugs) and had recently separated from Peter, who was violent, and the email also stated that Libby had bruising which related to an assault by Peter. SASC phoned Libby and she said that she had returned home to town A and was living five minutes from her family. Libby said she felt safe and did not feel an ongoing risk from Peter. Following the discussion with Libby, SASC decided that a safeguarding response was not required but that she would be referred for an assessment of her needs from the SASC community team. *(Source; SASC and SDAS IMR)*

3.5.11 **16 April 2015**, Libby met with her GP and discussed her pregnancy and drug addiction therapy. Libby told her GP that she needed to be admitted somewhere away from her dealers and that she had been told by her midwives that she needed to see her GP and be referred somewhere away so that the baby can grow safely.

3.5.12 Following the consultation, the GP wrote to colleagues in social services and a specialist obstetric and expressed in the letter the vulnerabilities of Libby and her unborn baby. The GP wrote "I wish to ensure that a necessary co-ordinated health and social care response is in place for this lady (Libby) and if you have any questions then please get in touch with us." *(Source; CCG IMR)*

The GP showed a compassionate and responsible approach seeing risk and assessing the safeguarding needs for Libby and her unborn baby and their care, an example of good practice.

3.5.13 Libby phoned SDAS on **17 April 2015** and stated that she owed many people money and when asked about whether an Independent Domestic Violence Advisor (IDVA) had contacted her, Libby said she was not sure as she received lots of calls from different agencies.

3.5.14 The GP phoned Somerset Direct requesting a call from the social worker allocated to Libby on **30 April 2015** following the letter that had been sent on **16 April 2015**. An email was sent by the SASC call centre to the locality team duty inbox requesting a call to the surgery. SASC had no record of the letter on Libby's file or whether anyone contacted the GP.

3.5.15 SASC have recognised this as a missed opportunity to engage with Libby and potentially to offer or signpost to support. *SASC now have a new recording system in place and any request for contact would now be sent using a system and not an email.*

3.5.16 The GP received a letter from the Third Party Acute and Emergency Service (SomFT) on **6 May 2015.** The letter set out a protective plan for Libby including all the risks that were impacting on her wellbeing.

This exchange of communication between health professionals considered mental capacity and a person-centred focus on collaborative working to keep Libby and the unborn baby safe.

3.5.17 On the same day, a mental health nurse from the hospital contacted SASC hoping to speak with Libby's allocated social worker. They wanted to know if a MARAC referral had been made. A SASC social worker spoke with the mental health nurse, and it was noted the "complex and volatile nature of this case." It was agreed that an urgent assessment was needed. *(Source, SASC and CCG IMR)*

3.5.18 **13 May 2015**, the GP made a referral to the mother and baby unit at a hospital in the nearest city, stating that the GP had grave concerns about the wellbeing of the unborn baby and having a place of safety would be ideal. The GP recorded a note on Libby's file about a disclosure of domestic abuse before the separation with Peter. The GP records also indicated that the health visitors and SCSC were making a referral to a MARAC and therefore the GP did not need to refer.

3.5.19 The SCSC social worker recorded that a referral was sent to MARAC with a DASH risk assessment on **19 May 2015.**

The notes on SomFT records indicate that a MARAC risk assessment was completed by SCSC social worker, and that the GP was also aware of the referral. SomFT do not have on record that the MARAC was discussed at the relevant MARAC meeting in

May and if it had been discussed, SomFT would have recorded this on their file as there is always a representative from SomFT at the MARAC. As detailed in paragraph 1.7.6 there are no available record of MARAC referrals prior to 2019. The Independent Chair is aware that there have been issues relating to the recording of MARAC meetings, what was discussed and what action were agreed. It is understood that there has been significant work undertaken to improve the MARAC process in Somerset and this will be discussed later within section seven of this report.

3.5.20 Libby visited a face-to-face clinic (SDAS) **on 14 May 2015.** Libby said she felt very isolated, alleged that her family relationship had broken down, she had no money, hated being on her own and was thinking about going back to a relationship with Peter. A discussion took place with Libby about the risks of getting back with Peter and the risk of Libby's drug use on her unborn child.

3.5.21 **22 May 2015**, Libby's allocated SASC social worker contacted the mental health nurse at the hospital, SCSC and SDAS to explain that there was now an allocated social worker for Libby and her unborn baby.

3.5.22 The SASC social worker spoke with the SCSC social worker who said that Libby was not eating very much due to lack of money but was prioritising money for drugs despite being on methadone. *This was an example of a welfare issue as Libby was not providing herself and her unborn child with adequate nutrition.*

3.5.23 The SASC social worker also spoke with SDAS, and it was agreed that the SCSC social worker was the most appropriate person to speak to Libby regarding the risk of domestic abuse. The SDAS worker explained that the referral they made to SASC was about Libby being socially isolated and not domestic abuse. *(Source; SASC, CSC, PHNT and SomFT IMR)*

3.5.24 **Early June 2015,** a SASC social worker spoke with Libby on the telephone to conduct an assessment. The outcome of the call was that Libby had no eligible care and support needs. Libby did not need ongoing support from SASC but would need ongoing support from SDAS, the midwife and SCSC and then SASC closed Libby's case. *(Source; SASC IMR)*

3.6 Key Practice Episode Two – Birth of the Alex and safeguarding concerns for Alex

3.6.1 **June 2015,** Alex was born and was methadone dependent because of Libby's drug use during pregnancy. A multi-agency discharge meeting was held at the hospital before Libby and Alex were discharged. All key family members, including Peter, and professionals (social worker, NICU outreach team, specialist midwife and

SDAS) attended. The meeting established a clear plan of care and support for Libby and Alex. It set out the expectations and schedules of each party which included Peter, although Libby was uncertain about his involvement with Alex.

Following the birth, Alex was made subject of a Child Protection Plan[17] under the category of neglect and SCSC also recommended a Public Law Outline[18] (PLO) meeting. The plan of support consisted of Peter not being able to stay overnight at home to reduce the concerns around further domestic abuse, regular visits by Libby's mother and father, visits by SCSC and regular planned support from health and SDAS. *(Source; CSC IMR)*

3.6.2 SCSC made a referral to SIDAS in **June 2015** and a Domestic Abuse Coordinator (DAC) was allocated to Libby to support her with domestic abuse issues. Between **mid-June** to mid **July 2015**, the DAC made five unsuccessful contacts to Libby, with one appointment finally being made which Libby was unable to attend.

3.6.3 **25 July 2015** SCSC received an anonymous referral suggesting that Libby was intoxicated and had been involved in a road traffic accident. Further referrals were received by SCSC from South Western Ambulance Service NHS Trust (SWAST) and the local hospital with similar information. It was requested by SCSC that the Police made a welfare visit. The Police were concerned for Libby and Alex as their whereabouts was not known, and they instigated a missing person search*. Good practice by agencies and all showed concern for Libby and her youngest child.* A strategy meeting took place, and it was agreed that when Libby and Alex were found, Police Protection (PP) would take place for Alex. Libby and Alex were found later that evening, and Alex was taken into PP and taken to the local hospital for an assessment.

3.6.4 The following day, Alex was placed in temporary foster care and Libby signed a Section 20 Agreement[19] with SCSC for Alex to be placed voluntarily into foster care. During this time, Libby was only going to be allowed supervised contact with Alex. *(Source; SCSC and police IMR)*

3.6.5 Following the receipt of the referral from Libby's GP to the Community Mental Health Team, (CMHT), a telephone triage was undertaken with Libby on **7 August 2015.** Libby's long history of substance use, domestic abuse and her mental health

[17] A Child Protection Plan is made when a child is judged to be at risk of significant harm that affects the health , welfare and development of a child.www.scie.org.uk/publications
[18] Public Law Outline -A procedure that local authority must follow if there are sufficient concerns about a child in their area. www.familylwgroup.co.uk
[19] Section 20 is used to accommodate children who cannot live with their parent (s) www.childlawadvice.org.uk

were discussed. Libby spoke of her situation with Alex being taken into foster care following a car accident and that Libby was using opiates and was uncertain as to what would happen next. Libby was provided a mental health contact number and an agreed plan that CMHT would contact Libby following the agreement on what the next steps would be for her and the baby, had taken place. Libby did not respond to telephone or letter contact from CMHT and was then discharged by CMHT and referred back to her GP.

At the time there would not have been an automatic follow up by CMHT but Libby or the GP could have referred into the service. Since 2015, SOMFT have developed a No Response, Did Not Attend non engagement Incident Operating Procedure which provides a clear process for follow-up where patients have not responded to appointments and calls. (Source; SomFT IMR)

3.6.6 **4 August 2015**, a third party phoned SDAS to say that Libby was at another SDAS service user's house and was using opiates and crack and then drove her car with the baby in it. *(This incident should have been escalated by SDAS to SCSC as child was at risk)*

3.6.7 **11 August 2015**, a PLO meeting was held, and information was shared that over the weekend of late **July 2015**, Libby had been involved in two car accidents. One in the morning, when Alex was in the car. *(Source; SCSC IMR)*

3.6.8 The DAC (SIDAS) made an appointment with Libby, and this took place **1 September 2015,** and parts of the Overcoming Abuse Programme was discussed with Libby, this included;

- Domestic Abuse, Risk and staying safe
- Abusive behaviour and abusive relationships
- The impact on children
- Reflection, planning and moving on.

The DAC referred Libby to the group sessions of the programme for the new year (2016) but there was no evidence to suggest that Libby attended the group sessions. *(Source; SIDAS IMR)*

There was no information to confirm any follow up by SIDAS as to why Libby was unable to attend the sessions.

3.6.9 A Review Child Protection Conference took place on **7 September 2015.** It was highlighted that Libby had been attending a drug treatment programme with SDAS for approximately four weeks. This was part of a thirty-six-week programme and Libby said that she had been abstinent for the last two-three weeks.

3.7 Key Practice Episode Three- Removal of Alex and Sam from Libby's care

3.7.1 **11 September 2015**, Alex was placed with the mother and father of Libby and Sam remained in Gerry's care with support from Libby's parents. Libby was only allowed to have supervised contact with her children.

3.7.2 **14 September 2015**, Libby spoke with the Public Health Nursing Team and told them that Alex was in her care but at her parents' home. Libby explained that Alex had been in foster care following a traffic accident. The health visiting team in Libby's hometown were not aware of Libby and Alex being back in the area. *(Source; PHNT IMR)*

The information that Libby had moved in with her parents and was caring for Alex was disclosed by Libby and not SCSC. It shows that Libby was acting at the time in Alex's best interest. If SCSC had informed the health visitors of the situation, this would have helped health visitors to ensure continuity of care.

3.7.3 Libby visited her GP on **15 October 2015** for a consultation review of her anxiety and depression. A discussion took place with her GP about some engagement with the CMHT and Libby felt she would benefit from this and about Libby's use of antidepressants and her continued engagement with SDAS. Libby agreed to commence Sertraline[20] for her anxiety and depression.

3.7.4 The care proceedings ended on **10 March 2016**. In Libby's witness statement she claimed that the only abusive relationship she had was with Peter. The social worker also provided information to state that Libby was attending the Freedom Programme[21], Alex was in the care of Libby's parents, and they were granted a Child Arrangement Order for Alex and Somerset County Council were granted a twelve-month Supervision Order. Libby was only allowed supervised contact with Alex, but Libby was hoping that that Alex would return to her care in the future when it was safe to do so. *(Source ; SCSC IMR)*

3.8 Key Practice Episode Four- Libby's relapse into taking drugs and increased mental health issues.

3.8.1 **In May 2016**, during a routine Child in Need visit, SCSC recorded that Libby was having unsupervised visits with Alex with the plan that Alex would move back with her in three months' time once the care proceedings had ended. At the time, Libby was staying at Gerry's house during the week as he was away working, and

[20] Sertraline - A drug used for depression
[21] Freedom Programme– Supports women to flee domestic abuse www.freedomprogramme.co.uk

with her mother and father at the weekend. It was noted that Libby was having unsupervised contact with both her children. *(Source; SCSC IMR)*

Although at the time there was a supervision order in place, this did not prevent Libby from having unsupervised contact. Family meetings were being held to review contact and looked at increasing this between Libby and her youngest child. There were no concerns from the visit by the social worker, however when concerns were raised by Gerry, appropriate steps were taken by the Gerry and Libby's mother and father to ensure there was no unsupervised contact.

3.8.3 **13 May 2016,** Gerry contacted SCSC and reported that Libby had relapsed and was taking drugs again. Libby attended a SDAS clinic **19 May 2016,** and she reported being stressed about her relationship with her parents and that she was finding it increasingly difficult living at her parents with the situation being very stressful, and she wanted to move to Gerry's home, but this would make the care and residency of Alex more complex. SDAS advised that this would need to be negotiated with her parents and SCSC.

Although Libby stated she was stressed about her relationship with her parents, SCSC stated that they found Libby's parents very supportive of both Libby and the children.

3.8.3 **By July 2016,** Libby was caring for Alex on her own but was also heavily supported by her mother and father. Libby was engaging with SDAS and her GP. *(Source; SCSC IMR)*

3.8.4 **13 October 2016**, Libby had a face-to-face care plan meeting with SDAS. Libby said that she was still living between her parents and Gerry's home and that she lacked motivation, low moods and was struggling with her housing situation.

3.8.5 Libby visited her GP to discuss depression on **17 October 2016** and again Libby said she had lost motivation, was feeling lonely and wanted another relationship but that she was unhappy with her appearance. The GP recommended some relevant reading to Libby, and she commenced a further anti-depressant prescription and was given forms for Talking Therapies*. Good practice to have a constant GP who Libby had trusted and therefore have easier conversations. (Source; GP IMR)*

3.8.6 Benas was arrested on **23 October 2016** and was charged for a road related incident and for driving under the influence of alcohol. *(Source; Police IMR)*

3.8.7 **19 December 2016**. Libby told SCSC social workers that she had relapsed and was taking drugs again and that she felt under pressure from people around her. Support was offered to Libby and whilst no formal assessment was carried out, which would not be unusual as the case was already open, visits were completed that day

to Libby and her parents given the concerns raised and the social worker made her assessment based on the visits. Contact was made by the SCSC social worker with SDAS to ensure that Libby was supported. *(Source; SCSC and SDAS IMR)*

3.8.8 **3 March 2017**, the twelve-month supervision order for Alex with SCSC ended.

3.9 Key Practice Episode Five – Increased concerns for Libby's mental health and substance misuse and alleged involvement with County Lines.

3.9.1 The police received a call from Libby's mother on **20 March 2017** saying that Libby had gone missing with Alex and that she believed that Libby had gone to use drugs, therefore putting Alex at risk. Libby's mother said that she had also notified SCSC as they were involved with the family. The police quickly located Libby via a friend and Libby stated that she was not missing and was angry that the police had been involved. The police did check that both Libby and Alex were fit and well. The police did note that the property of the friend that Libby and Alex were staying had links to drug intelligence for the supply of drugs.

3.9.2 **23 March 2017**, SCSC were notified that there were further concerns for Libby's drug misuse and behaviour with reports that she was going missing with her youngest child. The mother and father of Libby stated that Libby's demeanour and engagement had changed. The family were concerned that Libby was using heroin and not able to parent the children safely when in her care. SCSC were completing an assessment for Sam, along with CIN plan for Alex.

3.9.3 On the same day, Gerry returned to his home (Libby was still living in the house during the week) to find drug paraphernalia and what looked like stolen goods, men's clothing in large quantity with the tags still on. Gerry contacted the police and asked for a reference number and Gerry explained that he was taking action to remove Sam from Libby's care. The police did visit the property and no drugs or stolen property were found. *(Source; Police and SCSC IMR)*

3.9.4 SDAS received a phone call from a pharmacy that Libby was using on **6 April 2017,** to say that Libby's behaviour had changed. Libby was rude to staff and customers and was refusing to wait for her medication. Libby attended a clinic with SDAS on **13 April 2017** but refused to stay, was tearful and said she had relapsed and was having minimal contact with her children.

Again on **14 April 2017**, the pharmacy reported that Libby was smelling of alcohol and there was a suspicion that she was stealing from the pharmacy.

3.10 Key Practice Episode Six- Libby arrested and sentenced to a Community Order and safeguarding concerns for Libby

3.10.1 **May 2017,** a multi-agency meeting took place and police intelligence was shared that Libby was dependent on drugs and was being cuckooed and that she had stopped taking her methadone prescription.

3.10.2 **1 July 2017**, a security guard at a local supermarket saw Libby on CCTV pick up two candles, put one back and the other just vanished and Libby walked past the till, not making any attempt to pay. Libby was apprehended outside the store by another security guard and was asked about the candles in her bag at which point one of the candles fell from Libby's bag. The security guards tried to persuade Libby to go back into the shop, but Libby started to scream and shout and pushed the security guards to get away and as the security guards tried to restrain Libby, she kicked one of the guards and dug her nails into the other.

3.10.3 In the early hours of **8 July 2017** an anonymous caller phoned the police and reported a vehicle being driven in a local area by a female who was intoxicated. The vehicle was found by the police; the vehicle had stopped but with the brake lights on. The police approached the car and recognised Libby who was in the driver's seat. A friend was sitting in the passenger seat and the keys were in the ignition. Libby smelt of alcohol and she was asked to provide a roadside breath test, which she did, and it was positive. Libby did disclose that she had relapsed into drugs following the breakdown of her relationship with her previous partner after experiencing domestic abuse. Libby said that she was thrown out of her accommodation and had lost contact with her children. Libby said that the offence on **1 July 2017** was for financial gain to fuel her drug habit. Libby engaged with SDAS, and she explained that she had been in a car accident, her case was reopened, and she was offered community transport to support access to her meetings with professionals. *(Source; Police, SDAS and SCSC IMR)*

3.10.4 **18 July 2017**, Libby was arrested following a further car incident and she failed to provide a specimen. Libby pleaded guilty at a magistrate's court and was given a Community Order, disqualified from driving and required to participate in a nine-month drug rehabilitation programme. *(Source; Probation IMR)*

It would appear from information in the IMR's that Libby did not complete the drug rehabilitation programme and professionals state that Libby had multiple opportunities to engage with agencies but that she never did. Professionals never seem to ask the question why Libby did not attend, was it fear of others and trying to protect her own safety. Professionals need to try to understand the trauma that someone may be experiencing which may inhibit engagement.

3.10.5 **8 August 2017**, Libby was due to appear before a magistrate for the incident **1 July 2017** and for failing to provide a specimen on **18 July 2017** and was due to have an on the day report prepared but she failed to attend and a warrant without bail was issued. Later, the same day, Libby turned up at the wrong magistrates' court heavily under the influence of alcohol.

3.10.6 **28 August 2017**, the police called SASC as they were concerned for Libby's wellbeing. The police reported that Libby was sofa surfing, she had met two men who were giving her money for sexual favours and Libby had told the police she felt trapped with no way out. Libby had moved to get away from the men but had ended up on the streets in another town in Somerset. A referral was sent to SASC for an adult safeguarding triage decision. Following an information check it was decided that there was no cause to progress to a Section 42 enquiry as Libby did not have care and support needs. It was felt that Libby had capacity to make decisions regarding her daily needs and that she was making decisions that were led by her addiction rather than because of impairment of her mind. *(Source; SASC IMR*) *The decision not to progress to a section 42 enquiry could have been impacted on for various reasons, processes in place at the time, level of training/experience of the practitioner, unconscious bias.*

3.10.7 **29 August 2017**, Libby attended SomFT Acute Hospital Accident and Emergency (A&E) with an abscess in her groin from intravenous drug use. Libby was admitted for treatment and self-discharged the following day against medical advice. Whilst Libby was in hospital, she was seen by the Psychiatric Liaison Team (PLT) and an SDAS engagement worker. Libby denied alcohol dependency to the PLT and there was no evidence of a mental health disorder and there was no reference to any domestic abuse concerns being recorded within Libby's notes. *(Source; SomFT and SDAS IMR)*

3.10.8 **30 August 2017**, Libby disclosed to SDAS that she had links with a Somalia gang member, and that other member of the gang had stabbed several people and that another SDAS service user had pimped her out. *(Source; SDAS IMR)*

3.10.9 **31 August 2017**, Libby was seen by the Liaison & Diversion Service (LADS) whilst at the magistrate's court and Libby was offered a mental health assessment which she declined. Libby also spoke with a probation officer, and she told them that she had been battling with drugs since she was 21 years old and described using crack cocaine, six bags of heroin and drinking six-seven cans of cider, on daily basis. Libby was sentenced to a twelve-month community order with a rehabilitation requirement with her 1st review being **3 October 2017.** *(Source; Probation)*

Libby never completed her twelve-month community order and breach proceedings were issued. Again, professionals stated that Libby was not engaging and appeared not to consider Libby's safety and vulnerabilities.

3.10.10 **September 2017**, the children's case was closed to SCSC, with the following arrangements that Sam lived with the Gerry and the mother and father of Libby as required (Gerry needed to work away at times) and Alex remained with Libby's parents were advised that they needed to ensure that Libby did not have access to Alex on her own until she had demonstrated and been assessed by professionals to have managed her addiction and drug seeking behaviour. *(Source; SCSC IMR)*

3.10.11 Libby attended SomFT A&E on **6 October 2017** with right knee pain and known deep vein thrombosis (DVT) in her leg and Libby was admitted for pain management and further investigation. Libby remained in hospital for four days, but it was recorded that she was frequently on and off the ward and on **9 October 2017**, Libby left the hospital in a taxi. Libby was discharged from the hospital on **10 October 2017** with a reference on her file about substance misuse and alcohol withdrawal but there was no mention of any domestic abuse. The hospital contacted the Offender Manager (OM) Probation Service saying that Libby had been in hospital and was being very chaotic. The hospital asked if Libby had been in contact with SDAS. *This was evidence of good practice and effective communication.* The OM informed the hospital that Libby was in breach of her sentence due to non-attendance at meetings and she had not contacted SDAS, and the OM confirmed that breach proceedings had commenced with a hearing likely to be in **November 2017**. An OASys was completed on **8 November 2017** (six months late) and was incomplete and therefore there was no initial sentence plan in place to inform what offending work was going to be completed with Libby. Despite Libby having children, there was no contact with SCSC. *(Source; SomFT/Probation and SDAS IMR)*

3.11 Key Practice Episode Seven - Libby identified as being part of an incident of cuckooing.

3.11.1 **From November 2017 onwards,** the police records identified Libby was being seen by the police as the main instigator for the cuckooing of a vulnerable male called "Fred", who was reported as being held hostage at his home address. It was recorded by the Police that Fred was forced to take out money to give to Libby and other Organised Crime Group (OCG) members, whilst at the same time, Libby was having? financial support from her parents. Libby stated to her parents that the money was to pay rent to Fred whilst Libby was living with him and his mother. *Libby may have been financially abused by the OCG*

3.11.2 Operation Ash was formed to collate a team of Officers to disrupt criminal activities linked to County Lines. The operation was successful in removing the organised crime group from Fred's property. *(Source; Police IMR)*

It is not clear from information provided as to whether Libby was offered any support or guidance about her apparent actions.

There also appears to have been very little intelligence/information about Fred including his vulnerabilities. As part of the DHR, the SASC representative on the DHR Panel said that they would ensure that there was a follow up by SASC to see if Fred had any safeguarding needs.

3.11.3 **27 November 2017**, Libby appeared before the magistrates' court on a breach warrant order and was given a £50 fine. Libby failed to attend her initial appointment with the OM following her breach on **30 November 2017** and a final warning letter was issued.

3.11.4 Libby did attend one of her two appointment with the OM on **7 December 2017** and her induction paperwork was completed. The OM explained to Libby what would happen if she did not comply with her order. Libby disclosed she was using three or four bags of heroin daily which she injected, she was still shop lifting and being paid for sex to fund her habit. Libby said she had tried to contact SDAS and had tried to give up heroin on at least five occasions. Libby said she was "fed up with the life she was leading and wanted to give up drugs again." The OM said they would contact SDAS and TNT. *(Source; Probation IMR)*

TNT confirmed that they had a referral from Probation, but that they were unable to make face to face contact with Libby. As described in paragraph 1.7.3, TNT had limited resources in Somerset in 2017 and therefore the form of engagement was by the phone and not outreach. Following a number of telephone and text contacts and trying to arrange to meet with Libby, TNT closed the referral, in order to support new referrals. Information was shared between Probation, TNT and SDAS that Libby had not attended any arranged appointments. There appears to have been no follow up contact with Libby, by Probation to try to understand what barriers Libby was experiencing in contacting services which may have been able to support Libby.

3.11.5 Libby self-referred to SDAS on **11 December 2017** where she disclosed that she was in her words a "sex worker" and daily heroin user and later in the day Libby was admitted to hospital and commenced a methadone prescription.

3.11.6 **14 December 2017**, Libby attended SomFT Minor Injury Unit (MIU) with a groin abscess from injecting heroin and crack cocaine. Libby told professionals that she was sofa surfing since fleeing domestic violence.

There is no record of any further exploration of the domestic abuse disclosure and could identify a lack of professional curiosity. Since 2017, SomFT have undertaken work in relation to professional curiosity and domestic abuse including the MIU.

As Libby had highlighted that she was homeless it would have been good practice for Libby to have been signposted or her consent sought to contact the housing department to make them aware of her housing situation.

3.11.7 **17 December 2017**, Libby again attended SomFT A&E with increased pain following her MIU attendance. Libby was admitted for further investigation and treatment but there was no reference to domestic abuse and no routine enquiry was made by any professional in A&E or whilst Libby was on the ward, and she spent ten days in hospital.

At the time of Libby's admission, the community and acute services were not part of the same Trust and therefore did not have access to each other's records and therefore the reference to domestic abuse in the MIU would not have been shared. The Trusts have now merged and there are now less systematic barriers. (Source; SomFT IMR)

3.11.8 **In December 2017**, Libby met with her OM, and she informed the OM of being in hospital with a DVT and she was given Methadone daily. Libby said she wanted to move closer to her family and children, but she was not currently stable enough as there were old drug acquaintances living in the area. The OM noted that Libby appeared motivated to move away from her present lifestyle. *(Source; Probation IMR)*

3.11.9 **Late December 2017** Libby had a consultation with her GP about drug addiction therapy. The GP discussed with Libby the need for the hospital to prescribe Methadone and due to a bed shortage at the hospital, she would have to be accommodated in a hotel over the weekend. *(Source; CCG IMR)*

3.11.10 **In January 2018**, Libby informed her OM that she was staying with a friend in the local area and that she was given temporary accommodation in another area but was unsure as to whether to take it as some of her old acquaintances lived nearby. Libby said she was receiving methadone from SDAS and was feeling much better. The Probation Service sent a referral for Libby to (TNT), and a case worker was assigned. (*At the time of the referral to TNT, there were only two case workers*

within the Criminal Justice and Diversion Service). The TNT case worker texted Libby to arrange to meet and Libby responded with a date (15 January 2018) but that due to her having to sofa surf, a venue and time needed to be organised. On the day of proposed meeting Libby messaged the TNT caseworker to say she had a bug and could not meet, and a further meeting was arranged on 25 January 2018. Libby text TNT case worker to say because of things going on she could not meet but the case worker did speak with Libby later in the day and it was agreed that the case worker would take Libby to the local council housing service. **29 January 2018**, the TNT case worker texted Libby about visiting the local Council offices for some advice and Libby was asked if she had any transport to get to the council offices. The case worker explained that she would not be available to take Libby to the council offices until **mid-February 2018** to help sort out her accommodation and Libby said that this would be fine. **14 February 2018**, TNT case worker contacted the local housing department about the planned visit with Libby and was told to arrive at a certain time in order to be seen first. The case worker tried to contact Libby by phone, but this was not successful, so a text message was sent. The local housing department contacted the TNT caseworker to say that Libby had already made a housing claim and therefore not to attend the council. Libby was contacted by the case worker and a further meeting was arranged but Libby cancelled the meeting, stating she had a row with the person she was staying with. TNT case worker was concerned about not being able to meet with Libby and contacted the Probation service. TNT case worker explained about her concerns with Libby's housing arrangements and that she appears to be staying with a man in exchange for sex and there was a concern around domestic violence and the Probation Service confirmed that they were not aware of the situation. TNT case worker then contacted another council in the area to ask if they had any temporary accommodation and was advised to contact SIDAS with a view to getting Libby into a Refuge. Libby was contacted by the case worker and asked Libby's permission to contact SIDAS. Libby was not keen for this to happen, saying she had no money and needed her prescription. TNT case worker recorded that she was not sure if she should leave the decision to Libby to make as she was clearly in some danger staying where she was. Libby was advised to phone 999 by TNT caseworker in the event of an emergency. **22 February 2018** TNT caseworker sent an email to SIDAS for advice and further information about Libby's situation. TNT records showed that Libby was referred to Home Group which supported women with accommodation needs and it was noted that Libby was eligible for the sex workers outreach programme but there is no further information as to whether Libby engaged in the programme as the case worker is no longer

employed by TNT and the notes at the time were not recorded on the present case note recording system. *(Source; Probation IMR and TNT chronology of contact)*

It is not clear from information provided as to whether the Probation Service was updated further on Libby's situation, which should have happened.

3.12 Key Practice Episode Eight- Homelessness and Libby operating as a Sex Worker.

3.12.1 **Early March 2018**. Somerset Wide Integrated Sexual Health Service (SWISH) raised concerns about domestic abuse with SomFT internal Safeguarding Service following their contact with Libby. It was identified that Libby had been engaged with sex work to fund her substance misuse and there were concerns about her homelessness. It was noted that Libby was sleeping on the sofa of a previous SWISH client and felt obligated to pay him with sex. Libby did not want to report this to the police, but on the advice of the SomFT Safeguarding Service, SWISH made a referral to SIDAS. On receiving the referral, SIDAS liaised with SDAS to determine if there was a risk for Libby being accommodated in a refuge whilst she was still using substances and to understand her treatment plan as she was on methadone. It was agreed that a safe house would be a better option. At the time SIDAS had no safe house available locally so contact was made with neighbouring areas and Libby was offered a place in another large town about thirty miles away. Libby was asked to make direct contact. *(Source; SomFT, SDAS and SIDAS IMR)*

Libby had significant trauma in her life and therefore it was not best practice for a DA specialist service to ask a client to make direct contact.

3.12.2 **16 March 2018** an IDVA had a telephone call with Libby and Libby said she would like to move back to the local area. Libby told the IDVA that she had been in temporary accommodation and was waiting for a hostel place, that she went to stay with a friend and although Libby let the housing officer know that she would be late for an appointment, they said they were unable to provide anything as she had missed her appointment. Libby went on to explain that two years ago she had lived in Town A, and this was a private property and that she had left the property to live in her Gerry's house as he was away with the Armed Forces and when he returned, he asked her to leave. (It was not clear when Libby left the Gerry's property) Libby said she did not want to live in certain area as she had helped police with enquiries and felt she would not be safe. The IDVA advised Libby to contact the police if she was harassed or further assaulted. *(Source; SIDAS IMR)*

Libby had shared information that she did not feel safe (a disclosure) and therefore the risk should have been reported and support given by the IDVA. The Housing

issue that Libby was experiencing would now be better resolved due to the Domestic Abuse Act 2021 which would have supported Libby as she was homeless and experiencing domestic abuse and would have an automatic priority need for homelessness assistance and a priority need for accommodation[22].

3.12.3 The IDVA contacted Libby on **19 April 2018** (there had been two previous unsuccessful calls to Libby in early April with voicemail messages left by the IDVA but no response from Libby) and Libby was asked if she had contacted the local Housing offices as advised. Libby said no and asked if the IDVA would speak with them. The IDVA explained that housing may not speak to an IDVA without Libby's consent, but the IDVA would try. A call was made to local Council Housing, but without consent the housing department would not discuss Libby's situation. Following the meeting, the IDVA spoke with her manager who stated that the only housing options for Libby were in a different county.

3.12.4 The IDVA phoned Libby on **20 April 2018** and left a voice mail to tell Libby that SIDAS had no safe house space but that she needed to discuss other options with Libby. Libby made no response so a text message was sent on **26 April 2018** which stated that if the IDVA had not heard from Libby **by 2 May 2018**, then the file would be closed. On the same day, the IDVA contacted SWISH to let them know the situation and SWISH confirmed that Libby had not turned up for an appointment with them. SIDAS closed the case **3 May 2018** due to non-engagement. *(Source; SIDAS IMR)*

Although the IDVA did try to support Libby by trying to engage on her behalf with the local housing authority, there appears to be no consideration by SIDAS professionals about any basic safeguards in place before the case was closed.

3.12.5 A new Offender Manager (OM) was allocated to Libby on **3 May 2018** and the OM contacted the Court team to request information about Libby's drug rehabilitation requirements (DRR) as the OM could not see any records of a DRR being heard in court.

3.12.6 A Breach report was prepared on **3 May 2018** as it was decided due to the limited time on Libby's order and the poor compliance by Libby to date that the best option would be to revoke Libby's existing Community Order and re-sentence her. The OM assessment was if Libby were able to assure the court of her commitment to improved future engagement and compliance with a Community Order and Rehabilitation activities requirements then Libby would be able to access services

[22] Homeless due to domestic abuse National Homelessness Advice Service Sept 2021 www.hhas.org.uk

which could help her. The new OM also contacted TNT caseworker to inform her that Libby had breached her sentencing requirements. It was agreed that the new OM would meet with the TNT caseworker and Libby. *(Source; Probation IMR and TNT case notes)*

3.12.7 **16 May 2018**, Libby's breach was withdrawn in the interest of justice. Libby contacted the OM and disclosed that she was emotional and distressed, and Libby said a MARAC was completed a few weeks ago due to a serious sexual assault and that she was a victim of the man with whom she was living. Libby said she felt trapped and had been advised to contact the local Council for housing as she wanted to get independent accommodation so she could see her children who were living with her mother and father. *(Source; Probation IMR)*

Following a request from the Independent Chair there is no evidence from any agency that a MARAC referral was made or considered at a meeting. This will be discussed in section seven of this report.

3.12.8 During June **2018 and early July 2018,** TNT and the Probation Service tried to set up a three-way meeting with Libby, but no meeting took place. Phone contact was made with Libby by TNT in **early July 2018** and Libby stated that she was sofa surfing again and was desperate for help, but Libby was told that TNT had been trying to support but that she needed to engage to get help. TNT case worker recorded that they were looking to close the referral for non-engagement so they could have opportunity to support new referrals. It was recorded in Libby's case notes that she would be given details of the Women's Centre in the area. *(Source; TNT case notes)*

3.12.9 **2 July 2018**, Libby had not met with her OM for a while but when they did finally meet, Libby said she was living with a friend. Libby said that she was in an abusive relationship and that the male had been given an eviction order and therefore there was a need to change her address. Libby said there had been a MARAC assessment recently and that she had met this new partner when she was working as a sex worker. Libby said she had a keyworker at SDAS and that she was on methadone but still using 1-2 bags of heroin a day and that she would like her own accommodation and that she was in receipt of universal credit.

3.12.10 **17 August 2018**, the OM phoned Libby and Libby said she was no longer living with her friend as there were people staying that she did not want to mix with. Libby said she wanted support, but the OM said that there were agencies wanting to support her but that she needed to engage. *(Source; Probation IMR)*

3.12.11 Libby met with SDAS for a needle exchange intervention on **11 December 2018** and she reported that she had moved from town A to town B as her partner was "not being nice" and she was now homeless, on the streets or sofa surfing and although she had been to the local council, she was advised that she had no local connection. (Source; SDAS IMR) *A disclosure should have been explored by SDAS.*

The above housing issue indicates that not all agencies understand the requirements about homelessness and the duty to refer. It should also be noted that the Domestic Abuse Act 2021 does not require a victim of domestic abuse to have a local connection to be a priority for housing although this was not applicable in 2018.

3.12.13 **14 December 2018**, Libby again attended SomFT A&E with a right hip abscess because of intravenous drug abuse. Libby was admitted for treatment including opiate withdrawal and during Libby's stay in hospital, she saw the PLT, and Libby demonstrated that she understood the impact of her substance use and housing situation had on her mental health, and she was keen to engage with SDAS. *(Source; SomFT and SDAS IMR)*

3.12.14 The GP tried to call Libby on **10 January 2019** regarding a Hepatitis B result but there was no response.

3.12.15 Libby again met with SDAS for a needle exchange intervention, and she reported that whilst staying at a YMCA in town B she had been robbed by two females and that she had no money. SDAS contacted the police and Libby was placed in emergency accommodation for two weeks in town C.

3.13 Key Practice Episode Nine - Libby's increased involvement with County Line and cuckooing.

3.13.1 Police attended an address in the town D on **10 February 2019** following reports of a female screaming at the property. Libby and her friend would not engage with the police despite extensive efforts. The police officers did note on his visit to the property, the extensive damage to a fence panel and kitchen window. The police suspected that a County Lines Organised Crime Group (OCG) were involved and that a male had cuckooed the address. A further attempt was made to engage with Libby and her friend, but they were not willing to speak with the police. *Libby and her friend may have been in fear of the OCG*. A Community Impact Assessment was completed with the local authority on **13 February 2019** and one action was to increase patrols in the area[23]. *(Source; Police IMR)*

[23] A community impact statement allows the community to say how crime has affected it. This information can be used in criminal trials

3.13.2 Libby attended SomFT A&E on **12 February 2019** after presenting at the MIU with abdominal pain and a head injury having been involved in a road accident two days before. Libby was given an examination and CT scan and nothing clinically, seemed to need treatment. The staff nurse did contact SomFT Safeguarding Service raising concerns that Libby had been given money for transport to get to the local housing department office regarding temporary accommodation but that she had returned to the ward at the hospital and was refusing to leave. Libby's notes show no reference to domestic abuse but notes Libby's capacity to make "unwise" decisions regarding her accommodation. *Making reference to an unwise decision could be seen as an example of professional bias.* Contact was made with SDAS and the Hospital In Reach Social(HIS) work team. *(Source; and SomFT IMR)*

3.13.3 **13 February 2019**, Libby's father contacted the police to report that he and his wife had guardianship for Alex, and that Libby has arrived at the house intoxicated and the family would not let her see her son. Libby has punched her father and when the officers arrive, it was confirmed that whilst Libby had planned supervised visits with her children, ad hoc visits were not permitted due to Libby's extensive drug use and "chaotic lifestyle*." chaotic lifestyle is a phrase often used by professionals and the community to describe often complicated and challenging lives of people who have substance use issues and may be homeless. Such lives can be challenging and may appear to an outsider as unmanaged but people in such situations have developed a range of skills and networks to survive and such a term can stigmatised someone*[24]. The Libby's father was clear that he did not wish to pursue a prosecution but that he would call the police if Libby returned. Libby's father said that the children did not see anything, and the LSU referred both Sam and Alex to SCSC, Education and Health and a Treat as Urgent[25] marker was added to Libby's parents' home.

3.13.3 In **February 2019**, Libby's family confirmed that she moved back from town C to live near them in one of their properties

3.13.4 Libby stated the police that she was homeless, although information provided by Libby's family established that she was living in one of their properties from February 2019. There is no information as to why Libby said this to the police. The police officer completed a BRAG vulnerability rating. A BRAG is a Blue, Red, Amber, Green vulnerability rating tool that supports the police to identify and record vulnerability they see when attending an incident or speaking to a victim over the

[24] www.issup.net Chaotic Lifestyles International Society of substance use professionals
[25] A treat as urgent marker on a property notifies the police to prioritise its response

phone[26]. Libby explained to the officer about her disadvantages, no home, no money, involved in drug and alcohol, mental health issues and suffering physical violence and is sexually exploited. The BRAG assessment was rated as Amber, but the Police IMR author noted that it should have been red as there was an immediate risk to Libby and her wellbeing and there was a referral to the LSU but there were no referrals pathways to mental health or substance misuse services. *(Source; Police IMR)*

3.13.5 **22 February 2019**, Libby was again admitted to SomFT acute hospital for a pain in her left groin following injecting of substances. In was highlighted on Libby's notes that she would leave the ward for extended periods of time and the reason was not clear. *The Libby's mother confirmed that she saw Libby during this timeframe and that Libby was taking Alex to nursery. The Independent Chair asked SomFT to check their records and they advised that the information provided was correct, but the family believe that it is not correct. Libby may have been using time she was away from the ward to visit her family and help with childcare issues, but this cannot be confirmed either way.* Libby said she was not using drugs, but she was drinking alcohol. The ward contacted the SOMFT Safeguarding service who provided the ward with contact details for SDAS and HIS. It was believed that Libby had an appointment arranged with a housing department, but Libby self-discharged herself against medical advice on **27 February 2019.** *(Source; SomFT IMR and family)*

3.13.6 Libby disclosed to SDAS on **27 February 2019** that the man she had been staying with would only take her to hospital if she performed a sexual act on him and that she had been raped recently and Libby declined support to report the rape but there are no reasons given as to why. A referral was made to TNT, but there was no follow up by SDAS as to whether Libby engaged. TNT did telephone Libby in late **March 2019,** but Libby said it was not a suitable time to talk and it was agreed that a call would be made a few days later. There was nothing further on Libby's records to say that there was any further contact by TNT. *(Source; SDAS IMR)*

The SDAS IMR author identified that professionals did not consider doing a DASH or a referral to the local Sexual assault Referral Centre to enable Libby to access support/advice and counselling. There also appears to have been no information provided to Libby around access to the local Somerset and Avon Rape and Sexual Abuse Support Service (SARSAS)[27]. The IMR author has made the recommendation to refresh all staff's awareness of the DA processes.

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[26] www.avonandsomerset.police.uk/proceduralguidancedomesticviolenceandabuse

[27] www.sarsas.org.uk

3.13.7 The GP had a telephone conversation with Libby on **13 May 2019** regarding her antidepressants. A discussion took place about Methadone and any support she was receiving, and Libby said she would like to restart antidepressants and have a mental health referral as she felt that she may be bi-polar. Libby said she was sleeping in the day and staying up all night reading. The GP requested a face-to-face consultation so that all the referrals could be made, and a mental health assessment could be addressed. *(Source; CCG IMR)*

An example of Libby was trying to take some ownership about her recovery.

3.14 Key Practice Episode Ten - Libby being cuckooed and in fear of County Line Organised Crime Groups.

3.14.1 The police took a call from Libby on **18 August 2019** saying she was vulnerable, and that people were controlling her due to County Lines. Libby had received threatening text messages and a group from London had stayed for a few days, but she managed to get the group to leave the house. The IMR author noted that the call log was not transferred to the main police recording system as Libby stated explicitly to officers who attended that she did not want to make a complaint about the text messages or any further contact about it. *(Source; Police IMR)*

3.14.2 **21 August 2019**, the police were called to Libby's address as there had been an altercation. The police identified that there were two men with London accents staying at Libby's home who "come and go as they please." Although Libby and her female friend were not at the address, a welfare check was completed the next day, and a BRAG was again recorded as amber. The LSU were asked to follow up and a TAU marker was placed on the house.

3.14.3 When referred to the LSU, a professional stated that "*This does not meet the threshold for making a referral to SASC. Cuckooing has been mentioned but there is nothing to suggest that this has taken place ".*

The Police IMR author stated that it was felt that "The LSU were incorrect in the statement as there is a threshold for a referral to SASC if someone is suspected of having care and support needs or is unable to protect themselves against abuse /neglect. "

3.14.4 Libby contacted the police on **3 September 2019** to tell the police that County Lines OCG members are coming to her property and that she is frightened. Libby said that she allowed them to use her address to feed her drug habit but that she was now staying with a friend. The local police team were contacted, who

constructed a Problem-Solving Plan[28]. The Lead police officer for the problem-solving plan set various actions for the police which included engaging with Libby and offering safety advice around not speaking with the males concerned and not inviting them into her property. The Anti-social behaviour team and targeted patrols regularly visited Libby to check her welfare and on one occasion a police officer took Libby to a local health centre to assist a GP to review injuries to her leg. The Anti-Social Behaviour Team had firm plans to tackle anti-social behaviour in the street and Libby was given a cuckooing letter that detailed practical advice including avenues within the criminal justice system. Libby was discussed within One Team[29] regularly and it was reported that there were less OCG at Libby's address and that she felt safer. Libby was helpful in assisting the police by passing on intelligence on various offenders although Libby did not want to make any formal statements as she may/would have been fearful of negative reprisals. *Good safeguarding practice by the police (Source; Police IMR)*

3.14.5 Libby had a phone call with SDAS on **26 September 2019** and she reported that she had been burgled and that another SDAS service user had a set of her keys. The *worker did not query if this was reported to police/council to see if locks could be changed.*

3.14.6 The PLT received a call from the local hospital on **7 October 2019** requesting a review of Libby who was an outpatient and was noted to have social concerns including vulnerability and involvement with County Lines and was suicidal. Libby was discharged from the local hospital before PLT could assess her. Libby was added to CMHT caseload and following CMHT's liaison with SDAS and a referral to Libby's GP it was agreed a joint assessment would take place between SDAS and CMHT.

3.14.7 During this assessment, Libby described there was no trauma history prior to her starting to smoke heroin aged 20. Libby stated she had experienced sexual, physical and emotional abuse during her adult life, and she had been subject to cuckooing on several occasions, the police were aware, and she had been told that she should phone 999 if something was happening. Libby said she felt too frightened to call 999 when the perpetrator was in the house.

3.14.8 Libby had a further two sessions with the CMHT in **November 2019** and then started to disengage with the support. Libby was cancelling the meetings or not

[28] A series of tried and tested steps to guide and structure efforts to reduce crime in an area.www.college.police.uk

[29] One team- monthly, multi-agency meeting (e.g. Housing, Health, Mental Health SDAS, Social Services and Environmental Services to discuss vulnerable people and chaired by district council member in 2019

responding to calls from the service despite several calls from CMTH. *A further example of professionals saying Libby was not responding to phone calls but there was no documentation as to whether CMTH considered why or trying any other method of engagement. (Source; SomFT IMR)*

3.14.9 Libby had a phone call with SDAS on **9 December 2019** and she explained that she had been banned from the pharmacy and that she had "put up" two homeless people who had stolen her TV. SDAS tried to contact Libby following this information to change her pharmacy and complete a urine screen. Libby did not attend despite several contacts by SDAS. *A further example of Libby not engaging, and the need for professional to ask why, possible trauma in a victim's life. (Source; SDAS IMR)*

Libby was issued with a Child Abduction Warning Notice[30] (CAWN) on **23 December 2019** as part of a child safeguarding /problem solving plan for a child at risk of Child Criminal Exploitation. The child was said to have been a frequent visitor to Libby's home. Libby was a mentioned party and prohibited from having contact with the child. Libby was also given a Section 8[31] warning letter at her home address as was Libby's mother and landlord of the property where Libby was living which related to drug use/dealing from the address. The police informed SCSC and the school that the child attended was also involved in the process.

3.14.10 Up until the **end of 2019**, the police recorded multiple intelligence regarding Libby's drug and supply use. Libby was often the person reporting the intelligence for example who was carrying weapons and dealing drugs which related to the County Lines. *(Source; Police IMR)*

This supplying of intelligence to the police could have heightened safety risks for Libby, although there was no indication that the risk to Libby was raised, or police policies and processes relating to the handling and processing of intelligence were not followed.

3.14.11 **30 January 2020**, Libby told CMHT that she had relapsed into taking crack and heroin and was entangled in potential criminal activity through association with alleged offenders. Libby knew that when her substance abuse was reduced there was an improvement in her mental health and Libby showed a good awareness that

[30] Child Abduction Warning Notice-CAWN is used to safeguard vulnerable children from abuse and exploitation by adults who take advantage of a child being taken away from the care and control of their parent/carer. www.www.library.college.police.uk

[31] www.legislation.gov.uk 8 Misuse of Drugs Act 1971 Warning letter-

she needed to stop contact with the people who took drugs, but isolation caused her to return to these people. Libby knew she needed to phone 999 if she was afraid.

3.14.12 On the same day, Libby had a face-to-face meeting with SDAS, and she reported that she was not eating well and not happy with her weight. Libby stated that she had a recent knock on the door by some known associates and admitted that she took part in a one-off drug session with a group of people, and she had "spent £600 on the drugs and that everything had fallen apart". *(Source; SomFT and SDAS IMR)*

3.14.13 **27 February 2020**, Libby met with her GP as she had a sharp pain on her left side. The GP conducted a physical examination and Libby told the GP that the pain was spreading to her back and shoulders. The GP completed a physical examination but there appeared to be no questioning about what/if anything had happened. Libby had a history of being a victim of domestic abuse and her drug addiction often put her at risk. *A missed opportunity to discuss domestic abuse/violence. (Source; CCG IMR)*

3.14.14 Libby did not attend her follow up appointment with CMHT on **23 March 2020.** This was changed to a telephone appointment in response to the first Covid 19 lockdown. Libby was contacted on a several occasions by professionals in CMHT by telephone and letter, but Libby did not respond, and she was discharged back to her GP on **8 April 2020**. *(Source; SomFT IMR)*

There is no record of any barriers which meant that Libby was unable to respond although Covid 19 restrictions and the way that service provision moved to telephone calls and not face to face may have impacted on Libby. Agencies and professionals need to ask the question why a victim did not attend, what could be the barriers?

3.14.15 Libby was in contact by phone with SDAS on **7 April 2020** and she reported that she had taken diazepam along with Methylenedioxymethamphetamine (MDMA or commonly known as ecstasy). Libby said her drinking had escalated and that local dealers were no longer selling crack cocaine, only cocaine and that dealers were asking if they could prepare drugs in her house. The key worker completed a Covid 19 check and made sure that Libby was not having any suicidal ideations and was given a crisis number. *(Source; SDAS IMR)*

There appears to have been no vulnerability risk assessment conducted for Libby and the police were not informed about the situation.

3.14.16 Libby met with her GP on **28 August 2020** regarding lower back pain. The GP checked Libby and there was nothing wrong with Libby's movement and no further action was recommended. *(Source; CCG IMR)*

There is no evidence that the GP undertook a clinical enquiry with Libby about domestic abuse despite the knowledge of previous domestic abuse. The CCG IMR highlighted that Libby had a good relationship with her GP and Libby complaining of back pain may have been an excuse to disclose abuse that she may have been experiencing. This example highlights how important it is for professionals to make a clinical enquiry about domestic abuse. Evidence highlights that GPs are often best placed to make a clinical enquiry about domestic abuse.

3.14.17 **4 December 2020**, Libby reports that she is being harassed and intimidated by a male called Chris. Libby states that she was supporting Chris's partner as a victim of DA and therefore Chris had a vendetta against her. The friend was interviewed separately and although Libby did not want to prosecute the male, he was stopped and searched and was found in possession of class A drugs and two knives. The suspect was charged and remanded for court the next day. *(Source; Police IMR)*

3.14.18 **2 January 2021**, Libby attended SomFT MIU for a wound to her thumb. There was no record of any concerns relating to domestic abuse. *(Source; SomFT IMR)*

3.14.19 **21 April 2021**, Libby had a telephone consultation with her GP relating to lower back pain. Libby told her GP that she had put on three stone in weight because of the back pain as she could not walk much. *It is not clear from information as to why Libby had back pain*. Libby also said she had some further issues and was breathless. The GP requested to see Libby **6 May 2021** but there is no record that this appointment happened. *(Source; CCG IMR)*

The Pain Management Clinic which was arranged for Libby to attended was not available during the Covid 19 Pandemic lockdown so this may have been a barrier for Libby to seek assistance. The Covid Pandemic would also have heightened the risk for Libby, but this will be explored in the analysis.

3.15 Key Practice Episode Eleven - Known relationship between Libby and Benas and first contact relating to domestic abuse in the relationship.

3.15.1 **14 May 2021**, Libby called the police to report that her partner had "punched her several times, tried to strangle her, thrown her downstairs and that she was covered in blood". Libby confirms that the partner was Benas and that he had come

home, was intoxicated, was verbally abusive to Libby and the altercation became physical. A friend of Libby's witnessed the incident and when the police arrived both were found hiding in the bathroom. Libby and her friend were intoxicated, and the decision was made by the police to not interview Libby and her friend until they had "sobered up." The police looked for Benas, but he was not found, and he was never arrested for the assault. Libby's friend did not want to give the police a statement and Libby was offered an ambulance, but she did not want one called. The police supervisor did consider an evidence led prosecution but felt that the threshold for such a prosecution would not be met. The police supervisor also felt that to go against the wishes of Libby and may dissuade her from reporting further incidents to the police.

The IMR author watched the body worn camera footage and states that they would not agree that Libby and her friend were incoherent. Libby was frightened, crying but was articulate in what happened. Libby also stated that Benas said, "If you speak to officers you will burn." A DASH risk assessment was completed and scored as 8, medium risk which the IMR author believed was the correct score on the known information. The IOPC report did highlight that the attending police did take steps to safeguard Libby which included a DASH and a PPN although the view of the IOPC case decision maker was the risk rating of the DASH may not have been appropriate due to the allegations of strangulation and threat of burying Libby in the garden. The IOPC report also highlighted that in their view that although Libby was intoxicated that she could give an account of what happened, but the IOPC reviewer understood that the police took the decision not to interview as they are guided by the principles of achieving best evidence it may have explained why the decision was made to try to get a statement the following day. The IOPC report did state that the police need to balance the risk of delaying the account as a delay may have a significant impact on a victim's engagement, which in the case of Libby, it did as she did not want to give an account when the police finally spoke with her.

3.15.2 The police made attempts to contact Libby on **2 June 2021.** This was 19 days after the incident and there is no indication as to why there was a delay although the police officers involved did state that they had tried to contact Libby prior to this date, but nothing had been recorded on the police system. It is not clear whether there were any capacity issues at this time, and England was still in a national lockdown until July 2021 which may have impacted of service delivery.

It had been reported that Libby had allegedly had her phone stolen by Benas and therefore she made not have had access to a phone and no home visit was made.

This could have been an example of Benas controlling Libby, ensuring she could not seek support or contact the police.

3.15.3 Face-to-face contact was finally made with Libby on 3 June 2021, and Libby felt that she did not want to provide a statement or a prosecution. (*Source; Police IMR)*

3.15.4 During late **August 2021**, drug intelligence of varying gradings and threat levels were recorded by the Police suggesting that the street where Libby lived had an issue with drug supply and County Lines. Libby was mentioned as someone who would need welfare checks as "she is vulnerable to exploitation." *(Source; Police IMR)*

3.15.5 On **10 September 2021,** the pharmacy contacted SDAS to report that Libby was behaving very erratically, was slurring and was confused about the day of the week. Libby had sent Benas to collect her methadone, but this was declined and therefore Libby attended. SDAS tried to contact Libby several times and SDAS spoke with the pharmacy about completing a welfare check if Libby attended the pharmacy. *(Source; SDAS IMR)*

3.15.6 Neighbours reported to the police on **18 September 2021** that two people had been seen using a wheelie bin and ladder to climb into Libby's home. The suspects, a male and female said that Libby had given them permission to stay. Libby confirmed this but said she was frightened of the male and wanted him to leave. The Neighbourhood Police Team helped Libby bag up the male's clothes and Libby was given safety planning advice and Libby said that she had almost daily contact with the NPT. *(This is an example of good practice)* Libby stated that she did not want to make formal complaint but that she found the police visits reassuring. *(Source; Police IMR)*

As Libby stated she was frightened, there appears no questioning of why she was frightened, but the police knew of the male having strong links with County Lines and therefore concluded that this may be the reason for Libby being in fear and not wanting to make a formal complaint.

3.15.6 Libby had a clinic review with SDAS on **11 October 2021** (phone call) and Libby said she was with her family and therefore not able to discuss issues in depth. The SDAS worker asked Libby about her presentation at the pharmacy and Libby explained that she had taken a homeless person in, and he had started to invite a drug user to the house. Libby said she could only resolve the issue with support from the police. Libby told the worker that she knew she had to address her drinking

and her behaviour. There was no questioning by the case worker about Libby's safety, relationship status, mental health or exploitation. *(Source ;SDAS IMR)*

The IMR author identified that a multi-disciplinary meeting should have been arranged for a client who was not able to engage and there should have been a referral to adult services.

3.16 Key Practice Episode Twelve – Escalation of domestic abuse by Benas

3.16.1 **27 October 2021**, Libby contacted the police to say she was a victim of a domestic abuse incident. Officers arrived at Libby's late afternoon and Libby said that Benas had put a pillow over her face and punched her. The police recorded that Libby was very hostile and not willing to speak and police body worn video's showed Libby crying and in an elevated level of stress. Libby was heard shouting "I do not want him charged." Libby appeared frightened and made it clear that she could not pursue a complaint against Benas.

3.16.2 In Libby words "I'm f----d, you don't know what he is like, his connection, "Eastern European Mafia". On arrival Libby and Benas had been separated to allow Libby to speak in safety *(good practice*) and following this incident, Benas was arrested and taken into custody. (Good practice) Libby was frightened of a reprisal from Benas and did not want to complete a DASH. The Police spoke with the neighbours who stated that the altercation between Libby and Benas has lasted for many hours. *(Source; Police IMR)*

Benas is displaying examples of behaviour consistent with the Homicide Timeline[32] *and this will be explored in the analysis section 5 of this report.*

3.16.3 **30 October 2021**, Libby reported a further assault but when the police arrived, she refused them entry. Libby did not say who had her assaulted her, she just said "*Arrest him and leave."*

3.16.4 The case was assessed by the internal police Domestic Abuse Triage (DAT*)(to note no partner agencies are present at the DAT)* but there but there was no referral to a specialist DA support service and the DASH was recorded as standard risk as Libby did not provide any real detail about the incident. *(Source; Police IMR)*

Libby's family informed the Independent Chair that Alex was visiting Libby at home as it was the school half term, but the police were not aware or saw a child at Libby's home when they visited, following the incident.

[32] The Homicide Timeline-Dr Jane Monckton-Smith 2019 www.glos.ac.uk

3.16.5 **30 October 2021**, Libby phoned the police but was speaking very quietly. Libby said that people were coming to get her, and she needed police assistance. The call handler asked Libby to speak louder, and Libby became abusive.

3.16.6 The police attended the address where Libby was found panicked and armed with a screwdriver and Libby would not say who was coming for her. The Police gave Libby safety advice including about leaving the house she was at and helped by calling other friends of Libby. Libby stated that she wanted to stay where she was (not her own home) as she trusted the occupant "100%". The police checked if the person "out to get Libby" had access to a vehicle, knew where she was, and she stated that the person had no vehicle and probably did not know where she was. Libby was told to call 999 if anything happened further, but the police also said that Libby needed to give further information so they could help her. The police ensured that all communal doors were locked and the front door. The IOPC report identified that everything that could have been done was completed and there was some good practice in trying to safeguard Libby. *(Source; Police IMR)*

3.16.7 **1 November 2021**, Libby is escorted out of a local supermarket following verbal and physical aggression towards staff. Libby had been banned from her local supermarket but could use the pharmacy for her Methadone prescription. This matter was not pursued due to Libby's subsequent death. *(Source; Police IMR)*

3.16.8 **5 November 2021,** Libby contacted the police in distress as she was stranded and had concerns about people in her home. Two police officers noticed Libby crying and stopped to help her and they took Libby home. On the way, Libby disclosed that she had no electricity and the police offered to take Libby to top up her electricity. Libby went on to say that a male, was coming to her home, whenever she wanted, and she was scared of him (not Benas). The police took Libby home, searched the house and told Libby to change the locks and she was given 999 advice. Libby said she would go and stay with a friend and see the police neighbourhood officers the next day. The police returned to the local police station and discussed Libby's welfare and their concerns. There was an opportunity for the police to consider a Brag but there was also some additional effort by the police to help safeguard Libby. *(Source; IOPC report)*

3.16.9 **6 November 2021**, a caller to the police states that a female had come at him with a knife and Libby is mentioned but not directly involved with the incident. There was no further information on this phone call, so the caller is not known and there was no action by the police. *(Source; Police IMR)*

3.17 Key Practice Episode Thirteen - Death of Libby

3.17.1 **November 2021**, Libby was found at her home with a large laceration to her neck. A post-mortem took place 8 November 2021 and Operation SARDEL commenced. There were multiple arrests and Benas admitted murder and was sentenced to 14 years and ten months.

4 Overview

4.1 Overview of Information from family and friends

4.1.1 The mother and father of Libby participated in the review as they expressed the wish that learning by agencies from Libby's tragic death may result in beneficial change to better support victims of domestic abuse. The Independent Chair met with the family on three occasions, with all the meetings being were face to face. The family were supported at the meetings by the Victim Support Homicide Worker, with whom the family had built up an established, trusting relationship.

4.1.2 The mother and father of Libby described Libby as a kind and loving person, who was strong willed, a great communicator and was very empowered. The mother of Libby shared a video with the Independent Chair which showed Libby, which described what was happening in her life and how she was trying to manage the situation. *(The video was part of a webcast that Libby had set up).*

4.1.3 Both parents described how Libby got involved with drugs during her late teens. Libby used to attend raves and got into recreational drugs, but she had an addictive personality, and the drugs became an issue. Libby did go to substance misuse rehabilitation several times and her mother attended a couple of residential rehabilitation sessions with Libby, to support her.

4.1.4 Libby was married to Gerry for around seven years, and they had Sam. The relationship broke up and Libby met Peter, and they had the Alex. The parents spoke about Libby suffering from post-natal depression. *It is not clear whether Libby sought any help for her post-natal depression as there was no information provided within the IMR's.* Libby moved away from town A and went to live in Oxfordshire and Ireland with Peter but when the relationship broke down, she returned to town A to be near her parents.

4.1.5 Libby moved into a rented property and did receive some benefits, but Peter never provided any maintenance money and therefore Libby struggled trying to support the children and herself. Libby's parents felt that Peter did expose Libby to further drug use.

4.1.6 Libby's parents spoke about Libby's marriage and how they felt that Gerry would control Libby and they gave examples of what they believed was domestic

abuse. Libby's parents felt that Libby went from one abusive relationship to another and she suffered emotionally and financially. The Independent Chair explained to Libby's parents that the information provided was not within the scope of the review but that she would reflect their thoughts in this section of the report.

4.1.7 Libby's parents explained that they were not aware of the relationship between Libby and Benas for quite a while, but that he did go to their house to do some work. They described Benas as a good worker, clean and tidy.

4.1.8 The family started to have concerns about the relationship when they found out that Libby was transferring her benefit money to Benas. *Example of economic abuse*. Libby's parents began to question how Benas managed to support a family in Eastern Europe including three children when he appeared to have very little work and they wondered if Benas was claiming a carers allowance as he said he was caring for Libby.

The Independent Chair contacted the Department of Work and Pensions on several occasion but has not been successful in gaining any information on whether Benas was claiming a carers allowance.

4.1.9 The mother and father of Libby began hearing from friends that Libby was afraid of Benas, and they questioned why the police did not do more following the incidents in **May and October 2021**. *The chronology explains the actions the police took at the time.*

4.1.10 Libby's parents felt that Libby did get some support from agencies, especially drug and alcohol services but that due to the resources of such services it was sometimes difficult for Libby to get an appointment close to home and she often did not have sufficient funds to travel to her appointments.

4.1.11 The family questioned whether Benas had a right to remain in the country following Brexit as although they believed he was filling in his Right to Remain in the UK, and they did not know if the application was completed. *The Probation Service have identified that Benas did have a Right to Remain in the UK up until his murder conviction.*

4.1.12 Libby's parents have parental responsibility for Alex, who seems well and leading an active life, but the mother of Libby said it is sometimes difficult to know how much to tell the child about Libby. Libby's mother feels that there is not always support available to help navigate how best to support a child whose mother died in the way that Libby did. Although SCSC were not directly involved with the family at the time of Libby's death, SCSC did make contact with mother and father of Libby,

and the Gerry to see if any support was needed. The family were advised that they could contact SCSC at any time in the future if they needed too.

4.1.2 Lucy - a friend of Libby (met Libby in the last few years of Libby's life)

4.1.2.1 Lucy met Libby in April 2021 via online training/therapy sessions which was run by a third party. The sessions were about connecting and making friendships and Lucy and Libby became friends. Lucy described Libby as full of energy, enthusiastic, a lively, fun person, Libby would be a "let's do it person." Libby was popular, generous and somebody who could draw people in and engage with them. Friend A did state that Libby could be very illusive, and she felt there was a lot going on in Libby's life of which she did not speak about.

4.1.2.2 Lucy said that Libby missed her children and Libby was hoping she may get them back. Libby did mention "her bloke" who it was presumed was Benas. Libby's life started to spiral out of control, and she would reach out to friend A to see if she could lend her money. On one occasion, Libby borrowed money from Lucy for Benas although the friend did say that Libby always paid her back. *This could be seen as potential economic abuse by Benas*. Lucy noticed that Libby began to feel frightened of Benas, saying she was going to move out next week.

4.1.2.3 Lucy felt that Benas was systematically destroying Libby's confidence, she was not the bubbly person she was, and Libby felt she was not able to confide in professionals despite trying to reach out to the police.

4.1.3 Ann -Lifelong friend of Libby

4.1.3.1 Ann had known Libby since they were eight years old. Ann described how both she and Libby became addicted to drugs in their late teens/early twenties. Ann described that she was a recovering addict but that her children were always her protective factor and that she had also suffered domestic abuse in a previous relationship.

4.1.3.2 Ann described how Libby would build up her life, be successful in a job and was managing to look after her children then she would push a self-destruct button and disappear.

4.1.3.3 Ann was aware of the relationship between Libby and Benas and understood that they met in town C, in a pub in 2020/21. Ann spoke about Benas saying he was involved with the Eastern European and had stabbed a person in his own country although the ACRO did not highlight any criminal offence of this nature.

4.1.3.4 As far as Ann was aware, Benas was not involved in organised crime in this country and that he lived in a caravan near town A and did some gardening work and he eventually moved in with Libby in Town A.

4.1.3.5 Ann explained how fearful Libby became of Benas, she was spending her life in constant fear. At one-point Benas moved a friend/supplier into the house increasing Libby's vulnerability.

4.1.3.6 Ann spoke of her surprise that she felt no safety measures were offered to Libby following the incidents in May 2021 and October 2021 although the chronology does identify safety measure offered by the police.

The police did visit Libby on several occasions in 2021 and it is not clear as to which incident Ann was referring to and the police did separate Libby and Benas following the incident on 30 October 2021 in order to allow Libby to disclose anything she wanted to.

4.1.3.7 Ann explained that she had numerous texts from Libby describing what was happening but also showing threatening texts from Benas to Libby.

4.1.4 Benas

4.1.4.1 The Independent Chair spoke with Benas in a video link and was accompanied by the Offender Manager (OM). The Independent Chair would like to thank the Probation service and the Offender Manager for enabling the meeting to take place. The meeting explored Benas's life in Eastern Europe, how he met Libby and if there was any agency support which could have helped him.

4.1.4.2 Benas explained that he came to the United Kingdom around 2010 to seek work as work was limited in Eastern Europe. Benas had separated from the mother of his three children who all remain living in Eastern Europe. Benas worked in a range of jobs including transport, gardening and odd job/maintenance role. Benas would rent rooms in houses or stay in caravan accommodation provided by his employer.

4.1.4.3 Benas spoke about meeting Libby in a pub just before the Covid Pandemic and that at the time she was sleeping in doorways and sofa surfing. When Libby moved to town A into a property, Benas moved in to live with her. Benas stated that he became Libby's carer. On being asked whether he received any benefits for this role he stated he did not know.

4.1.4.4 When Benas was asked whether he was involved with drugs and alcohol he stated that he did not do drugs but did drink, but, in his view, not excessively. *The Independent Chair did speak with OM following the meeting to check this statement*

and the OM confirmed that Benas did not appear to have an issue with drug abuse prior to being sentenced.

4.1.4.5 Benas stated that he had no issues with his employers whilst working in the United Kingdom. He was often paid in cash, and in his opinion, he was paid well. He never had to seek support from agencies including health services during his time living in this country.

4.2 SUMMARY OF ENGAGEMENT WITH AGENCIES AND PROFESSIONALS INVOLVED

4.2.1 Avon and Somerset Police IMR (the police)

4.2.1.1 Between 2015 and up until Libby's death the police had over 100 contacts with Libby and or Benas, with the majority relating to Libby's drug use, supply within County Lines and associated criminality.

4.2.1.2 In 2015, Libby did report to the police that she was experiencing domestic abuse and there was an incident when Libby was driving her car with Alex in it. In 2016, there were no contacts between with Libby and the Police. In 2017 again there was just one safeguarding incident relating to Alex and nothing until later in 2017. Libby was linked to high-risk offenders which increased her risk.

4.2.1.3 Libby came to the police attention as it was believed that she may have been an instigator for Cuckooing a vulnerable male along with other members of an Organised Crime Group (OCG). Operation Ash was formed to collate a Team of Officers involved in investigation of crimes to implement disruption tactics linked to County Lines criminal activity. The operation was successful in removing the OCG from the vulnerable adult's home.

4.2.1.4 During 2018, there were no DA incidents reported by Libby to the police and Libby was not included within a list to check within Operation Encounter[33].

From early 2019, Libby was identified by the police as running drugs along County Line in area C. This was followed a month later by an incident in town D where Libby and a friend were shouting outside a property which was followed quite quickly by the police attending an incident at Libby's parents' home, when Libby reportedly punched her father. Contact between Libby and the police continued throughout 2019 and 2020 mostly related to drug issues, criminal damage, and harassment.

[33] Operation Encounter a complex highly specialised long running attempt to rid Somerset County Lines activity and criminality under the Misuse of Drug Act 1971.

The police received the first report of domestic abuse by Benas on Libby late spring 2021. Libby confirmed the relationship with Benas and that he had thrown her down the stairs and grabbed her by the throat. Libby told the police that Benas told her "*If you speak with the Officer you will burn*." Benas had left the scene and was not found by officers.

4.2.1.4 The IMR author has challenged the way the police managed this incident, and this will be explored in the analysis and lessons to be learnt section of this report. During the summer of 2021, there were a number of police contacts with Libby relating to drug intelligence.

4.2.1.5 Mid-Autumn 2021, Libby again reported being a victim of domestic abuse. The altercation lasted several hours according to a neighbour with Benas putting a pillow over Libby's face and punching her. Benas was arrested but Libby felt unable to engage with the police and the matter was closed. Later in October 2021 there were two other incidents including one in town D. Libby kept telling the police he has assaulted me but would not name the person. Early November 2021, the police receive a call from a male saying a female has come at him with a knife. The following day Libby died.

4.2.2 Probation Service

4.2.2.1 Libby was known to the probation Service from August 2017 to August 2018. At the time the Probation Service was provided by Bristol, Gloucestershire Somerset and Wiltshire CRC (a private provider) who had face to face contact with Libby twice during this period and did not attend four appointments and breach proceedings were instigated.

4.2.2.2 Probation tried to support Libby by making referrals to TNT and SDAS, but Libby was unable to attend any of the appointments or make contact with them, but this was never explored.

4.2.2.3 In 2017, a OASys was completed six months late and was not completed and hence Libby had no initial Sentence Plan. There was contact between the Probation Service and SCSC despite Libby having children and there was no home visit by the Probation Service to review Libby's accommodation and her medication. The OM relied on Libby's own disclosures. There was no contact between the OM and Libby between January and April 2018 and no action was taken in the form of enforcement.

In April 2018, a Start Community Order OASys assessment was completed after eight months of the sentence. This was completed as a basic layer one OASys and should have been a level three OASys. The OM at the time recorded that Libby was engaging well with Probation Supervision despite attending only one supervision session and having not been in contact for over four months.

4.2.2.4 Benas was sentenced to a twelve-month Community Order in November 2016 for driving under the influence of alcohol, no licence, and no insurance. Benas appeared to have complied with his sentence and it was recorded that he engaged with his OM and participated in relevant RAR days and alcohol programmes.

4.2.3 Somerset Clinical Commissioning Group (CCG) now Somerset Integrated Care Board from July 2022 (ICB)

4.2.3.1 Libby had 16 face to face contacts with her GP and 26 telephone consultations. Libby had a further 26 contacts with non-GP professionals from the GP practice including administration professionals and clinicians. Four contacts related to domestic abuse whilst others related to support for Libby's pregnancy and her drug addiction therapies.

4.2.4 Somerset Partnership NHS Foundation Trust (SomFT)

4.2.4.1 Libby had nine contacts with SomFT with the majority being related to the physical impact of her substance abuse, especially complications from intravenous drug use. During some of Libby's admissions, SomFT staff were concerned about Libby's presentation and behaviour such as leaving the ward for long periods of time. SomFT staff did seek advice from the Trust's safeguarding Service, four times about Libby's housing needs and substance abuse but SomFT noted that Libby had the mental capacity to respect her decision making and did not have care and support needs at the time.

4.2.5 Somerset Public Health Nursing Team

4.2.5.1 From 2015-2016, the Health visitors met with Libby on nine occasions either face to face in her own home or in her parent's home. The health visitors had an additional eight telephone conversations with Libby. The health visitors also have a further four joint meetings with social workers and contributed to seven face to face multi agency meetings.

4.2.5.2 There was strong evidence of a joined-up approach between SCSC and the health visitors. During the pre-birth period prior to the Alex's birth there was a level of trust built up between Libby and professionals and on discharge following the birth of the Alex. All the key members of the family were involved with professionals to ensure that Libby and Alex were supported appropriately.

4.2.6 Somerset Children Social Care (SCSC)

4.2.6.1 Libby and her children became known to SCSC in April 2015. From 2015 up until Libby's death there was 18 referrals to SCSC. There were three Children and Family Assessments completed for Alex Libby and two-family assessments for the eldest child.

4.2.6.1 Libby did inform SCSC about domestic abuse she was experiencing from her previous partner and SCSC did put in place safety plans to support Libby and her children which included muti agency support.

4.2.6.2 SCSC involvement ended with Libby, her family and the children in 2017 although there were a number of contact records between February 2018 and May 2019 mainly relating to police incidents concerning Libby. The social worker did contact Libby's mother and father who confirmed that the children were residing with them and that all contact was supervised between the children and Libby.

4.2.7 Somerset Adult Social Care (SASC)

4.2.7.1 Libby had seven contacts with SASC between January 2015 up until early November 2021 of which three related to domestic abuse. The main period of contact was 2015, 2017 and 2019.

4.2.7.2 SASC engaged in multi-agency work following referral from SDAS, the GP, the police and mental health nurses. During 2015 Libby was allocated a social worker who consulted with mental health support services. The police contacted SASC in 2017 relating to their concerns about Libby's wellbeing as she was sofa surfing and in 2019 the police requested emergency accommodation for Libby as she was at risk of County Lines.

4.2.8 Somerset Integrated Domestic Abuse Service (SIDAS)

4.2.8.1 Libby was referred to SIDAS in June 2015 by SCSC. Libby was supported by a Domestic Abuse Coordinator on a one-to-one basis. The DAC delivered part of the Overcoming Abuse programme with Libby, including staying safe, abusive relationships, impact on children and planning, moving on.

4.2.8.2 There was only one face to face meeting with Libby, but the DAC understood the need for Libby to attend her substance misuse groups as a priority.

4.2.8.3 SIDAS received a further referral from SWISH in March 2018 relating to Libby which cited sofa surfing and sexual abuse. SIDAS liaised with SDAS to identify the most appropriate accommodation for Libby and due to her substance misuse, it was agreed that a safe house would be the better option. SIDAS could not identify any safe houses at the time of the referral, but they located a refuge space some distance away from the area and asked Libby to make direct contact with the accommodation. Libby has a telephone conversation with the SIDAS IDVA in March 2018 about her situation and was advised by the IDVA to contact the police in the event of further assaults or harassment. The IDVA tried to contact Libby again in April 2018 but was not successful. Late April 2028, the IDVA did manage to speak with Libby and Libby asked that the IDVA could speak with Mendips Housing but the IDVA explained that without consent by Libby, Mendip Housing would not speak directly to the IDVA. The IDVA did say she would try to speak with Mendip Housing team, but it was confirmed that in order to discuss Libby's case, she would need to consent. The IDVA left two further messages for Libby in late April 2028 , one a voice mail and one a text which stated that if there was no response by 2 May 2028, then the file would be closed.

4.2.8.4 Libby did not make contact with the IDVA and the IDVA then contacted SWISH to explain the situation with Libby and that the case was closing. SWISH stated that they would try to contact Libby although she had missed an appointment with them. SIDAS contact with Libby ceased in September 2018.

4.2.9 Somerset Drug and Alcohol Service (Turning Point) (SDAS)

4.2.9.1 SDAS had 124 contacts with Libby during the period 2015 up until November 2021. Most of the contact was relating to Libby's substance misuse. SDAS did support Libby through multi agency working such as the local hospital, the pharmacy, SCSC and housing.

4.2.9.2 Of the 124 contacts there were about ten incidents which were felt could have been domestic abuse related. The IMR author highlighted the lack of professional curiosity about the nature of Libby's relationships which could have established the severity of risk that Libby was experiencing.

5. ANALYSIS

5.1 This analysis is based on information provided in the IMRs and responds to the key lines of enquiry as detailed in the TOR and issues that have arisen in consultation

with professionals. Where relevant this includes an assessment of appropriateness of actions taken (or not) and offers recommendations to ensure lessons are learnt by relevant agencies. The Chair and the Panel are keen to emphasise that these comments and recommendations are made with the benefit of hindsight.

5.2 Key Themes were identified through the IMRs and discussion with professionals involved with Libby, Benas, Sam and Alex and are as follows;

- Domestic Abuse: physical and coercive and controlling behaviour.
- Mental Health Issues.
- Substantial substance abuse by Libby and others
- Not seeing Libby at risk with associated vulnerabilities
- County Lines and organised crime
- Cuckooing
- Homelessness
- A victim being in repeated domestic abusive relationships.
- Lack of the Libby's voice being heard.
- Professional bias/unconscious bias- professionals seeing Libby's lifestyle as choice.
- Professional curiosity

5.3 Consider how (and awareness of) all forms of domestic abuse (including the non-physical types) are understood by the local community at large - family, friends, and statutory and voluntary organisations? This also to ensure that all dynamics of domestic abuse are explored including the links with substance abuse and mental health.

5.3.1 Libby suffered domestic abuse in a number of relationships and identified to professionals that Peter was abusing her when she returned to live in Somerset by locking her in the house to force her to withdraw from drugs, not allowing her money and forcibly stopping her from leaving the home through physical violence. When speaking with professionals, Libby seemed to minimise Peter's actions and blamed herself. SDAS were involved with Libby relating to her substance misuse and Libby informed them about the abuse she was experiencing with Peter, and they made a referral to SASC. A referral was also made to SIDAS, and a DAC tried to work with Libby to support her to minimise her risks and for to understand healthy/unhealthy relationship.

5.3.2 Libby continued to experience abuse in other situations. In 2018, the Somerset Wide Integrated Sexual Health service raised concerns regarding Libby experiencing domestic abuse and sexual exploitation.

5.3.3 Libby would appear to have understood that she was experiencing abuse but sometimes she blamed herself.

5.3.4 The police received the first report of domestic abuse between Libby and Benas in mid-May 2021. Libby had been physically abused, grabbed by the throat and verbally abused. The second recorded domestic abuse incident was the events in late October 2021. Neighbours told the police that the altercation between Libby and Benas went on for many hours and that Benas had put a pillow over Libby's face and punched her several times. Non-fatal strangulation is now a crime and detailed within the Domestic abuse Act 2021 and came into force 7 June 2022[34], but there was legislation at the time of this incident under section 47 Offences Against the Person Act 1861-Assault occasioning Actual Bodily Harm (ABH)[35]. ABH can include cases where the circumstances in which the assault took place are more serious e.g. repeated threats or assault took place on the same victim or significant violence. This could include non-fatal strangulation or suffocation.

5.3.5 Libby also exhibited emotional abuse, she was clearly frightened of Benas, his possible connections with organised crime and what may happen to her.

5.3.6 Libby's family and friends also identified the economic abuse that Libby was experiencing. Libby was transferring money from her benefits straight into Benas's account, Libby was borrowing from friends to give money to Benas. Although family and friends realised that this was some a of abuse, they did not understand that it was economic abuse and what they could do to support Libby and at the time the family did not have a clear understanding that Libby was also experiencing controlling, coercive behaviour which is a criminal offence as defined in 2015, Section 76 Serious Crime Act 2015.[36]

5.3.7 Agencies, professionals and the wider community need to understand all aspects of domestic abuse to ensure that a victim is appropriately supported but also that the wider community can identify abuse and seek help.

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[34] www.gov.uk/newnon-fatalstragulationoffencecomesintoforce- press release
[35] www.cps.gov.uk/ Section 47 Offences Against the Person Act 1861-Assault occasioning actual bodily harm (ABH)
[36] www.legislation.gov.uk.76 Serious crime act 2015 76 Controlling or coercive behaviour in an intimate or family relationship

5.4 To consider if all relevant civil or criminal interventions were considered and or used.

Civil Interventions

5.4.1 Housing-

5.4.1.1 From the SDAS IMR, when Libby returned to Somerset, she contacted two local Councils to seek what housing options were available. Both councils were only able to provide very limited information for this review due to the migration of information to a new computer system in August 2021. As Libby was not an active case at the time of this data transfer her records were destroyed.

5.4.1.2 The lack of information of housing decision making and rationale has created a gap which would have been of significant relevance for this review. Agencies involved with Libby have indicated that she was struggling with accommodation and debt, and she was very fearful of moving to certain parts of Somerset. A recommendation has been included in the DHR about the requirements for housing to retain information as detailed in the Date Protection Act 1998.

5.4.1.3 With the lack of historical information around Libby's contact with various housing options teams it is difficult to understand whether Libby received any support and if she did, what support was provided. The DHR Panel are aware that Libby lived in town A in one of her parents' properties, but nothing is known as to what type of property Libby lived in other locations, although hostels, emergency accommodation and sofa surfing are mentioned, and Libby was homeless on several occasions.

5.4.1.4 Housing would have been a basic need to Libby and trying to navigate housing options would have added to Libby's vulnerabilities.

5.4.1.5 It seems clear from this review that although the duty to refer process came into effect from 2018, there is still learning to be done and agencies need awareness of the process to seek consent from clients and make appropriate referrals. Public authorities and professionals need to understand their duty to refer a person who is defined as being threatened with homelessness under the Homelessness Reduction Act 2018[37] (England only).

5.4.1.6 The Domestic Abuse Act 2021 placed in legislation that eligible homeless victims of domestic abuse automatically have priority needs for homelessness

[37] www.legislation.gov.uk/Thehomelessness(reviewprocedure)regulations2018

assistance and that local authorities provide victims of domestic abuse lifetime secure tenancies[38].

5.4.1.7 Although Libby died in late 2021 and the panel is not clear about what housing support if any, Libby received, or whether Libby and her family knew what options were available to them to seek safer accommodation. The Somerset Domestic Abuse website[39] has useful information about housing support but from discussions with the family, Libby and the family were trying to manage many difficult situations it was not always possible to understand what housing support was available.

5.4.2 Support for a person being cuckooed.

5.4.2.1 In 2019, the police received a report that Libby was being cuckooed by men who were involved in serious crime. On referring to the LSU, it stated that the situation did not meet the threshold for a referral to adult social care. The police IMR author identified that the non-referral was due to the LSU's individual professional judgment, which was not correct practice. Referrals of this nature should be made, and it would be ASC triage to decide if the case meets the threshold or not. The DHR Panel and the police IMR author feel that this was a missed opportunity to protect and support Libby. The local Police Crime plan 2021-2025 identified that cuckooing is a serious issue in the area, and it was known Libby was vulnerable and as such was potentially an "easy target" for cuckooing. There was significant support by the Neighbourhood Police Team to support Libby and evidence identified that Libby had good communications with various officers within the Neighbourhood Team.

5.4.3.2 Many agencies were involved with Libby and it essential that all professionals who support victims of abuse (domestic/substance) understand the concept of cuckooing and where to get help for a victim.

5.4.3 Support for an adult at risk

5.4.3.1 Professionals within the police, and drug and alcohol services were concerned about Libby's physical and emotional wellbeing and several emails were sent to SASC from spring 2015, with the final contact being early 2019 by the agencies relating to concerns that they had around Libby. When Libby was spoken to by a social worker there was no cause to question Libby's mental capacity to make decisions and social workers assessed that Libby did not have care and support needs as identified by the Care Act 2014 although some evidence in the IMR's have suggested that Libby was

[38] Domestic Abuse Act 2021;Overarching factsheet. www.gov.uk
[39] www.somersetdomesticabuse.org.uk

not always looking after herself such as not feeding herself. The SASC IMR author did state that the record keeping by social workers was not always of a good quality and therefore it was not possible to know if a section 42 enquiry should have been implemented.

5.4.3.2 Somerset Safeguarding Adults Board did have a multi-agency process "What to do if it is not safeguarding" which allowed any professional to call a multi-agency meeting about a victim who may have needs and vulnerabilities but do not meet the criteria for a section 42 enquiry and try to seek options/solutions on how best to support the victim/person.

5.4.3.3 Somerset Adult Safeguarding Board reviewed the "What to do if it's not safeguarding guidance," in 2023 and in February it was relaunched as "Multi Agency Risk management (MARM) guidance"[40]. The relaunch has provided the opportunity to raise awareness with all professionals how they can support a vulnerable person who may not meet the threshold of a Section 42 referral. This DHR provides the opportunity to raise the profile of MARM to all agencies involved in this review and to all professionals within Somerset.

5.4.4 Interventions of Specialist Domestic abuse Services.

5.4.4.1 Libby was supported by SIDAS in 2015 and again in 2018. Libby was supported by a DAC who delivered parts of the Overcoming Abuse programme. Libby was again supported in 2018 following a referral from SWISH citing sexual abuse and sofa surfing. An IDVA contacted Libby and was able to understand Libby' issues and the IDVA tried to support Libby with contact with the local Council around housing. Although there was liaison between SIDAS, (SDAS) and SWISH relating to the most appropriate accommodation for Libby (SDAS) and updating SWISH in 2018 that Libby's case would close as Libby was not able to engage, there were opportunities to work more collaboratively. Libby was meeting face to face with SDAS workers and this did provide an opportunity for the SIDAS IDVA to meet Libby face to face. Using an existing appointment for Libby to engage with more than one agency may have helped Libby as she was struggling with finances and transport. It would be beneficial, knowing the links between domestic abuse and substance misuse, if SIDAS and SDAS review if they could work more collaboratively in order to support victims of domestic abuse. An agency recommendation has been included in section 8.2

[40] https://somersetsafeguardingadults.org.uk/wp-content/uploads/2023/11/SSAB-MARM-v1-2023-1.docx

5.4.4.2 From 2019 onwards the police made a number of referrals to the LSU around Libby being vulnerable. Libby was identified as being homeless, suffering drug misuse and a BRAG assessment was conducted which was rated amber and although a referral was made to the LSU no contact was made with Libby. This was a prime opportunity to convene a multi-agency meeting using the Guidance of "What to do if it is not safeguarding" (as it was in 2019) which is now MARM or refer to a MARAC or make a further referral to SASC.

5.4.4.3 The second referral to the LSU was that Libby was at risk of being cuckooed and Libby being at risk from males living with her. The LSU unit did not believe the threshold for a referral to SASC would be met. There were various other referrals by the police to the LSU, but no further referrals were made by the LSU to SASC during 2019-2021.

5.4.4.4 From May 2021, there were several domestic abuse incidents involving Libby, Benas with the police attending. There appears to have been no further referral to the LSU following the incidents in May 2021 and October 2021. This would seem to be a missed opportunity to try to get specialist domestic abuse support for Libby.

To note the IMR author highlighted in the IMR that the LSU has undergone an internal review and the police IMR author for this DHR will be using this DHR for further learning to improve professional practice within the LSU.

5.4.5 Multi Agency Risk Assessment Conference (MARAC)

5.4.5.1 A MARAC is a risk assessment meeting were professionals from different agencies share information on high-risk cases of domestic violence and abuse and put in place a risk management plan. The purpose of the MARAC is to safeguard a victim, manage perpetrators behaviours, safeguard professionals and make links with other safeguarding processes. [41]

5.4.5.2 Although agencies and Libby spoke of a MARAC being carried out in 2015/2016 there are no records of a referral and there is no reference of any later referrals to a MARAC. Following the assault by Benas on Libby in **May 2021,** there was no referral to a MARAC. This may have been because the DASH was scored as standard whereas the IMR author felt it should have higher as Libby mentioned weapons, suffocation and mentioned that "if *you speak to the police, I'm (Benas) going to bury you (Libby) in the garden."* The IMR author felt that if a more thorough assessment had taken place and Libby being assessed as high risk, then a

[41] www.safelives.org.uk Principles of an effective MARAC

referral to a MARAC could have taken place. This would have enabled a multi-agency approach to support Libby, including managing her welfare, safety and enabled safety planning to be implemented.

Criminal Interventions

5.4.6 Domestic Violence Protection Notice/Orders.

5.4.6.1 The DVPN/O has been in operation in all police forces since 2014. The DVPOs provide protection to a victim of domestic abuse to enable the police/magistrates' courts to put in place protective measures following a DA incident. A DVPN is an emergency non-molestation order and eviction notice issued by the police to a perpetrator. A DVPN can give a prevent a perpetrator contacting a victim for 28 days.

5.4.6.2 Following the incident on 27 October 2021, if the police had issued a DVPN/O then this could have allowed Libby some respite, allowed for a referral to a DA agency and which may have allowed an IDVA to make contact. Libby did struggle through fear of Benas to engage with the police, but an IDVA would have been independent of the police. The IDVA could have helped Libby review her options, but more importantly put safety plans into place.

5.4.7 Victimless Prosecution now referred to as evidence-led policing.

5.4.7.1 There was evidence that the police considered and discussed at different points in their contact with Libby the opportunity for a victimless prosecution and rationale as to why it was not pursued as detailed in the chronology.

5.4.7.2 Prior to a law change in 2001 if the police want to press charges for a domestic assault, they needed the alleged victim to cooperate. Since 2001, if a victim (Libby) did not want to press charges and the police feel it is in the public interest then the police can press charges but the evidential burden is the same to seek charges whether with or without a complainant and therefore it may not be granted. [42]

5.5 To determine if there were any barriers for Libby and or her family / friends faced in both reporting domestic abuse and accessing services. (This to be explored against the Equality Act 2010's protected characteristics).

5.5.1 Libby and her family had many contacts with different agencies throughout the period of this review. The contacts included the Police, SCSC, SASC, SomFT, GP,

[42] Victimless prosecutions www.justiceinspectorate.gov.uk

Public Health SIDAS and SDAS. Many of the contacts related to Libby's children, substance misuse, activities to support Libby's substance misuse and to a less reported extent, the domestic abuse Libby was experiencing.

5.5.2 Libby suffered with her mental health which often coincides with the loss of her children or the ability to see her children which would have caused Libby significant trauma. Research has identified that children are a protective factor for women and when they are taken away that increases a victim's vulnerability. [43] Libby's substance misuse and what was seen by some professionals as her lifestyle choices may have inhibited Libby's ability to navigate services that could have supported her and the family. Professionals did often state that Libby did not engage, did not turn up for appointments and it was never questioned as to why Libby did not attend.

5.5.3 Libby was more likely to have suffered domestic abuse because she was a female victim. Research shows that females are more likely to be repeat and chronic victims of domestic abuse. Evidence identified that Libby was a victim of abuse in her relationship with her previous Partner and then Benas. Although little is known about whether Libby had other relationships, the Police and other agencies did have information which indicated that Libby was experiencing abuse whilst sofa surfing.

5.5.4 Women's Aid highlight that women are more likely to experience repeated and severe forms of abuse, including sexual violence. They are also more likely to experience sustained physical, psychological, emotional abuse, or violence which results in death. Women experience higher rates of repeated victimisation and are much more likely to be seriously hurt and women are more likely to experience higher levels of fear. [44] The Home Office, Key Findings from Analysis of DHR 's September 2021, identifies that in the twelve months from late 2019, that 80 % of the DHR victims were female. The Office for National Statistics (ONS) identified that during the period April 2016-March 2019 222 females were killed by partners and on average three women were killed every fortnight compared to 83 male victims a ratio of around three female victims for every one male victim.

5.5.5 When Libby was pregnant with Alex, she was experiencing domestic abuse from Peter. Libby was supported by SCSC, midwives at the local hospital, GP and health visitors during her pregnancy. The information provided within the review highlighted some good multi agency work between the GP, social workers and health visitors to ensure strong support for Libby and her unborn child. There was some good continuity of care by Libby's GP and health visitors which Libby

[43] www.communitycare.co.uk/birthmothersand/theirchildreninrecurrentcareproceedingsinengland
[44] www.womensaid.org.uk Domestic Abuse is a gendered crime

responded to. Support for Alex continued once he was placed in the care of Libby's mother and father.

5.5.6 It is not clear what support Libby was provided with, following the removal of Alex from her care but she was vulnerable and several DHR's have identified that the loss of a child can impact on heavily on a woman experiencing domestic abuse and often support for the mother is not available[45]. It is important for professionals working with mothers whose children are taken into a care system to identify the increased risks relating to a mother. PAUSE[46], a national charity which is available in Somerset supports mothers who have had children removed from their care by providing a practitioner who supports a woman to move to a more positive future.

PAUSE was not operating in Somerset in 2015 but became part of the Somerset Family Safeguarding model[47] in 2020.

5.5.7 Libby's metal health and her substance abuse would have added to Libby's vulnerabilities which would have impacted on her health and wellbeing. Safelives report "Safe and well; Mental Health and Domestic Abuse" [48]found a strong association between having mental health problems and being a victim of domestic abuse. It also identified that domestic abuse can often go undetected within mental health services and that of domestic abuse services are not always equipped to support mental health problems. The SomFT IMR author identified a couple of occasions when professionals had the opportunity to speak with Libby about domestic abuse, but this did not happen and therefore it was not possible to understand the traumas in Libby life and provide additional support.

5.6 Review the interventions, care and treatment and or support provided. Consider whether the work undertaken by agencies in this case was consistent with the organisations professional standards and domestic abuse policy, procedures and protocols including safeguarding adults and children.

5.6.1 The Police IMR author has been very open and transparent that the police did not always follow the domestic abuse guidance for the police force. The Police IMR author stated that domestic abuse incidents are seen as high priority by the police force as DA within the area represents a greater proportion of overall crime locally (12%) than nationally (8%). Libby was not contacted for 19 days by the police

[45] https://www.reigate-banstead.gov.uk/downloads/file/6621/executive_summary_-_mary
[46] www.pause.org.uk
[47] Somerset Family Solutions www.somerset.gov.uk
[48] www.safelives.org.uk-Safe and Well: Mental Health and Domestic Abuse

following the incident in May 2021 although "*the Officer in Charge (OIC) did state that other attempts were made to contact Libby, but they were not recorded.*"

5.6.2 The police IMR also noted that the DASH scoring may not have been as high as it should have been on certain occasions, but this may have been impacted upon by the difficulty in engaging with Libby. Some of the language used by professionals in describing Libby's behaviour may not have been the most appropriate such as "*erratic behaviour was making it difficult to gain information and we will get more details when she is sober*" were just a few examples of how Libby's behaviour was recorded. The Police IMR author reviewed the bodycam and stated that although Libby was emotional, she was clear about what had happened although it was noted that Libby was hostile and this made it more difficult for the police to engage, this was also noted within the IOPC report. The police noted that Libby was more hostile to the police in subsequent visits which made it difficult for them to engage with Libby and complete accurate risk assessments and obtain evidence. Libby's suggested hostility may have been due to fear and trying to protect herself.

5.6.3 It is important that all professionals use appropriate language when describing a victim of domestic abuse as victims can be facing multiple disadvantage and trauma and professionals need to understand the complexities in a victim's life.

5.6.4 The Police IMR author also commented that they felt that the police did not always follow the forces DA procedural guidelines, but following Libby's death, significant learning has taken place with the individual police involved with Libby and several recommendations have been made for the police force to implement. See section 8.2.

5.6.5 Several referrals were made to SASC, with the last contact being **2019**. SASC made decisions based on the information they received which may not have provided sufficient information to provide a full picture of what was going on in Libby's life. As already highlighted, the LSU did not make a referral to SASC when the police identified that Libby was being cuckooed. If a referral had been made, then SASC could have assessed the information and reviewed whether an assessment of Libby's need/support should be carried out. The LSU also did not make a referral to SASC following the incident when Libby allegedly hit her father. If a referral had been made for this incident, then again SASC could have built up a clearer picture relating to the care and support needs that Libby may have had.

5.6.7 As already detailed, the Probation Service, from 2014 up until June 2021 was provided by Community Rehabilitation Companies and in Somerset this was provided by BGSW CRC. The CRC was responsible for delivering community

sentences for medium and low risk offenders (of which Libby would have been). In 2018, it was announced that Government would cease the CRC contracts fourteen months early as several providers had collapsed due to having lower activity and therefore lower payments. In 2020, Government announced that all offender management would be delivered by the National Probation Service[49].

5.6.8 Although the CRC's received criticism, they did provide new rehabilitation programmes but as their contact with Libby had identified there were several issues identified in their supervision of Libby. The OASys for Libby were not completed for many months meaning that there was no initial Sentencing Plan and therefore no offending work was ever completed with Libby. The OM's relied on information disclosed by Libby about her children, her accommodation and substance misuse and did not seek to establish the exact nature of Libby's issues by visiting her home and contact with other agencies. Although there were referrals to TNT (good practice) there was no follow up with Libby as to why she did not engage which should have taken place. There were periods of time during Libby's engagement with the Probation Service when Libby was out of contact and no enforcement action was taken. There was a lack of professional curiosity by OMs to review Libby's lived experience and to try to understand why she was not engaging with services.

5.6.9 Information provided by the Probation IMR author has highlighted that lack of contact with Libby, lack of enforcement action against Libby meant that Libby was unable to get the supervision and support that may have helped her to address her substance misuse, her housing issues and emotional wellbeing.

5.7 Review the communication between agencies, services, friends and family and transfer of relevant information to inform risk assessments and management and the care and service delivery of all agencies involved.

5.7.1 When Libby returned to live in Somerset and disclosed domestic abuse by Peter, there was some effective communication between SCSC, SDAS, the Police, SASC and SIDAS to try to support Libby and the family. When Alex engaged in care proceedings, SCSC held meetings with Libby and the family to ensure a comprehensive approach and support was put in place for the child and Libby.

5.7.2 There were good examples of sharing of information between Libby's GP, mental health services and SASC. Although there was sharing of information between the police and SASC the information provided was not always sufficient for

[49] Transforming Rehabilitation and the Probation Reform Programme April 2021 www.publications.parliament.uk

SASC to make decisions upon. The police also identified that they do not have referral pathways around aspects of mental health and substance misuse and if an adult does not consent to their information being shared it is rare that this can be overridden.

5.7.3 The DHR Panel would recommend that the police and relevant agencies work together to seek extra referral pathways for the LSU relating to mental health and substance misuse.

5.8 Identify any care or service delivery issues, alongside factors that might have contributed to the incident.

5.8.1 The police have identified that there were significant pressures within the police force in 2021 which may have impacted on the speed of the response to the domestic abuse incident in May 2021. England was still experiencing the Covid Pandemic with many agencies suffering staff shortages due to illness and with emergency operating procedures still in place which may have impacted on support for Libby.

5.8.2 During the Covid Pandemic, the back treatment clinic which Libby was attending, ceased to operate. This could have meant that Libby was experiencing pain which would have impacted on her physical and mental health wellbeing.

5.9 Review documentation and recording of key information, including assessment, risk assessments and care plans and management plans.

5.9.1 As already highlighted, some records were not of a good quality as identified in the SASC IMR. The Police IMR author identified that the BRAG[50] and the DASH relating to the two incidents of domestic abuse by Benas in May and October 2021 were not scored sufficiently high.

The BRAG guidance defines a vulnerable person as someone believed to be at risk of harm, abuse or exploitation and may need support and intervention. A BRAG rating for Libby following an incident in 2019 was amber and the IMR author and the DHR Panel feel it should have been red. Libby described to the police that she was sofa surfing, using drugs, needed support to get her life back and was suffering multiple disadvantages.

5.9.2 Following the referral to the LSU by the police the LSU stated that the case did not meet the threshold for a referral to SASC. Although, with the information

[50] BRAG, Blue Red Amber and Green vulnerability rating tool that supports the police to identify and record vulnerability when attending an incident or speaking on the phone.

received by the DHR panel, it would have been seen that Libby did have care and support needs a referral should have been made to SASC. Under the Care Act 2014, Libby would have had the right for her needs to be assessed against the Care Act eligibility criteria to determine how any identified needs could have been supported.

5.9.3 As already discussed, there are concerns that the DASH relating to the domestic abuse incidents in **October 2021** should have been more rounded as Libby mentioned potential risk from weapons, suffocation, guns and threats to burn the house down which would have been scored higher than standard, which it was. A DASH should not be a tick box exercise; it should be informed by professional curiosity.

5.10 Examine whether agencies considered and understood all Libby's vulnerabilities including substance misuse, potential exploitation/sexual coercion, the intersection of those vulnerabilities and their impact on accessing support and what support was provided or not to Libby.

5.10.1 Although many agencies were involved with Libby and several understood what Libby's lived experience was, there was never a complete multi agency response and therefore not all information was known by every agency. SDAS knew that Libby was experiencing substance misuse, homelessness and mental health issues but they were not fully aware as they were not professionally curious about Libby's relationships and the domestic abuse she was experiencing. The police knew how vulnerable Libby was, and there were some good examples when the police supported Libby by checking in on her, taking her to her GP.

5.10.2 Libby was extremely vulnerable, she was homeless at certain points in the last four years of her life, suffered chronic substance misuse, poor physical and mental health, including severe back pain and anxiety. Libby was victim of sexual exploitation, cuckooing, domestic abuse and had lost the care of her children.

5.10.3 If a MARAC or "What to do if it not safeguarding" now a MARM multi agency process had taken place this may have led to a more coordinated, planned approach to supporting Libby.

5.10.4 Libby mentioned to several professionals within agencies how she felt pressured by her parents and Gerry although agencies identified how supportive her parents were. There is no doubt that Libby's parents were trying to do the best for Libby and her children and if there had been a multi-agency approach to support Libby then this could have helped the wider family on how best to support Libby. Advocacy may also have helped Libby to have a voice and a sense of involvement in

decision making. Professionals need to understand what advocacy services there are which could have given Libby, a voice, which could have been provided by TNT and PAUSE.

5.11 Are agencies sufficiently understanding of unconditional/unconscious bias and the impact on such bias on providing support for Libby.

5.11.1 Comments within some IMR's around what had been written within case notes would indicate that there was unconscious bias relating to Libby. Words/phrases used by professionals following certain incidents included*, "Erratic behaviour, so difficult to engage, choosing to feed her drug habit instead of feeding herself,"* and Libby's lifestyle choices.

5.11.2 Libby was engaged in criminal activity, she herself described herself as a sex worker, although the DHR panel would see Libby as being sexually exploited. Libby was known to the police, SDAS, SomFT for her substance misuse, and this could have impacted on their unconscious bias and how they supported Libby as professional may have viewed Libby's lifestyle as a choice.

5.11.3 Unconscious bias can depend on a person's life experience, beliefs, and views they have that might not be right or reasonable. Unconscious bias is triggered by our brain automatically making quick judgements and assessments. Professionals need to be aware that it is in all of us and before we can start to mitigate it is important to recognise and understand what biases you may have.[51]

5.11.4 When victims of domestic abuse have a drug dependency, professionals can often view this as a lifestyle choice and not consider why they have a dependency, what are the triggers, the impact on their vulnerabilities. If professionals do not challenge their unconscious bias, it may mean that the response to a victim is not as speedy as it should be, and empathy may be lacking.

5.11.5 A report by Alcohol Change UK – "How to use legal powers to safeguard highly vulnerable dependent drinker in England and Wales." - Professor Preston Shoot and Mike Ward[52] state in their research that professionals assume that substance misuse is a lifestyle choice and often it is not, and professionals need to understand this and not be biased against a victim.

5.12 Examine whether services and agencies ensured the welfare of any adults at risk, whether services took account of the wishes and views of members of

[51] www.imperial.ac.uk Unconscious bias
[52] . www.alcolocolchange.org UK

the family in decision making and how this was done and if criteria for interventions were appropriately set and correctly applied.

5.12.1 SDAS, SomFT and the police did consider the welfare of Libby and saw the risks she was being exposed to, although with no multi agency approach, the full risks would not have been explored. Referrals were made to adult social care and adult social care made the assessment that Libby did not have any care and support needs as defined by the Care Act 2014. No further referral was received by SASC from 2019 although it is known that the police made information known to LSU who felt that a referral relating to Libby being cuckooed and therefore vulnerable would not meet the criteria for a SASC referral despite there not being a threshold. Professionals need to be reminded that people have a right to a section 9 needs assessment, but they may not always receive support if they do not have eligible needs.

5.13 Whether practices by all agencies were sensitive to the gender, age, disability, ethnic, cultural, linguistic and religious identity of both the individuals who are subject in this review and whether any additional needs on the part of either were explored, shared appropriately and recorded.

5.13.1 Libby was supported by a several services as already discussed earlier in the report. Libby was more likely to be a victim of domestic abuse as a female. What is not clear is whether professionals considered Libby as a mother, having both her children removed from her care, and the impact that this had on Libby's mental health. Libby was aware that she needed to get her substance misuse under control to see her children. Libby was experiencing mental health issues; she was experiencing low moods and anxiety and was in fear for her life. Not all professionals fully understand the protective factors of domestic violence victims, but one is the nurturing of a child parent interaction[53]. There is evidence that Libby did try to manage her substance misuse but when she was unable to see her children Libby would often return to substance misuse and actions to enable her to feed her substance misuse and protect herself. SCSC, Public Health, SDAS did support Libby when Alex was born and especially when there were concerns around domestic abuse and safety plans were put into place for Libby and the children.

5.13.2 Although there was some positive multi agency support between SCSC, SDAS and health for Libby, professionals may not have always considered the strong maternal bonds between a mother and her children and the impact that this has on their mental health for the rest of their lives. Research by Warwick University and

[53] www.dvchildwefare.org Protective factors for survivors of domestic violence.

Refuge "Domestic Abuse and Suicide"[54] highlighted that children were a protective factor for victims of domestic abuse, and this was endorsed by Friend B.

5.14 To acknowledge the ethnicity of the perpetrator and whether this impacted on any help he might or should have received including availability of services/public funds.

5.14.1 Information provided by Benas indicates that his ethnicity did not impact on any help he may need. He felt his ethnicity was no barrier to seek any services although if he needed to register with a GP he may have struggled as he did live in various places, although he stated he never needed a GP.

5.15 Whether organisations were subject to organisational change and if so, did this have any impact over the period of the DHR. Had it been communicated well enough between partners and whether this impacted in any way on partnership agency's ability to respond effectively (including the Covid Pandemic) .

5.15.1 The police IMR noted that during 2021, when Libby was reporting domestic abuse by Benas, it took nineteen days to for the police to contact Libby which was a significant amount of time. Resourcing issues may have impacted on the timeline for contact England was still in a Covid lockdown and police had also been prioritised to support certain operations. The police IMR author stated that even if there were capacity issues, the police force gives a high priority to domestic violence incidence and as such the period between the incidence in **May 21** and the contact with Libby of nineteen days later would not be seen as good practice although police officers involved with the incident did inform the IOPC that they had tried to contact Libby but had not recorded the information. If agencies do have capacity issues, then the agency involved need to factor this into any risk assessment.

5.15.2 Despite the Covid Pandemic, Libby still attended her GP practice which allowed for a more appropriate consultation. The GP appeared to have provided a continuity of care throughout the pandemic for Libby.

5.15.3 The Covid Pandemic may have increased Libby's isolation of which she had highlighted as an issue to mental health professionals in 2019. Research by the Home Office explored the impact of Covid 19 on domestic abuse and suspected victims of death by suicide. The research highlighted that victims of domestic abuse felt more isolated and struggled to manage their mental health and substance

[54] www.warwick.ac.uk/domesticabuseandsuicide Ruth Aitken and Vanesa E Munro 2018

misuse. The SomFT IMR author noted that Libby did not re engage with mental health services for support once the first Covid 19 lockdown came into force.

Good Practice.

I. The GP continued to provide face to face support to Libby during the Covid Pandemic.
II. Libby received continuity of care from her GP building up trust.
III. A police officer supporting Libby extensively in 2019/2021 when she was very vulnerable by making welfare checks of Libby, taking her to the GP and collating intelligence from Libby about OCG.
IV. Public Health had a high level of contact with Libby during the antenatal and birth of Alex, including contact with other health professions and social care.
V. There was good multi- agency work relating to the "One Team" a meeting whereby local agencies convene to discuss vulnerable people which included Libby.

6.CONCLUSION

6.1 Libby was a vulnerable adult who had experienced substance misuse for many years, domestic abuse by multiple partners, OCG, homelessness, exploitation in many forms, loss of care of her children, mental and physical health issues. There is evidence to suggest that professionals sometimes viewed the choices that Libby made were her "lifestyle choices" and the fact she had mental capacity this could have limited what support was available to her.

6.2 Libby appeared to feel very isolated as she felt pressure from her family and professionals did not seem to fully understand that some of Libby's decisions were being made from fear for her life. A trauma informed response may have challenged professionals and the family perspective. Trauma informed approach by professionals is often identified within DHRs and although training is important, a trauma informed way of working should be embedded into everyday practice with agencies. This is not just a local issue it is a national issue and at a national level, agencies should ensure that professionals have training that includes what is trauma, what is a trauma informed response and how to work in a trauma informed way.

6.3 Although there was some good practice in supporting Libby, there were some examples of unconscious bias for example Libby prioritising drugs over feeding herself and not being sober enough to give a statement.

6.4 Although there was one multi agency meeting, "One Team" in 2021 there was no MARAC or other multi agency forum to identify Libby's support needs and SCSC

stated that information from the One Team was not shared with them. Agencies dealt with their element of support for Libby without a full understanding of what Libby was experiencing and therefore there was not the opportunity to provide a coordinated approach to best support Libby. The Covid Pandemic 2020/2021 had an impact on agencies ability to work collaboratively during this unprecedented time and nationally the government has recognised there have been lessons learnt and agencies need to reflect on the lessons learnt for any future unprecedented events.

6.5 If a multi-agency approach had been implemented for example "What to do if it's not Safeguarding" now MARM or a MARAC, then a more planned holistic programme of support may have helped Libby. Several IMR authors and the DHR Panel identified a lack of professional curiosity by professionals when supporting Libby and if a more comprehensive picture of Libby's life could have been established, a more holistic range of support could have been offered to Libby.

6.6 Libby told friends that she felt that she would die at the hands of Benas, and she must have lived in fear for many months in 2021 (and this was confirmed by friends). Friends said that "Benas took away Libby's confidence and she became quite withdrawn." Despite this, there are videos of Libby being vibrant and full of life in the last few months of her life. Libby loved her children, did try to resolve her drug and alcohol issues and wanted to improve her life.

7. LESSONS LEARNT

The death of Libby identified lessons to be learnt by agencies and the wider community. The DHR Panel accept that this review has the benefit of hindsight and a comprehensive insight into the contact that Libby and Benas had with various agencies.

7.1 Professional Curiosity and understanding the need to know the victim better. 7.1.1 This review identifies that Libby was experiencing many issues in her life which made her vulnerable and open to being exploited by others including organised crime. Libby was suffering from physical and mental health issues; the misuse of drugs; sexual exploitation; domestic abuse, loss of the care of her children, periods of homelessness all of which made Libby vulnerable. Libby was also spending much of her life living in fear.

7.1.2 The IMRs identified that if professionals had been more curious about Libby's life, then agencies would have had a better understanding of her needs and the risk she was encountering. For example, if workers in SDAS, who had a long association with Libby, had been more curious about Libby relationship status then this would

have allowed risks to have been explored and support to be offered Libby. The probation service also identified that a lack of professional curiosity about the relationship between Libby and Benas may have been a missed opportunity to understand the risks posed to Libby.

7.1.3 Professional curiosity (or lack of it) is a theme running through many published Domestic Homicide Reviews. Professional curiosity is the capacity and communication skills to explore and understand what is happening to someone rather than making assumptions.

7.1.4 What is important is that professionals are who are engaging with a person who has multiple vulnerabilities such as Libby are provided with the tools to increase their skill to be professionally curious. It will be important that a professional understand the barriers that someone like Libby was facing and the intersectionality of all the issues. It is also important that agencies ensure that professional curiosity is embedded in professional practice through supervision, reflection and leaning from reviews will help professionals/ practitioners enhance their awareness.

7.1.5 At a national level, the *Annual Review of Local Child Safeguarding Practice Reviews and Rapid Reviews 2021(LCSPR)*[55] highlights that many reviews are critical of practitioners for not being professionally curious. Although professional curiosity is extensively used in Child Practice Reviews, the same could be said of DHRs and SARs. The *LCSPR* states that the challenge for front line practitioners is to develop authentic relationships with children and families to effect positive change. It was also highlighted that at times, practitioners were not suitably curious or challenging. When professionals are supporting victims of abuse or adults who may need support, there is often a need for a "second question." The report goes on to describe organisations need a culture of openness to allow practitioners to ask for support when needed and that practitioners must feel safe to admit their concerns about a family, a child or in this case an adult, or it could be a victim of domestic abuse, knowing that these will be taken seriously and acted upon.

7.2 Professionals need to understand Unconscious Bias/Conditional Bias and how this can impact on support for a vulnerable adult

7.2.1 Everyone has their own unconscious bias. Even for people who are open minded and only observe the facts before concluding, it is likely that some bias will shape their opinion. Professionals can exhibit unconscious bias which means that

[55] Annual Review of LCSPRs and Rapid reviews- The Child Safeguarding Practice Review Panel March 2021 www.assets.publishing.service.gov.uk

they look for evidence to support their pre- held views and this can lead to poor decision making.[56]

7.2.2 This report has identified that some professionals may have exhibited some unconscious bias when supporting Libby and may have viewed Libby's lifestyle of substance misuse, involvement with OCG, working as a sex worker as a "lifestyle choice" instead of trying to understand the trauma and fear in Libby's life. Libby may have been fearful for her life, and this may have impaired her ability to speak clearly. Research has identified that people should challenge their un-conscious bias regarding people "choosing to live or like a self-neglecting lifestyle."[57]

7.2.3 It is important that professionals understand their own unconscious bias and that decisions should be made based on fact, challenge and open discussion. Agencies should also challenge the language used by professionals to ensure it is appropriate.

7.3 Professionals to understand the need for a multi-agency approach in supporting vulnerable adults.

7.3.1 Libby was involved with several agencies over many years including drug and alcohol services, health services, domestic abuse services, SCSC and the police. Although the police referred Libby to the LSU unit on several occasions around safeguarding concerns about Libby being cuckooed, the LSU deemed that a referral would not reach the threshold for an assessment by SASC and therefore no referral was made.

7.3.2 It is also not clear why agencies did not refer Libby to a MARAC following the incident in May 2021 but if a referral was made then this may have enabled a comprehensive review of what Libby was experiencing and comprehensive safety planning and support could have been considered for Libby. In the last two years, Safelives, on behalf of the SSP, have carried out a comprehensive review of the MARAC in Somerset and policy and procedures have been updated. It will be important that the SSP continually review and audit the MARAC process to ensure it is supporting victims of domestic abuse.

7.3.3 The review of "What to do if it's not Safeguarding" now rebranded as MARM provides a further opportunity for a multi-agency approach for a vulnerable person when there is an inherent risk associated with their lives. It will be important that professionals in all agencies understand and utilise the guidance to enable a multi-

[56] The University of Edinburgh , Equality, Diversity and Inclusion -Unconscious bias- www.ed.ac.uk
[57] www.royalsociety.org Unconscious Bias

agency approach and support for a victim of domestic abuse who may not have eligible care and support needs.

7.3.4 All agencies within Somerset should have knowledge of the guidance and ensure that professionals within their organisation understand that they have a tool which can be used to support a vulnerable adult with multiple needs.

7.4 Better understanding by professionals about assessment of need under the Care Act 2014

7.4.1 Section 9 Care Act 2014[58] places a duty on a local authority, where it appears to the local authority that an adult may have needs for care and support, to assess what those needs are. Libby was referred to SASC in 2015, 2017 and 2019. Based on the information provided a decision was made that there was no role for SASC to support Libby. The IMR author noted that decisions may have been marginal and as the SASC record keeping was poor on several occasions it was not possible to confirm whether an assessment should have been carried out.

7.4.2 No further referrals were made to SASC during 2020 and 2021 by agencies despite Libby's contact with the police, SDAS, mental health services, GP's, and housing. Information provided by the IMR's highlights Libby continued substance misuse, sexual exploitation, cuckooing, domestic abuse, and periods of homelessness which could have led to a safeguarding referral and an enquiry under section 42 of the Care Act 2014.

7.4.3 SASC can only make decisions on the information they are provided within the referral and the DHR Panel have requested that the police and SASC review what information is essential to make appropriate decisions but being mindful of resources within the police.

7.5 Better Understanding by Professionals of the duty to refer homelessness cases to housing authorities and the impact of the Domestic Abuse Act 2021 on housing support for victims of domestic abuse.

7.5.1 Housing is a key issue for victims of domestic abuse and although victims have more support available following the implementation of the Domestic Abuse Act 2021 there is still much work to be done to ensure all professionals, not just housing professionals understand the impact of different housing legislation and what is required to ensure better support for victims of domestic abuse.

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[58] Care Act 2014 www.legislation.gov.uk

7.5.2 Abraham Maslow's hierarchy of needs[59] identifies that shelter is one of the fundamental needs of humans along with food, water, warmth and for a victim of domestic abuse it is essential as it can provide security and safety.

7.5.3 It is important that there is training for professionals in the police, health, social care and relevant third sector providers on housing legislation and how it can be used to better support victims of domestic abuse.

7.5.4 It is also important that a wider awareness campaign for the community about what housing support is available for victims of domestic abuse should take place to better support victims of domestic abuse and their families.

7.6 Agencies and Professionals to understand why victims/vulnerable adults do not attend.

7.6.1 Many of the agencies within this review highlighted that Libby did not attend appointments or make contact with them. Libby was referred to TNT and although they contacted Libby she did not respond and therefore the referral ceased. SIDAS and SomFT highlighted the same difficulties in supporting Libby.

7.6.2 As described, Libby was experiencing multiple disadvantage which impacted on her ability to engage. Agencies and professionals need to challenge their mindset and be asking why is it that the person is not engaging e.g., have they lost a phone, have they moved or are they in crisis. The DHR Panel do understand that agencies are impacted by limited resources, but it may be beneficial that agencies review their "Did not attend policy" to ensure that they work in partnership with other agencies especially in cases where someone is known to have multiple complex issues.

7.7 Lack of enforcement of sentencing requirements

7.7.1 During 2017 and 2018, Libby was not attending her meetings with her OM, and this was not being followed up by the OM. Libby was required to participate in a drug rehabilitation programme but there was no action taken when Libby did not attend the programme. The lack of follow up as to why Libby was not engaging with her sentencing requirements meant that Libby did not get the support which may have helped her substance misuse and allowed professionals within the Probation service a better understanding of the issues that Libby was facing and therefore the ability to offer appropriate support to help rehabilitate Libby.

[59] www.simplypyschology.org Jan 2024 Maslow's Hierarchy of needs paper 1943 "A theory of human motivation"

7.8 Retention of Information

7.8.1 It has been difficult to build a full picture of the impact on Libby's life from her housing situation due to the lack of information available to this review. We know that Libby was involved with at least two local authority housing departments, but it is not known what support/advice Libby received as when records were migrated to a new IT system, the historical records, of which Libby was one, were not kept.

7.8.2 We know from information that Libby was homeless, sofa surfing, sleeping on the streets, in a hostel and Libby's housing situation would have impacted on her vulnerabilities such as her mental health, physical health, her substance misuse and increased risks in her life.

7.8.3 Housing is a critical issue for victims of domestic abuse, and this is highlighted by the inclusion of new housing legalisation in the Domestic Abuse Act 2021. The information about the support provided by local authority housing department to a domestic abuse victim will also be important so housing department can review how they are responding to new legislation but also to learn from historical cases as to how better housing support can be provided to victims of domestic abuse. In order to ensure the retention of important information then a recommendation relating to retention of data by housing departments is included in section eight.

7.9 Safeguarding of Children and domestic abuse

7.9.1 The chronology highlights that the last involvement of SCSC with Libby, her family and child was in 2017 and the police have stated that they never had reason to believe that any of Libby's children were present in the household when they were responding to incidents. Libby's family have stated that the children did visit Libby, especially during school holidays, after school, and Benas spoke of the children visiting the house and he would take the children to the park. Agencies do need to have an understanding of family dynamics as children may be impacted directly or indirectly by domestic abuse. Children Social Care, Adult Social Care and NHS England promote a Think Family approach which means looking at a family as a system, working to a family's strength and mitigating risks by providing support[60].

7.9.2 The Domestic Abuse Act 2021 automatically categorises children affected by domestic abuse as victims regardless of whether they were present during violent incidents. Somerset Council on behalf of the SSP have developed an online learning Foundation Programme on Domestic Abuse and a couple of the modules consider

[60] Socialworkwithadaults.blog.gov.uk Think Family -think solutions that benefit everyone.

the impact on children living with domestic abuse. The DHR Panel recommend that SSP review the content of the modules relating to children to include any learning from this review. Also, if family members who may be formal or informal kinship carers have concerns around the risks relating to domestic abuse and birth parents, they need to know the channels to highlight their concerns.

7.10 Escalation of Risk

7.10.1 Although the relationship between Libby and Benas only became known to the police in May 2021 following the first report of a domestic abuse incident, there was an escalation of incidents in October/early November 2021(27/30 October and 5 November). Libby was experiencing an escalation of abuse by Benas. The Homicide Timeline[61] is based on proven research by Professor Jane Monckton Smith that identifies eight stages leading up to a perpetrator committing a homicide. Libby was experiencing an escalation of abuse; friends had stated that she was going to break up the relationship with Benas which may have changed his thinking to revenge. All professionals dealing with domestic abuse should have an understanding of the homicide timeline as it will help support risk assessments and safety planning for the victim.

7. 11 Post Review Learning

7.11.1 In conversation with Libby's family who are the parental guardians of Alex, it is acknowledged that they have a young child to raise but are keen to know how best to support them about remembering Libby and what to tell them about what happened. It should also be highlighted that Benas could be released from prison at a time when the children become young adults.

7.1.2 Libby's mother and father want to ensure that Alex is supported through the process of understanding what Libby experienced and how she died. It would be beneficial to have beneficial to have some national support / guidance on how parents/grandparents/carers can best navigate children through this process.

The family have received support from a Child Bereavement Therapist funded by Victim Support Homicide Service and support will be lifelong from Victim Support. Support to the family and the children will also be available from Victim Support as and when parole is applied for by Benas. Libby's family are also aware of the Kinship Carers Forum.

[61] www.dvact.org Homicide Timeline 2020

8. RECOMMENDATIONS

8.1 Local

1. That the Safer Somerset Partnership seek assurance from agencies involved in this review that

a) develop practitioners' professional curiosity skills (drug and alcohol services, mental health, specialist domestic abuse services and housing) and

b) Improving knowledge in case supervision for line managers covered in training and encouraged through supervision and other means available.

Ownership – Safer Somerset Partnership and agencies involved in this DHR

2. a) Somerset Safeguarding Adults Board to relaunch the guidance "What to do if it is not safeguarding" and to seek assurance that professionals within partner agencies have knowledge of and understand how to implement the guidance. *(Completed and now rebranded as Mult Agency Risk Management, MARM February 2024)*

b) SSAB to review the MARM in February 2025

Ownership – Somerset Safeguarding Adults Board

3. That all agencies who contributed to this DHR, review their "Did Not attend" Policy (or equivalent) to ensure that they work in partnership with other agencies especially in cases where someone is known to have multiple complex needs and also may be experiencing a barrier to engagement due to their location e.g. rural v town – particularly to include reference to dynamics of domestic abuse and impact that has on engagement for a survivor.

Ownership – Agencies involved in this DHR

4. Using this DHR as a case study, agencies involved in this review include guidance/training for professionals on the following subject matter;

unconscious bias relating to substance misuse/victim blaming and to ensure that this includes guidance to support managers to be able to challenge and support professional through supervision.

Ownership – All agencies involved in this DHR

5. Somerset Council (Housing) to ensure that all agencies who have a duty to refer if a service user who may be homeless or threatened with homelessness understand their duty and are provided with guidance on the required process to make a referral.

Ownership – Somerset Council (Housing)

6. Somerset Council (Housing) to ensure that when a new Information Technology system is introduced that within the procurement process there is a requirement that data relating to individuals is retained for seven years and that access can be made by the housing service to seek historic information on a client if required.

Ownership -Somerset Council-Housing

7. Somerset Council Community Safety Team to develop guidance (7-minute briefing) for agencies on appropriate language when describing a victim of domestic abuse or sexual exploitation and agencies to ensure that professionals across the Safer Somerset Partnership agencies are provided with the guidance.

Ownership – Somerset Council Community Safety Team

8. Somerset Council Community Safety Team to ensure that the impact of economic abuse is included within its training modules and to ensure that cuckooing and organised crime are included as being relevant to domestic abuse.

Ownership – Somerset Council Community Safety Team

9. SSP to continue to review and audit the updated MARAC procedures in Somerset, to ensure that MARAC referrals are discussed at a MARAC and decisions are recorded.

Ownership – Safer Somerset Partnership

10*.* Somerset Council Community Safety Team to ensure that within its training module that children are included as being relevant to domestic abuse.

Update- this recommendation has been implemented.

Ownership – Somerset Council Community Safety Team

National

11. Safer Somerset Partnership to request that the Home Office in partnership with other government departments identify how agencies can embed trauma informed practices within their professional practice. This to include social workers, health practitioners, police and probation.

Ownership -Safer Somerset Partnership

8.2 Agency recommendations

8.2.1 Avon and Somerset Constabulary (The Police)

1. Head of Victim Care, Safeguarding & Vulnerability to continue activity with relevant colleagues across the force to support understanding of the complexity of vulnerability and multiple disadvantages, particularly in relation to victims who may present as suspects of crime.
2. LSU to bolster their directory of support services and referral pathways for all victims- Completed January 2023

8.2.2 Somerset Adult Social Care

1. To ensure ASC staff consider the impacts of substance misuse when undertaking Care Act Assessments and how this may impact on an individual's care and support needs, and decision making.
2. SCC Adult Safeguarding Staff are supported to understand research and practice guidance of working with people who have addictions, to support their decision making.

8.2.3 Somerset Clinical Commissioning Group now NHS Somerset Integrated Care Board from July 2022

1. When a person has made a disclosure of domestic abuse, even if well known, practitioners could use the opportunity to explore further and complete a DASH form/signpost to SIDAS.
2. If a person has contact with a GP service about their mental wellbeing, substance and/or alcohol misuse and/or pain that does not appear to have a clear medical cause, that GP practices should include a clinical enquiry about Domestic Abuse in the consultation.

8.2.4 Probation

1. The New Probation Office Service performance measures states that all Initial Sentence Plans need to be completed within 15 working days of a Person on Probation's initial appointment. This is being implemented by the new probation service and is monitored and Probation Service locally are reaching their targets now.
2. Enforcement policy needs to be adhered to, for all failed appointments a formal warning should be issued providing the Person on Probation an opportunity to provide evidence for their failure to attend. This is being monitored by the new probation service and incremental improvements are being achieved.
3. Home visits to be completed on a regular basis given the chaotic nature of Libby's lifestyle a home visit should have been completed. Home visits provide a valuable window into the person on probations circumstances and lifestyle. By seeing someone in their own environment, it enables staff to verify their self-report of their circumstances including who they are living with, identifying any issues with the property or the local area and understanding the impact of the person on probation's role in their family, household and community. This can aid a comprehensive assessment of risk, needs and safeguarding concerns in relation to children, vulnerable adults, and partners in cases of domestic abuse. The New Probation Service has the following home visit schedule which must be adhered to following the commencement of supervision. Within 10 working days for any person on probation subject to National Security Division oversight. Within 15 days of the start of supervision for individuals who are a high risk of serious harm. Within 15 working days to all

Registered Sex Offenders – regardless of level of risk, within 15 working days for all individuals convicted of/or identified as having been involved in Child Sexual Exploitation, within 6 weeks of the start of supervision for individuals who are a medium risk of serious harm, within 12 weeks of the start of supervision for individuals who are a low risk of serious harm. Whenever Libby moved a home visit should have been completed. This is now being implemented in the new probation service – the above are the new expectations for the future;

4. All Police intelligence reports to be followed up and outcome recorded on the system.
5. Referral should have been made to CYPS, the OM only accepted the word of Libby for what was going on with regards to her two children, liaison should have been made with CYPS and clearly recorded. NEW SAFEGUARDING POLICY IN PLACE NATIONALLY which is being followed
6. There were numerous gaps in recording within Libby's NDELIUS records, records need to be updated as and when the incident occur – This is being monitored by the new probation service in relation to recording of outcomes for appointments.
7. Probation Service are currently considering nationally a resource for Domestic Abuse checks and providing more resources for this service in conjunction with the Police. This will be by the provision of additional administrative staff, related to police provision for this specific task. Recommendation to be updated and finalised when the full details of this National Response are available.
8. Regular Police checks to be made on the addresses of Service Users to establish is any issues. It is worth noting that the Probation Service now receives regular arrest and Domestic Violence information concerning Service users, in 2017/2018 this procedure was not in place.

8.2.5 Somerset Drug and Alcohol Service

1. Further training to staff around identifying, escalating, managing safeguarding concerns/risks, and sharing safeguarding concerns with relevant external agencies
2. Training to staff around professional curiosity/investigative mindset
3. Staff refresher around domestic abuse processes inc. managing disclosures, DASH, safeguarding referrals

8.2.6 Somerset Public Health Service

1. Public Health Nursing adopt the Health Visitor centralised triaging and duty system to improve adherence to the Pre-birth SOP.
2. Children Social Care to notify other agencies/service when someone/family of concern moves into the area.

8.2.7 DHR Panel recommendation for Somerset Integrated Domestic Abuse Service and Somerset Drug and Alcohol Service.

SIDAS and SDAS to review how they work collaboratively and if improvements can be made to better support victims of domestic abuse.

TERMS OF REFERENCE FOR REVIEW PANEL

DHR 044 - Version Three

1. Introduction

1.1 The chair of the Safer Somerset Partnership has commissioned this DHR in response to the death of Libby. The death is believed to be murder, with the person causing harm being her partner.

1.2 All other responsibility relating to the review commissioners (Safer Somerset Partnership) namely any changes to these Terms of Reference and the preparation, agreement, and implementation of an Action Plan to take forward the local recommendations in the overview report will be the collective responsibility of the Partnership.

2. Aims of the Domestic Homicide Review Process

2.1 Establish the facts that led to the death on 7th November 2021 and whether there are any lessons to be learned from the case about the way in which local professionals and agencies worked together to safeguard the family.

2.2 Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result.

2.3 To produce a report which:

- summarises concisely the relevant chronology of events including:
  - the actions of all the involved agencies;
  - the observations (and any actions) of relatives, friends and workplace colleagues relevant to the review
  - analyses and comments on the appropriateness of actions taken;
  - makes recommendations which, if implemented, will better safeguard people experiencing domestic abuse, irrespective of the nature of the domestic abuse they've experienced.

2.4 Apply these lessons to service responses including changes to policies, procedures, and awareness-raising as appropriate.

- Identify what those lessons are, how they will be acted upon and what is

expected to change as a result.

- Apply these lessons to service responses including changes to policies and procedures as appropriate.
- Prevent domestic violence and abuse homicide and improve service responses for all domestic violence and abuse victims and their children through improved intra and inter-agency working.
- Establish the facts that led to the incident and whether there are any lessons to be learned from the case about the way in which local professionals and agencies worked together to support or manage the person who caused harm.

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

3. Scope of the review

The review will:

- Consider the period from 01.01.2015 to 07.11.2021, subject to any significant information emerging that prompts a review of any earlier or subsequent incidents or events that are relevant. (This date range has been chosen because of Adult Social Care and SIDAS both receiving information about domestic abuse during 2015, and the birth of Libby's second child)
- Request Individual Management Reviews by each of the agencies defined in Section 9 of the Domestic Violence Crime and Victims Act (2004) and invite responses from any other relevant agencies or individuals identified through the process of the review.
- Seek the involvement of the family, employers, neighbours & friends to provide a robust analysis of the events. Taking account of the coroners' inquest in terms of timing and contact with the family.
- Aim to produce a report within 6 months of the DHR being commissioned which summarises the chronology of the events, including the actions of involved agencies, analysis and comments on the actions taken and makes any required recommendations regarding safeguarding of families and children where domestic abuse is a feature.
- Consider how (and if knowledge of) all forms of domestic abuse (including the non-physical types) are understood by the local community at large – including family, friends and statutory and voluntary organisations. This is to also ensure that the dynamics of coercive control are also fully explored.
- To discover if all relevant civil or criminal interventions were considered and/or used.
- Determine if there were any barriers Ms Ashwell or her family/friends faced in both reporting domestic abuse and accessing services. This should also be explored:
    - Against the Equality Act 2010's protected characteristics.

- Examine the events leading up to the incident, including a chronology of the events in question.

- Review the interventions, care and treatment and or support provided. Consider whether the work undertaken by services in this case was consistent with each organisation's professional standards and domestic abuse policy, procedures and protocols including Safeguarding Adults and Safeguarding Children.

- Review the communication between agencies, services, friends and family including the transfer of relevant information to inform risk assessment and management and the care and service delivery of all the agencies involved.

- Identify any care or service delivery issues, alongside factors that might have contributed to the incident.

- Examine how organisations adhered to their own local policies and procedures and ensure adherence to national good practice.

- Review documentation and recording of key information, including assessments, risk assessments, care plans and management plans.

- Examine whether agencies considered and understood all Libby's vulnerabilities including substance misuse, potential exploitation/sexual coercion, the intersecting of those vulnerabilities and their impact on her accessing support, and what support was provided (or not) to Libby.

- Are agencies sufficiently understanding of unconditional bias, and the impact of such bias on providing the support to Libby?

- Examine whether services and agencies ensured the welfare of any adults at risk, whether services took account of the wishes and views of members of the family in decision making and how this was done and if criteria for intervention were appropriately set and correctly applied in this case.

- Whether practices by all agencies were sensitive to the gender, age, disability, ethnic, cultural, linguistic and religious identity of both the individuals who are subjects of the review and whether any additional needs on the part of either were explored, shared appropriately and recorded.

- To acknowledge the ethnicity of the perpetrator and whether this impacted on any help he might or should have received including availability of services/recourse to public funds?

- Whether organisations were subject to organisational change and if so, did it have any impact over the period covered by the DHR. Had it been communicated well

enough between partners and whether that impacted in any way on partnership agencies' ability to respond effectively (including the Covid pandemic).

4 Role of the Independent Chair (see also separate Somerset DHR Chair Role document)

- Convene and chair a review panel meeting at the outset.
- Liaise with the family/friends of the deceased or appoint an appropriate representative to do so. (Consider Home Office leaflet for family members, plus statutory guidance (section 6))
- Determine brief of, co-ordinate and request IMR's.
- Review IMR's – ensuring that incorporate suggested outline from the statutory Home Office guidance (where possible).
- Convene and chair a review panel meeting to review IMR responses
- Write report (including action plan) or appoint an independent overview report author and agree contents with the Review Panel
- Present report to the CSP (if required by the SSP Chair)

5 Domestic Homicide Review Panel

5.1 Membership of the panel will comprise:

Agency	Representative
Independent Chair	Liz Cooper
Adult Social Care	Louise White
Avon and Somerset Police	T/DI Su Parker
Integrated Care Board	Emma Read
Children's Social Care	Kelly Brewer
Probation	Via Liz Spencer
Safer Somerset Partnership (SCC Public Health)	Suzanne Harris
Somerset Drug and Alcohol Service	Jane Harvey-Hill
Somerset Integrated Domestic Abuse Service (The You Trust – 2020 +)	Tonia Redver

Somerset Integrated Domestic Abuse Service (Livewest Housing – 2015 to 2020)	Mel Thomson
Somerset NHS Foundation Trust	Heather Sparks/Vikki Hanna

This will be confirmed at the first Review Panel meeting in October 2022

5.2 Each Review Panel member to have completed the DHR e-learning training as available on the Home Office website before joining the panel. (online at: https://www.gov.uk/conducting-a-domestic-homicide-review-online-learning)

Safer Somerset Partnership

Feel Safe, Be Safe

EXECUTIVE SUMMARY

of the

DOMESTIC HOMICIDE REVIEW

relating to the death of Libby

on behalf of:

Safer Somerset Partnership

Report author; Liz Cooper

Independent Chair

Report submitted to Home Office: October 2024

Report updated: June 2025 following feedback from the Home Office

EXECUTIVE SUMMARY CONTENTS

1.0 THE REVIEW PROCESS

1.1 This Executive Summary outlines the process and findings of a Domestic Homicide Review (DHR) undertaken by the Safer Somerset Partnership(SSP) into the death of Libby. All the names in this review have been anonymised for the purpose of confidentiality.

1.2 The following pseudonyms have been used in this review to protect the victim, alleged perpetrators and family.

	Pseudonym
Victim	Libby
Perpetrator	Benas
Eldest child of the victim	Sam
Youngest child of the victim	Alex
Victim's husband and father of Sam	Gerry
Victim's partner and father Alex	Peter

1.3 Libby's death took place in November 2021 and the Safer Somerset Partnership was notified about a potential DHR and it was determined that the criteria for a DHR had been met under DHR Statutory Guidance 2016, in particular paras 5(1), 18 and 27(c).[62]

1.4 A criminal investigation followed Libby's death resulting in a trial at a Crown Court at which Benas was convicted of Libby's death and was sentenced to life in prison with a minimum term of fourteen years and ten months.

2.0 CONTRIBUTERS TO THE REVIEW

2.1 This DHR has followed the statutory guidance issued following the implementation of Section 9 of the Domestic Violence Crime and Victim Act 2004 as well as the local DHR protocol developed by the Safer Somerset Partnership.

2.2 The following agencies submitted Individual Management Reviews (IMRs) detailing their contact with Libby, Benas and relevant family members.

x. Avon and Somerset Constabulary (the Police)
xi. Probation Service (Although both Libby and Benas were historically supervised by the privatised provider of probation services, Bristol, Gloucestershire, Somerset and Wiltshire Community Rehabilitation Company BGSW CRC)
xii. Somerset Clinical Commissioning Group(CCG) now NHS Somerset Integrated Care Board (ICB) (on behalf of the GP)
xiii. Somerset NHS Foundation Trust (SomFT)
xiv. Somerset Public Health Nursing Team
xv. Somerset Adult Social Care (SASC)
xvi. Somerset Children Social Care (SCSC)

[62] DHR-Statutory-Guidance-161206.pdf(publishing.service.gov.uk)

xvii. Somerset Integrated Domestic Abuse Service (SIDAS)

xviii. Somerset Drug and Alcohol Service (Turning Point)(SDAS)

The IMRs were completed by senior staff who had no direct management involvement with the family or the incident.

2.3 The Panel gave detailed consideration and professional challenge to the IMRs submitted by these agencies and the final documents have contributed significantly to this report.

2.4 Following receipt of the IMR's and contact with Libby's family it was identified that Libby did have contact with housing services at Mendip District Council and Somerset West and Taunton District Council. Information was requested from both organisations but due to the migration of housing information to a new system, historical data was not available for this review. Homelessness was a significant issue for Libby and therefore it is disappointing that the DHR Panel have not been unable to review the contacts that Libby had with any housing support.

2.5 The Independent Chair met with Libby's parents on three occasions (face to face) and Libby's parents had a virtual meeting with the DHR Panel prior to the report being sent to the Home Office. A Victim Support advocate supported the parents, and the parents were provided with a copy of the draft overview report to make contributions as appropriate and they received a final copy of the DHR Overview Report, Executive Summary and Action Plan. The Independent Chair kept the family updated on progress of the DHR via the Victim Support advocate, as this was their preferred method.

2.6 Two friends of Libby contributed to the DHR which added further context as to what issues Libby was experiencing. The contacts were provided by Libby's family.
Gerry, Libby's ex-husband and father of Sam, were both invited to speak with the Independent Chair, but no response was received.
2.7 The Independent Chair wrote to Benas via the prison governor and a virtual meeting took place with Benas.

2.8 To support this DHR, the Independent Chair spoke twice with senior managers at The Nelson Trust[63] (TNT), an organisation based in the Southwest providing a trauma informed approach to support women who have experienced abuse and trauma which is often masked with substance dependency meaning that the women have multiple complex needs and whom Libby had had contact with.

3.0 THE REVIEW PANEL MEMBERS

[63] www.nelsontrust.com

3.1 Panel Membership

The Panel consisted of senior representatives from the following agencies:

- Liz Cooper -Independent DHR Chair/Overview Report Author
- Suzanne Harris - Somerset County Council (Public Health and SSP)
- Heather Sparks /Vicky Hanna- Somerset NHS Foundation Trust
- DI Su Parker and Dave Marchant -Avon and Somerset Constabulary
- Julia Mason Somerset Integrated Care Board -
- Toni Redvers- The You Trust- present Somerset Integrated Domestic Abuse Service from 2020 (SIDAS)
- Melanie Thomson-Live West (Housing Association) SIDAS provider up to 2020
- Liz Spencer-Probation Service
- Louise White-Somerset Adult Social Care
- Kelly Brewer -Somerset Children Social Care
- Jane Harvey Hill -Somerset Drug and Alcohol Service provided by Turning Point
- Patricia Ashfield- Mendip District Council up to 2023 and Somerset Council from 2023

3.2 The Review Panel met on seven occasions, all virtually and agency representatives were of the appropriate level of expertise.

4.0 CHAIR OF THE DHR AND AUTHOR OF THE OVERVIEW REPORT

4.1 The Chair and author of the review is Liz Cooper, formerly Assistant Chief Executive at Spelthorne Borough Council (Surrey). Liz has a wide range of expertise including Services for Vulnerable Adults and Children, housing and domestic violence. She has conducted partnership Domestic Homicide Reviews for the Home Office and has attended Home Office Independent Chair training for DHRs and further DHR Chair training with Advocacy after Fatal Domestic Abuse (AAFDA). Liz is a member of AAFDA DHR Chairs Network and Liz has also been involved with several Serious Case Reviews. Liz has no connection with any of the agencies in this case.

5.0 TERMS OF REFERENCE

5.1 Terms of Reference (TOR) were agreed by the DHR Panel in **April 2022** and were regularly reviewed and amended as further details of events in Libby's life emerged. The full TOR is included in Appendix One.

5.2 At the first meeting, the Review Panel considered the initial scoping exercise by the SSP about agency contact with Libby, Libby's family and Benas. This included significant contact with Libby and the family over several years and it was agreed that

the review would cover the period **1 January 2015** up until **Autumn 2021** unless there were significant events of relevance prior to this. (This date range has been chosen because of Somerset Adult Social Care (SASC) and Somerset Integrated Domestic Abuse Service (SIDAS) both receiving information about domestic abuse in 2015 and the birth of Alex).

Key lines of enquiry ; The Review Panel considered both the generic issues as set out in the DHR statutory guidance and identified the following case specific issues;

- Consider how (and if knowledge of) all forms of domestic abuse (including the non-physical types) are understood by the local community at large – including family, friends and statutory and voluntary organisations. This is to also ensure that the dynamics of coercive control are also fully explored.

- To discover if all relevant civil or criminal interventions were considered and/or used.

- Determine if there were any barriers Libby or her family/friends faced in both reporting domestic abuse and accessing services. This should also be explored against the Equality Act 2010's protected characteristics.

- Examine the events leading up to the incident, including a chronology of the events in question.

- Review the interventions, care and treatment and or support provided. Consider whether the work undertaken by services in this case was consistent with each organisation's professional standards and domestic abuse policy, procedures and protocols including Safeguarding Adults and Safeguarding Children.

- Review the communication between agencies, services, friends and family including the transfer of relevant information to inform risk assessment and management and the care and service delivery of all the agencies involved.

- Identify any care or service delivery issues, alongside factors that might have contributed to the incident.

- Examine how organisations adhered to their own local policies and procedures and ensure adherence to national good practice.

- Review documentation and recording of key information, including assessments, risk assessments, care plans and management plans.

- Examine whether agencies considered and understood all Libby's vulnerabilities including substance misuse, potential exploitation/sexual coercion, the

intersecting of those vulnerabilities and their impact on her accessing support, and what support was provided (or not) to Libby.

- Are agencies sufficiently understanding of unconditional bias, and the impact of such bias on providing the support to Libby.

- Examine whether services and agencies ensured the welfare of any adults at risk, whether services took account of the wishes and views of members of the family in decision making and how this was done and if criteria for intervention were appropriately set and correctly applied in this case.

- Whether practices by all agencies were sensitive to the gender, age, disability, ethnic, cultural, linguistic and religious identity of both the individuals who are subjects of the review and whether any additional needs on the part of either were explored, shared appropriately and recorded.

- To acknowledge the ethnicity of the perpetrator and whether this impacted on any help he might or should have received including availability of services/recourse to public funds ?

- Whether organisations were subject to organisational change and if so, did it have any impact over the period covered by the DHR. Had it been communicated well enough between partners and whether that impacted in any way on partnership agencies' ability to respond effectively (including the Covid pandemic).

6. SUMMARY CHRONOLOGY

The DHR Panel received extensive information from the agency IMRs and the DHR panel used the Social Care Institute for Excellence "Learning Together"[64] to identify the Key Practice Episodes (KPE) in the lives of Libby, her children, her family and Benas .

6.1 Background Information

Libby lived in Somerset for many years and started to take heroin in her twenties, she met Gerry and they got married and had Sam (oldest child). The marriage ended and Libby met Peter in 2013. Libby spent time away from living in Somerset but returned with Peter when she was pregnant with Alex.

6.2.1 **KPE One: Libby pregnant with Alex, child safeguarding concerns and Libby experiencing domestic abuse.**

6.2.1 **Spring 2015**, Libby came to the attention of Somerset Children Social Care (SCSC) as the Public Health Nursing Team were concerned about Libby's unborn child

[64] www.scie.org.uk/children/learningtogether/

due to domestic abuse and parental substance misuse. Libby met with SCSC and she disclosed information about her substance misuse but also that Peter was forcing her to stay in her room by locking the door to ensure she went through withdrawal. Libby stated that if she tried to leave then Peter would restrain her by pulling her hair. Libby also went on to explain that Peter would not allow her access to money. Following the disclosure and the concerns for Alex, SCSC convened an initial Child Protection meeting[65].

6.2.2 In **April 2015**, Libby admitted herself to hospital with acute withdrawal symptom of an herbal supplement having been locked away in her room by Peter. Libby was referred to Somerset Drug and Alcohol Services (SDAS), who assessed Libby and Libby was then provided with prescribing clinic. SDAS made a referral to Somerset Adult Social Care (SASC) as they had concerns for Libby's welfare

Later in **April 2015**, Libby met with her GP and discussed her drug use and her pregnancy. Following the consultation, the GP was concerned and wrote to social services expressing their concerns for Libby and the unborn child. There was no record of the letter on Libby's file. In **May 2015**, the GP made a referral to a mother and baby unit at the local hospital stating his concerns for the welfare of Libby and her unborn child.

Late **May 2015**, Libby had a face-to-face meeting with SDAS and she stated that she felt very isolated , she had no money and that her family relationship had broken down and that she was considering going back to Peter SDAS explained the risks of Libby going back to Peter.

Late **May 2015**, Libby was assigned a SASC social worker but following an assessment it was deemed that Libby had no ongoing care and support needs but that she would need to continue with support from SDAS , the midwife, SCSC and then SASC closed Libby's case.

6.3 KPE Two: Birth of Alex

6.3.1 **July 2015**, Alex was born with drug dependency. A multi-agency discharge meeting took place with Libby, family and practitioners to establish a clear plan of care and support for Libby and Alex. Alex was made a subject of a Child Protection Plan[66]. SCSC referred Libby to Somerset Integrated Domestic Abuse Services (SIDAS) and a Domestic Abuse Coordinator(DAS) was allocated to Libby in June 2015.

6.3.2 Late **July 2015**, A missing person search was instigated due to concerns for Libby and Alex following an anonymous referral that Libby had been involved in a car accident and was intoxicated. Following a strategy meeting between SCSC and the police it was agreed to take Alex in to foster care.

[65] Child Protection meeting -A meeting to consider if a child needs a Child Protection Plan
[66]

6.3.3 During **August and September 2015**, Libby engaged with SIDAS and participated in parts of overcoming domestic abuse programme and Libby's GP referred her to the local mental health team for support.

6.4 KPE Three: Removal of Alex and Sam from Libby's care.

6.4.1 **Mid-September 2015**, Alex was placed with Libby's mother and father and Sam remained in Gerry's care with support from Libby's parents. Libby's mental health continued to be an issue and she was supported by her GP and she continued with SDAS. The care proceedings for both children concluded in March 2016.

6.5 KPE Four : Libby's relapse into taking drugs and increased mental health issues.

6.5.1 **May 2016**, Libby had moved into Gerry's house as he was away in the week and she moved back to her parents at the weekend. Gerry contacted SCSC to say that Libby had relapsed into taking drugs again. Libby to meet with SDAS and she explained how stressed she was with her living arrangements and the pressures that everyone placed on her.

6.5.2 Libby visited he GP in **October 2016**, and stated that she was lacking motivation, felt pressure from everyone around her and was unhappy with her appearance. The GP referred Libby to self-therapy and reviewed her antidepressants.

6.5.3 In **December 2016**, Libby told SCSC social workers that she had relapsed into taking drugs as she felt pressured by everyone around her. SCSC contacted SDAS to ensure that Libby was supported.

6.6 KPE Five : Increased concerns for Libby's mental health and substance misuse and alleged involvement in County Lines.

6.6.1 **March 2017**, Libby's mother phone the police as she was concerned that Libby had taken Alex and that she had gone to use drugs and was putting Alex at risk. SCSC were informed and the police located Libby and Alex and both were fine. Libby was angry with the police and stated she was not missing. Later in March 2017, Libby's parents contacted SCSC as they were concerned for Libby's health as they believed she was using drugs again and not able to care for the children if they were in her care. Libby attended SDAS and was very tearful and she disclosed she had relapsed due to not having much contact with the children.

6.7 Key Practice Episode Six - Libby arrested and sentenced to a Community Order and safeguarding concerns for Libby.

6.7.1 **May 2017**, a multi-agency meeting took place and police intelligence was shared that Libby was dependent on drugs and that she was being cuckooed.

6.7.2 **July 2017**, Libby was arrested for shop lifting and failure to provide a specimen following a car accident. Libby was given a Community Order, disqualified from driving and was required to attend a drug rehabilitation programme.

6.7.3 Late **August 2017**, the police called SASC as they were concerned for Libby's wellbeing. It was reported that Libby was sofa surfing and that she had met someone who were giving her money for sex. SASC carried out a safeguarding triage and as Libby had capacity and there were no care and support needs, the case was closed.

6.7.4 Late **August 2017**, Libby attended the Somerset Foundation NHS Trust (SomFT) local hospital Accident and Emergency department with an abscess in her groin from intravenous drug use. Libby was admitted to a ward for treatment but Libby discharged herself. Libby was admitted into hospital again in October 2017 for four days.

6.8 KPE Seven- Libby identified as being part of an incident of cuckooing

6.8.1 **November 2017**, the police recorded that Libby was identified as a main instigator of cuckooing of a vulnerable adult although this was disputed by Libby's family as they were providing funds to Libby to pay her rent. The police believed that an Organised Crime Group (OCG) was also involved. The police managed to remove the OCG from the vulnerable adult's home.

6.8.2 **Late November**, Libby appeared before a magistrate due to a breach of her warrant order and was given a fine. Libby met with her Offender Manager (OM) (Probation) in December 2017 and she disclosed that she was using substantial amounts of heroin daily and she was shop lifting and being paid for sex to fund her habit. Libby did say she was fed up with her life and wanted to give up drugs. Libby reengaged with SDAS and Libby was readmitted to hospital in December 2017, due to further abscessed on her groin .

6.8.3 In **January 2018**, Libby was staying with friends but contacted the local Council housing department to seek support for finding accommodation. Libby was being supported by The Nelson Trust (TNT), an organisation that advocates for women with complex needs and are involved with the criminal justice process.

6.9 KPE Eight-Homelessness and Libby being paid for sex.

6.9.1 **March 2018**, Somerset Wide Integrated Sexual Health Service (SWISH) raised concerns with the SomFT Mental Health Safeguarding Service following contact with Libby. They were concerned that Libby was being paid for sex in order to buy drugs. They were also concerned that Libby was sofa surfing. Contact was made with SIDAS and SDAS and SIDAS tried to find accommodation for Libby. Libby was offered a place but it was some miles away and Libby was told to make direct contact. Despite trying to find Libby accommodation , nothing was local and Libby remained sofa surfing.

6.9.2 **May 2018**, Libby's OM started to prepare a Breach report as Libby had had poor attendance with her OM with a plan to resentence her.

6.9.3 During the remainder of **2018** Libby remained in contact with SDAS, she remained homeless and spent further time in hospital in **December 2018** due to a further abscess relating to intravenous drug use.

6.10 KPE Nine -Libby's increased involvement with County Lines and cuckooing.

6.10.1 **February 2019**, the police identified Libby as being in a property which was identified as being part of a County Lines OCG. A Community Impact Assessment[67] was completed with the local authority which resulted in increased patrols within the area.

6.10.2 Again in **February 2019**, Libby's father contacted the police as Libby had arrived at their home and she was intoxicated and had punched her father. Libby's father told the police he did not want to pursue any prosecution but the police referred Sam and Alex to SCSC , Education and Health.

6.10.3 In late **February 2019**, Libby was admitted again to SomFT acute hospital due to pains in her groin following injecting of substances. Libby would go missing from the ward but it would appear that she would be going to her parent's home as it was half term and the children were with her parents. Libby discharge herself against medical advice but SomFT Safeguarding Service did refer Libby to SDAS. Libby did engage with SDAS who continued to provide support to Libby to try to manage her substance misuse.

6.10.4 Late **February 2019**, Libby moved into a home near her parents which was owned by them.

6.11 KPE Ten- Libby being cuckooed and in fear of County Line Organized Crime Groups.

6.11.1 **August 2019**, Libby phoned the police to say that she was being controlled by OCG's. Libby went on to explain that she had received threatening text messages from a London gang and some had stayed for a few days but that she had managed to remove the men from her home. Libby also stated that she did not want face to face contact with the police or any further contact. Later in August , the police were called to Libby's home as there had been an altercation between some males in the property and although Libby was not present, the police did carry out safeguarding checks and a Treat as Urgent[68] was placed on the property.

6.11.2 **September 2019**, Libby contacted the police again and told them that OCGs were coming into her property and that she was frightened. The police commenced a Problem-Solving Plan, which included offering safety advice to Libby and targeted

[67] A community impact assessment allows the community to say how crime has affected it. It can be used in criminal trials,

[68] Treat as Urgent is a marker that the police place on a property which means they should attend as a matter of urgency.

patrols of the area. Libby was also discussed regularly at the One Team meeting to review her situation[69].

6.11.3 In **October 19** through to **December 2019**, Libby continued to engage with SDAS and mental health support.

6.11.4 **January to August 2020**, Libby disclosed to SDAS and SomFT mental health services that she was low, she was using more drugs but really wanted to reduce her intake but was struggling.

6.11.5 **December 2020**, Libby reported to the police that she felt harassed and intimidated by a male but that she did not want to make a formal complaint. The police did interview the male and the male did have drugs on him and possessed a knife. The male was arrested.

6.12 KPE Eleven- Known relationship between Libby and Benus and first contact relating to domestic abuse in the relationship.

6.12. 1 **May 2021**, Libby called the police to say that her partner, Benas had punched her several times and tried to strangle her. The police attended Libby's home and she and a friend were found hiding in the bathroom. Libby and her friend had been drinking so a decision was made not to interview Libby until they had "sobered up". The police did look for Benas but he was not found and the police did consider an evidence led prosecution but they felt that it would go against Libby's wishes as she felt unable to prosecute.

6.12.2 **September 2021**, neighbour of Libby's reported to the police that men were accessing Libby's home and when Libby was spoken to, she did say she was frightened of a male and wanted him to leave but that she did not want to make a formal complaint. The police gave Libby safety advice.

6.13 KPE Twelve -Escalation of Domestic Abuse by Benas

6.13.1 **October 2021**, Libby contacted the police to say she was experiencing domestic abuse. When the police arrived , Libby said that Benas had put a pillow over her face and had punched her. The police recorded that Libby was scrying and in a high level of stress. Libby made it clear that she did not want Benas charged and that she could not pursue a complaint. Libby stated that Benas had contact with the "Eastern European Mafia". Benas was arrested and taken into custody but Libby was clear she did not want to pursue a conviction as she was scared of reprisals.

6.13.2 **Late October 2021**, Libby reported a further assault by "someone" and the case was assessed by the police and safety advice was provided to Libby. Later, Libby phone the police again saying that people were coming to get her. The police attended the property where Libby had phoned from , (not her own), but Libby would not say who

[69] One Team is a local multi-disciplinary team consisting of relevant agencies and chair by the District Council

was out to get her. Libby said she wanted to stay at the house that she was located in. The police carried out checks and gave Libby safety advice.

6.14 KPE Thirteen- Death of Libby

November 2021, Libby was found at her home with large lacerations to her neck. The police commenced a criminal investigation and following multiple arrests, Benas admitted murder and was sentenced to fourteen years and ten months

7. KEY ISSUES /CONCLUSION ARISING FROM THE REVIEW.

7.1 Libby was a vulnerable adult who had experienced substance misuse for many years, domestic abuse by multiple partners, OCG, homelessness, exploitation in many forms, loss of care of her children, mental and physical health issues. There is evidence to suggest that professionals sometimes viewed the choices that Libby made were her "lifestyle choices" and the fact she had mental capacity this could have limited what support was available to her.

7.2 Libby appeared to feel very isolated as she felt pressure from her family and professionals did not seem to fully understand that some of Libby's decisions were being made from fear for her life. A trauma informed response may have challenged professionals and the family perspective. Trauma informed approach by professionals is often identified within DHRs and although training is important, a trauma informed way of working should be embedded into everyday practice with agencies. This is not just a local issue it is a national issue and at a national level, agencies should ensure that professionals have training that includes what is trauma, what is a trauma informed response and how to work in a trauma informed way.

7.3 Although there was some good practice in supporting Libby, there were some examples of unconscious bias for example Libby prioritising drugs over feeding herself and not being sober enough to give a statement.

7.4 Although there was one multi agency meeting, "One Team" in 2021 there was no MARAC or other multi agency forum to identify Libby's support needs and SCSC stated that information from the One Team was not shared with them. Agencies dealt with their element of support for Libby without a full understanding of what Libby was experiencing and therefore there was not the opportunity to provide a coordinated approach to best support Libby. The Covid Pandemic 2020/2021 had an impact on agencies ability to work collaboratively during this unprecedented time and nationally the government has recognised there have been lessons learnt and agencies need to reflect on the lessons learnt for any future unprecedented events.

7.5 If a multi-agency approach had been implemented for example "What to do if it's not Safeguarding" now MARM or a MARAC , then a more planned holistic programme of support may have helped Libby. Several IMR authors and the DHR Panel identified a lack of professional curiosity by professionals when supporting Libby and if a more comprehensive picture of Libby's life could have been established, a more holistic range of support could have been offered to Libby.

7.6 Libby predicted her death at the hands of Benas, and she must have lived in fear for many months in 2021 and this was confirmed by friends. Friends said that "Benas took away Libby's confidence and she became quite withdrawn." Despite this, there are videos of Libby being vibrant and full of life in the last few months of her life. Libby loved her children, did try to resolve her drug and alcohol issues and wanted to improve her life.

8. LESSONS LEARNT

The death of Libby identified lessons to be learnt by agencies and the wider community. The DHR Panel accept that this review has the benefit of hindsight and a comprehensive insight into the contact that Libby and Benas had with various agencies.

8.1 Professional Curiosity and understanding the need to know the victim better.

8.1.1 This review identifies that Libby was experiencing many issues in her life which made her vulnerable and open to being exploited by others including organised crime. Libby was suffering from physical and mental health issues; the misuse of drugs; sexual exploitation; domestic abuse, loss of the care of her children, periods of homelessness all of which made Libby vulnerable. Libby was also spending much of her life living in fear.

8.1.2 The IMRs identified that if professionals had been more curious about Libby's life, then agencies would have had a better understanding of her needs and the risk she was encountering. For example, if workers in SDAS, who had a long association with Libby, had been more curious about Libby relationship status then this would have allowed risks to have been explored and support to be offered Libby. The probation service also identified that a lack of professional curiosity about the relationship between Libby and Benas may have been a missed opportunity to understand the risks posed to Libby.

8.1.3 Professional curiosity (or lack of it) is a theme running through many published Domestic Homicide Reviews. Professional curiosity is the capacity and communication

skills to explore and understand what is happening to someone rather than making assumptions.

8.1.4 What is important is that professionals are who are engaging with a person who has multiple vulnerabilities such as Libby are provided with the tools to increase their skill to be professionally curious. It will be important that a professional understand the barriers that someone like Libby was facing and the intersectionality of all the issues. It is also important that agencies ensure that professional curiosity is embedded in professional practice through supervision, reflection and leaning from reviews will help professionals/ practitioners enhance their awareness.

8.1.5 At a national level, the *Annual Review of Local Child Safeguarding Practice Reviews and Rapid Reviews 2021(LCSPR)*[70] highlights that many reviews are critical of practitioners for not being professionally curious. Although professional curiosity is extensively used in Child Practice Reviews, the same could be said of DHRs and SARs. The *LCSPR* states that the challenge for front line practitioners is to develop authentic relationships with children and families to effect positive change. It was also highlighted that at times, practitioners were not suitably curious or challenging. When professionals are supporting victims of abuse or adults who may need support, there is often a need for a "second question." The report goes on to describe organisations need a culture of openness to allow practitioners to ask for support when needed and that practitioners must feel safe to admit their concerns about a family, a child or in this case an adult, or it could be a victim of domestic abuse, knowing that these will be taken seriously and acted upon.

8.2 Professionals need to understand Unconscious Bias/Conditional Bias and how this can impact on support for a vulnerable adult

8.2.1 Everyone has their own unconscious bias. Even for people who are open minded and only observe the facts before concluding, it is likely that some bias will shape their opinion. Professionals can exhibit unconscious bias which means that they look for evidence to support their pre- held views and this can lead to poor decision making.[71]

8.2.2 This report has identified that some professionals may have exhibited some unconscious bias when supporting Libby and may have viewed Libby's lifestyle of substance misuse, involvement with OCG, working as a sex worker as a "lifestyle choice" instead of trying to understand the trauma and fear in Libby's life. Libby may have been fearful for her life, and this may have impaired her ability to speak clearly.

[70] Annual Review of LCSPRs and Rapid reviews- The Child Safeguarding Practice Review Panel March 2021 www.assets.publishing.service.gov.uk

[71] The University of Edinburgh , Equality, Diversity and Inclusion -Unconscious bias- www.ed.ac.uk

Research has identified that people should challenge their un-conscious bias regarding people "choosing to live or like a self-neglecting lifestyle."[72]

8.2.3 It is important that professionals understand their own unconscious bias and that decisions should be made based on fact, challenge and open discussion. Agencies should also challenge the language used by professionals to ensure it is appropriate.

8.3 Professionals to understand the need for a multi-agency approach in supporting vulnerable adults.

8.3.1 Libby was involved with several agencies over many years including drug and alcohol services, health services, domestic abuse services, SCSC and the police. Although the police referred Libby to the LSU unit on several occasions around safeguarding concerns about Libby being cuckooed, the LSU deemed that a referral would not reach the threshold for an assessment by SASC and therefore no referral was made.

8.3.2 It is also not clear why agencies did not refer Libby to a MARAC following the incident in May 2021 but if a referral was made then this may have enabled a comprehensive review of what Libby was experiencing and comprehensive safety planning and support could have been considered for Libby. In the last two years, Safelives, on behalf of the SSP, have carried out a comprehensive review of the MARAC in Somerset and policy and procedures have been updated. It will be important that the SSP continually review and audit the MARAC process to ensure it is supporting victims of domestic abuse.

8.3.3 The review of "What to do if it's not Safeguarding" now rebranded as MARM provides a further opportunity for a multi-agency approach for a vulnerable person when there is an inherent risk associated with their lives. It will be important that professionals in all agencies understand and utilise the guidance to enable a multi-agency approach and support for a victim of domestic abuse who may not have eligible care and support needs.

8.3.4 All agencies within Somerset should have knowledge of the guidance and ensure that professionals within their organisation understand that they have a tool which can be used to support a vulnerable adult with multiple needs.

8.4 Better understanding by professionals about assessment of need under the Care Act 2014

[72] www.royalsociety.org Unconscious Bias

8.4.1 Section 9 Care Act 2014[73] places a duty on a local authority, where it appears to the local authority that an adult may have needs for care and support, to assess what those needs are. Libby was referred to SASC in 2015, 2017 and 2019. Based on the information provided a decision was made that there was no role for SASC to support Libby. The IMR author noted that decisions may have been marginal and as the SASC record keeping was poor on several occasions it was not possible to confirm whether an assessment should have been carried out.

8.4.2 No further referrals were made to SASC during 2020 and 2021 by agencies despite Libby's contact with the police, SDAS, mental health services, GP's, and housing. Information provided by the IMR's highlights Libby continued substance misuse, sexual exploitation, cuckooing, domestic abuse, and periods of homelessness which could have led to a safeguarding referral and an enquiry under section 42 of the Care Act 2014.

8.4.3 SASC can only make decisions on the information they are provided within the referral and the DHR Panel have requested that the police and SASC review what information is essential to make appropriate decisions but being mindful of resources 8ithin the police.

7.5 Better Understanding by Professionals of the duty to refer homelessness cases to housing authorities and the impact of the Domestic Abuse Act 2021 on housing support for victims of domestic abuse.

8.5.1 Housing is a key issue for victims of domestic abuse and although victims have more support available following the implementation of the Domestic Abuse Act 2021 there is still much work to be done to ensure all professionals, not just housing professionals understand the impact of different housing legislation and what is required to ensure better support for victims of domestic abuse.

8.5.2 Abraham Maslow's hierarchy of needs[74] identifies that shelter is one of the fundamental needs of humans along with food, water, warmth and for a victim of domestic abuse it is essential as it can provide security and safety.

8.5.3 It is important that there is training for professionals in the police, health, social care and relevant third sector providers on housing legislation and how it can be used to better support victims of domestic abuse.

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[73] Care Act 2014 www.legislation.gov.uk

[74] www.simplypyschology.org Jan 2024 Maslow's Hierarchy of needs paper 1943 "A theory of human motivation"

8.5.4 It is also important that a wider awareness campaign for the community about what housing support is available for victims of domestic abuse should take place to better support victims of domestic abuse and their families.

8.6 Agencies and Professionals to understand why victims/vulnerable adults do not attend.

8.6.1 Many of the agencies within this review highlighted that Libby did not attend appointments or make contact with them. Libby was referred to TNT and although they contacted Libby she did not respond and therefore the referral ceased. SIDAS and SomFT highlighted the same difficulties in supporting Libby.

8.6.2 As described, Libby was experiencing multiple disadvantage which impacted on her ability to engage. Agencies and professionals need to challenge their mindset and be asking why is it that the person is not engaging e.g., have they lost a phone, have they moved or are they in crisis. The DHR Panel do understand that agencies are impacted by limited resources, but it may be beneficial that agencies review their "Did not attend policy" to ensure that they work in partnership with other agencies especially in cases where someone is known to have multiple complex issues.

8.7 Lack of enforcement of sentencing requirements

8.7.1 During 2017 and 2018, Libby was not attending her meetings with her OM, and this was not being followed up by the OM. Libby was required to participate in a drug rehabilitation programme but there was no action taken when Libby did not attend the programme. The lack of follow up as to why Libby was not engaging with her sentencing requirements meant that Libby did not get the support which may have helped her substance misuse and allowed professionals within the Probation service a better understanding of the issues that Libby was facing and therefore the ability to offer appropriate support to help rehabilitate Libby.

8.8 Retention of Information

8.8.1 It has been difficult to build a full picture of the impact on Libby's life from her housing situation due to the lack of information available to this review. We know that Libby was involved with at least two local authority housing departments, but it is not known what support/advice Libby received as when records were migrated to a new IT system, the historical records, of which Libby was one, were not kept.

8.8.2 We know from information that Libby was homeless, sofa surfing, sleeping on the streets, in a hostel and Libby's housing situation would have impacted on her

vulnerabilities such as her mental health, physical health, her substance misuse and increased risks in her life.

8.8.3 Housing is an important issue for victims of domestic abuse, and this is highlighted by the inclusion of new housing legalisation in the Domestic Abuse Act 2021. The information about the support provided by local authority housing department to a domestic abuse victim will also be important so housing department can review how they are responding to new legislation but also to learn from historical cases as to how better housing support can be provided to victims of domestic abuse. In order to ensure the retention of important information then a recommendation relating to retention of data by housing departments is included in section eight.

8.9 Safeguarding of Children and domestic abuse

8.9.1 The chronology highlights that the last involvement of SCSC with Libby, her family and child was in 2017 and the police have stated that they never had reason to believe that any of Libby's children were present in the household when they were responding to incidents. Libby's family have stated that the children did visit Libby, especially during school holidays, after school, and Benas spoke of the children visiting the house and he would take the children to the park . Agencies do need to have an understanding of family dynamics as children may be impacted directly or indirectly by domestic abuse. Children Social Care, Adult Social Care and NHS England promote a Think Family approach which means looking at a family as a system, working to a family's strength and mitigating risks by providing support[75].

8.9.2 The Domestic Abuse Act 2021 automatically categorises children affected by domestic abuse as victims regardless of whether they were present during violent incidents. Somerset Council on behalf of the SSP have developed an online learning Foundation Programme on Domestic Abuse and a couple of the modules consider the impact on children living with domestic abuse. The DHR Panel recommend that SSP review the content of the modules relating to children to include any learning from this review. Also, if family members who may be formal or informal kinship carers have concerns around the risks relating to domestic abuse and birth parents, they need to know the channels to highlight their concerns.

8.10 Escalation of Risk

8.10.1 Although the relationship between Libby and Benas only became known to the police in May 2021 following the first report of a domestic abuse incident, there was

[75] Socialworkwithadaults.blog.gov.uk Think Family -think solutions that benefit everyone.

an escalation of incidents in October/early November 2021(27/30 October and 5 November). Libby was experiencing an escalation of abuse by Benas. The Homicide Timeline[76] is based on proven research by Professor Jane Monckton Smith that identifies eight stages leading up to a perpetrator committing a homicide. Libby was experiencing an escalation of abuse ; friends had stated that she was going to break up the relationship with Benas which may have changed his thinking to revenge. All professionals dealing with domestic abuse should have an understanding of the homicide timeline as it will help support risk assessments and safety planning for the victim.

8. 11 Post Review Learning

8.11.1 In conversation with Libby's family who are the parental guardians of Alex, it is acknowledged that they have a young child to raise but are keen to know how best to support them about remembering Libby and what to tell them about what happened. It should also be highlighted that Benas could be released from prison at a time when the children become young adults.

8.11.2 Libby's mother and father want to ensure that Alex is supported through the process of understanding what Libby experienced and how she died. It would be beneficial to have some national support / guidance on how parents/grandparents/carers can best navigate children through this process.

The family have received support from a Child Bereavement Therapist funded by Victim Support Homicide Service and support will be lifelong from Victim Support. Support to the family and the children will also be available from Victim Support as and when parole is applied for by Benas. Libby's family are also aware of the Kinship Carers Forum.

9. DHR RECOMMENDATIONS

Local

7. That the Safer Somerset Partnership seek assurance from agencies involved in this review that

a) develop practitioners' professional curiosity skills (drug and alcohol services, mental health, specialist domestic abuse services and housing) and

b) Improving knowledge in case supervision for line managers covered in training and encouraged through supervision and other means available.

Ownership – Safer Somerset Partnership and agencies involved in this DHR

[76] www.dvact.org Homicide Timeline 2020

8. a) Somerset Safeguarding Adults Board to relaunch the guidance "What to do if it is not safeguarding" and to seek assurance that professionals within partner agencies have knowledge of and understand how to implement the guidance. *(Completed and now rebranded as Mult Agency Risk Management, MARM February 2024)*

b) SSAB to review the MARM in February 2025

Ownership – Somerset Safeguarding Adults Board

9. That all agencies who contributed to this DHR, review their "Did Not attend" Policy (or equivalent) to ensure that they work in partnership with other agencies especially in cases where someone is known to have multiple complex needs and also may be experiencing a barrier to engagement due to their location e.g. rural v town – particularly to include reference to dynamics of domestic abuse and impact that has on engagement for a survivor.

Ownership – Agencies involved in this DHR

10. Using this DHR as a case study, agencies involved in this review include guidance/training for professionals on the following subject matter;

unconscious bias relating to substance misuse/victim blaming and to ensure that this includes guidance to support managers to be able to challenge and support professional through supervision.

Ownership – All agencies involved in this DHR

11. Somerset Council (Housing) to ensure that all agencies who have a duty to refer if a service user who may be homeless or threatened with homelessness understand their duty and are provided with guidance on the required process to make a referral.

Ownership – Somerset Council (Housing)

12. Somerset Council (Housing) to ensure that when a new Information Technology system is introduced that within the procurement process there is a requirement that data relating to individuals is retained for seven years and that access can be made by the housing service to seek historic information on a client if required.

Ownership -Somerset Council-Housing

7. Somerset Council Community Safety Team to develop guidance (7-minute briefing) for agencies on appropriate language when describing a victim of domestic abuse or sexual exploitation and agencies to ensure that professionals across the Safer Somerset Partnership agencies are provided with the guidance.

Ownership – Somerset Council Community Safety Team

8. Somerset Council Community Safety Team to ensure that the impact of economic abuse is included within its training modules and to ensure that cuckooing and organised crime are included as being relevant to domestic abuse .

Ownership – Somerset Council Community Safety Team

9. SSP to continue to review and audit the updated MARAC procedures in Somerset, to ensure that MARAC referrals are discussed at a MARAC and decisions are recorded.

Ownership – Safer Somerset Partnership

10*.* Somerset Council Community Safety Team to ensure that within its training module that children are included as being relevant to domestic abuse.

Update- this recommendation has been implemented.

Ownership – Somerset Council Community Safety Team

National

11. Safer Somerset Partnership to request that the Home Office in partnership with other government departments identify how agencies can embed trauma informed practices within their professional practice. This to include social workers, health practitioners, police and probation.

Ownership -Safer Somerset Partnership

9.2 Agency recommendations

9.2.1 Avon and Somerset Constabulary(The Police)

3. Head of Victim Care, Safeguarding & Vulnerability to continue activity with relevant colleagues across the force to support understanding of the complexity of vulnerability and multiple disadvantages, particularly in relation to victims who may present as suspects of crime.
4. LSU to bolster their directory of support services and referral pathways for all victims- Completed January 2023

9.2.2 Somerset Adult Social Care

1. To ensure ASC staff consider the impacts of substance misuse when undertaking Care Act Assessments and how this may impact on an individual's care and support needs, and decision making.
2. SCC Adult Safeguarding Staff are supported to understand research and practice guidance for working with people who have addictions which will support their decision making.

9.2.3 Somerset Clinical Commissioning Group now NHS Somerset Integrated Care Board from July 2022

3. When a person has made a disclosure of domestic abuse, even if well known, practitioners could use the opportunity to explore further and complete a DASH form/signpost to SIDAS.

4. If a person has contact with a GP service about their mental wellbeing, substance and/or alcohol misuse and/or pain that does not appear to have a clear medical cause, that GP practices should include a clinical enquiry about Domestic Abuse in the consultation.

9.2.4 Probation

9. The New Probation Office Service performance measures states that all Initial Sentence Plans need to be completed within 15 working days of a Person on Probation's initial appointment. This is being implemented by the new probation service and is monitored and Probation Service locally are reaching their targets now.
10. Enforcement policy needs to be adhered to, for all failed appointments a formal warning should be issued providing the Person on Probation an opportunity to provide evidence for their failure to attend. This is being monitored by the new probation service and incremental improvements are being achieved.
11. Home visits to be completed on a regular basis given the chaotic nature of Libby's lifestyle a home visit should have been completed. Home visits provide a valuable window into the person on probations circumstances and lifestyle. By seeing someone in their own environment, it enables staff to verify their self-report of their circumstances including who they are living with, identifying any issues with the property or the local area and understanding the impact of the person on probation's role in their family, household and community. This can aid a comprehensive assessment of risk, needs and safeguarding concerns in relation to children, vulnerable adults, and partners in cases of domestic abuse. The New Probation Service has the following home visit schedule which must be adhered to following the commencement of supervision. Within 10 working days for any person on probation subject to National Security Division oversight. Within 15 days of the start of supervision for individuals who are a high risk of serious harm. Within 15 working days to all Registered Sex Offenders – regardless of level of risk, within 15 working days for all individuals convicted of/or identified as having been involved in Child Sexual Exploitation, within 6 weeks of the start of supervision for individuals who are a medium risk of serious harm, within 12 weeks of the start of supervision for individuals who are a low risk of serious harm. Whenever Libby moved a home visit should have been completed. This is now being implemented in the new probation service – the above are the new expectations for the future;
12. All Police intelligence reports to be followed up and outcome recorded on the system.
13. Referral should have been made to CYPS, the OM only accepted the word of Libby for what was going on with regards to her two children, liaison should have been made with CYPS and clearly recorded. NEW SAFEGUARDING POLICY IN PLACE NATIONALLY which is being followed

14. There were numerous gaps in recording within Libby's NDELIUS records, records need to be updated as and when the incident occur – This is being monitored by the new probation service in relation to recording of outcomes for appointments.
15. Probation Service are currently considering nationally a resource for Domestic Abuse checks and providing more resources for this service in conjunction with the Police. This will be by the provision of additional administrative staff, related to police provision for this specific task. Recommendation to be updated and finalised when the full details of this National Response are available.
16. Regular Police checks to be made on the addresses of Service Users to establish is any issues. It is worth noting that the Probation Service now receives regular arrest and Domestic Violence information concerning Service users, in 2017/2018 this procedure was not in place.

9.2.5 Somerset Drug and Alcohol Service

4. Further training to staff around identifying, escalating, managing safeguarding concerns/risks, and sharing safeguarding concerns with relevant external agencies
5. Training to staff around professional curiosity/investigative mindset
6. Staff refresher around domestic abuse processes inc. managing disclosures, DASH, safeguarding referrals

9.2.6 Somerset Public Health Service

3. Public Health Nursing adopt the Health Visitor centralised triaging and duty system to improve adherence to the Pre-birth SOP.
4. Children Social Care to notify other agencies/service when someone/family of concern moves into the area.

9.2.7 DHR Panel recommendation for Somerset Integrated Domestic Abuse Service and Somerset Drug and Alcohol Service.

1 SIDAS and SDAS to review how they work collaboratively and if improvements can be made to better support victims of domestic abuse.

TERMS OF REFERENCE FOR REVIEW PANEL

DHR 044 - Version Three

1. Introduction

1.1 The chair of the Safer Somerset Partnership has commissioned this DHR in response to the death of Libby. The death is believed to be murder, with the person causing harm being her partner.

1.2 All other responsibility relating to the review commissioners (Safer Somerset Partnership) namely any changes to these Terms of Reference and the preparation, agreement, and implementation of an Action Plan to take forward the local recommendations in the overview report will be the collective responsibility of the Partnership.

2. Aims of the Domestic Homicide Review Process

2.1 Establish the facts that led to the death on 7th November 2021 and whether there are any lessons to be learned from the case about the way in which local professionals and agencies worked together to safeguard the family.

2.2 Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result.

2.3 To produce a report which:

- summarises concisely the relevant chronology of events including:
  - the actions of all the involved agencies;
  - the observations (and any actions) of relatives, friends and workplace colleagues relevant to the review
  - analyses and comments on the appropriateness of actions taken;
  - makes recommendations which, if implemented, will better safeguard people experiencing domestic abuse, irrespective of the nature of the domestic abuse they've experienced.

2.4 Apply these lessons to service responses including changes to policies, procedures, and awareness-raising as appropriate.

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

- Apply these lessons to service responses including changes to policies and procedures as appropriate.
- Prevent domestic violence and abuse homicide and improve service responses for all domestic violence and abuse victims and their children through improved intra and inter-agency working.
- Establish the facts that led to the incident and whether there are any lessons to be learned from the case about the way in which local professionals and agencies worked together to support or manage the person who caused harm.

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

3. Scope of the review

The review will:

- Consider the period from 01.01.2015 to 07.11.2021, subject to any significant information emerging that prompts a review of any earlier or subsequent incidents or events that are relevant. (This date range has been chosen because of Adult Social Care and SIDAS both receiving information about domestic abuse during 2015, and the birth of Libby's second child)
- Request Individual Management Reviews by each of the agencies defined in Section 9 of the Domestic Violence Crime and Victims Act (2004) and invite responses from any other relevant agencies or individuals identified through the process of the review.
- Seek the involvement of the family, employers, neighbours & friends to provide a robust analysis of the events. Taking account of the coroners' inquest in terms of timing and contact with the family.
- Aim to produce a report within 6 months of the DHR being commissioned which summarises the chronology of the events, including the actions of involved agencies, analysis and comments on the actions taken and makes any required recommendations regarding safeguarding of families and children where domestic abuse is a feature.
- Consider how (and if knowledge of) all forms of domestic abuse (including the non-physical types) are understood by the local community at large – including family, friends and statutory and voluntary organisations. This is to also ensure that the dynamics of coercive control are also fully explored.
- To discover if all relevant civil or criminal interventions were considered and/or used.
- Determine if there were any barriers Libby or her family/friends faced in both reporting domestic abuse and accessing services. This should also be explored:
    - Against the Equality Act 2010's protected characteristics.

- Examine the events leading up to the incident, including a chronology of the events in question.

- Review the interventions, care and treatment and or support provided. Consider whether the work undertaken by services in this case was consistent with each organisation's professional standards and domestic abuse policy, procedures and protocols including Safeguarding Adults and Safeguarding Children.

- Review the communication between agencies, services, friends and family including the transfer of relevant information to inform risk assessment and management and the care and service delivery of all the agencies involved.

- Identify any care or service delivery issues, alongside factors that might have contributed to the incident.

- Examine how organisations adhered to their own local policies and procedures and ensure adherence to national good practice.

- Review documentation and recording of key information, including assessments, risk assessments, care plans and management plans.

- Examine whether agencies considered and understood all Libby's vulnerabilities including substance misuse, potential exploitation/sexual coercion, the intersecting of those vulnerabilities and their impact on her accessing support, and what support was provided (or not) to Libby.

- Are agencies sufficiently understanding of unconditional bias, and the impact of such bias on providing the support to Libby?

- Examine whether services and agencies ensured the welfare of any adults at risk, whether services took account of the wishes and views of members of the family in decision making and how this was done and if criteria for intervention were appropriately set and correctly applied in this case.

- Whether practices by all agencies were sensitive to the gender, age, disability, ethnic, cultural, linguistic and religious identity of both the individuals who are subjects of the review and whether any additional needs on the part of either were explored, shared appropriately and recorded.

- To acknowledge the ethnicity of the perpetrator and whether this impacted on any help he might or should have received including availability of services/recourse to public funds?

- Whether organisations were subject to organisational change and if so, did it have any impact over the period covered by the DHR. Had it been communicated well enough

between partners and whether that impacted in any way on partnership agencies' ability to respond effectively (including the Covid pandemic).

4 Role of the Independent Chair (see also separate Somerset DHR Chair Role document)

- Convene and chair a review panel meeting at the outset.
- Liaise with the family/friends of the deceased or appoint an appropriate representative to do so. (Consider Home Office leaflet for family members, plus statutory guidance (section 6))
- Determine brief of, co-ordinate and request IMR's.
- Review IMR's – ensuring that incorporate suggested outline from the statutory Home Office guidance (where possible).
- Convene and chair a review panel meeting to review IMR responses
- Write report (including action plan) or appoint an independent overview report author and agree contents with the Review Panel
- Present report to the CSP (if required by the SSP Chair)

6 Domestic Homicide Review Panel

6.1 Membership of the panel will comprise:

Agency	Representative
Independent Chair	Liz Cooper
Adult Social Care	Louise White
Avon and Somerset Police	T/DI Su Parker
Integrated Care Board	Emma Read
Children's Social Care	Kelly Brewer
Probation	Via Liz Spencer
Safer Somerset Partnership (SCC Public Health)	Suzanne Harris
Somerset Drug and Alcohol Service	Jane Harvey-Hill
Somerset Integrated Domestic Abuse Service (The You Trust – 2020 +)	Tonia Redver
Somerset Integrated Domestic Abuse Service (Livewest Housing – 2015 to 2020)	Mel Thomson

Somerset NHS Foundation Trust	Heather Sparks/Vikki Hanna

This will be confirmed at the first Review Panel meeting in October 2022

6.2 Each Review Panel member to have completed the DHR e-learning training as available on the Home Office website before joining the panel. (online at: https://www.gov.uk/conducting-a-domestic-homicide-review-online-learning)

Appendices A: Action Plan (this is a working document and subject to changes)

ACTION PLAN

Home Office	**HO**
Safer Somerset Partnership	**SSP**
Somerset Council	**SC**
Somerset Adults Safeguarding Board	**SSAB**

	Recommendation	***Scope***	***Action***	***Lead Agency***	***Key Milestone***	***Target Date***	***Completion date/Outcome***
1	***Recommendation One*** That the Safer Somerset Partnership seeks assurance from agencies involved in this review that they are using this DHR as a case study to a) develop practitioner's professional curiosity skills (drug	Local	1. Agencies review the learning in this DHR 2. Agencies include the learning from the DHR Libby	**SSP**	DHR report shared Agencies review and include the DHR learning in training and development about professional curiosity	June 2025	

	Recommendation	Scope	Action	Lead Agency	Key Milestone	Target Date	Completion date/Outcome
	and alcohol, mental health, housing, and specialist domestic abuse service practitioners) b) Improving knowledge in case supervision for line managers ***Ownership – Safer Somerset Partnership and agencies involved in this DHR***		as a case study in practitioners training and learning. 3. Agencies feedback to the SSP that this DHR has been included in learning about professional curiosity.		Professionals embed professional curiosity in their own practice when supporting victims of domestic abuse		
2	***Recommendation Two*** Somerset Safeguarding Adults Board to a)relaunch the guidance "What to do if it is not safeguarding" and to seek assurance that professionals within partner agencies have knowledge of and understand how to implement the guidance. *(Completed and now rebranded as Multi Agency Risk Management, MARM February 2024)*	Local	1. To relaunch "What to do if it's not Safeguarding" 2. Relaunched as Multi Agency Risk Management Guidance (MARM) 3. Review use of MARM after	**SSAB**	Updated and relaunched in Feb 2024 Practitioners utilise the MARM guidance to better support vulnerable adults including domestic abuse victims.	Review Feb 2025	Complete

	Recommendation	Scope	Action	Lead Agency	Key Milestone	Target Date	Completion date/Outcome
	b)SSAB to review the MARM in February 2025 *Ownership – Somerset Safeguarding Adults Board*		one year and SSAB to update SSP on use of the model/guidance				
3.	***Recommendation Three*** That all agencies who contributed to this DHR, review their "Did Not attend"(DNA) Policy (or equivalent) to ensure that they work in partnership with other agencies especially in cases where someone is known to have multiple complex needs and also may be experiencing a barrier to engagement due to their location e.g. rural v town – particularly to include reference to dynamics of domestic abuse and impact that has on engagement for a survivor. *Ownership – Agencies involved in this DHR*	Local	1. Agencies involved in this DHR review their DNA policy or equivalent to ensure that it considers barriers that a victim of domestic abuse may be experiencing. 2. The DNA includes and escalation policy for victims who are regularly reported as victims of	**All agencies involved in the DHR**	DNA policies reviewed and updated as required. DNA policies reflect and consider the barriers that a victim of domestic abuse may be experiencing. Write letter to agencies to ask them to review DNA policy	Oct 2025	

	Recommendation	Scope	Action	Lead Agency	Key Milestone	Target Date	Completion date/Outcome
			domestic abuse. Agencies report back to the SSP to identify any changes made to the DNA and share best practice with other agencies				
4.	***Recommendation Four*** Using this DHR as a case study, agencies involved in this review include guidance/training for professionals on the follow subject matter **unconscious bias** relating to substance misuse/victim blaming and to ensure that this includes guidance to support managers to be able to challenge and support professional through supervision. *Ownership – All agencies involved in this DHR*	Local	1. SSP to produce a briefing paper on the learning relating to this DHR 2. Briefing shared with agencies involved in the DHR 3. Agencies use the learning brief within training for professionals	**All agencies involved in the DHR**	Learning brief produced Learning brief shared Learning included in domestic abuse training for professionals	Sept 2025	Complete when briefing circulated

	Recommendation	Scope	Action	Lead Agency	Key Milestone	Target Date	Completion date/Outcome
5.	***Recommendation Five*** Somerset Council (Housing) to ensure that all agencies who have a duty to refer if a service user who may be homeless or threatened with homelessness understand their duty and are provided with guidance on the required process to make a referral. *Ownership – Somerset Council (Housing)*	Local	1. Somerset Council Housing review their guidance on duty to refer. 2. Update guidance as required Include in seven-minute briefing /training on housing and domestic abuse.	**SC Housing and SC Community Safety**	Professionals understand the duty to refer Professionals understand the guidance and procedures for referral process for a person in need of housing.	Complete	Duty to refer guidance circulate to Somerset domestic abuse board on 19th June 2024

	Recommendation	Scope	Action	Lead Agency	Key Milestone	Target Date	Completion date/Outcome
6	*Recommendation Six* Somerset Council (Housing) to ensure that when a new Information Technology system is introduced that within the procurement process there is a requirement that data relating to individuals is retained for seven years and that access can be made by the housing service to seek historic information on a client if required. *Ownership -Somerset Council-Housing*	Local	1. Procurement guidance for housing systems to include the requirements of any new supplier to retain information on clients for seven years, subject to ensuring GDPR is compliant. 2. A new supplier to provide historic information as requested by housing professionals.	**SC Housing**	Future procurement for housing software retains the ability to gain information about a victim of domestic abuse.	Ongoing, when new software for housing is commissioned	
7.	*Recommendation Seven* Somerset Council Community Safety Team to develop guidance (7-minute briefing) for agencies on appropriate	Local	1. Guidance to be developed utilising best practice and most	**SC Community safety Team**	7-minute briefing available as part of the training modules as provided by SC	Oct 2025	

	Recommendation	Scope	Action	Lead Agency	Key Milestone	Target Date	Completion date/Outcome
	language when describing a victim of domestic abuse or sexual exploitation and agencies to ensure that professionals across the Safer Somerset Partnership agencies are provided with the guidance. *Ownership-Somerset Council Community Safety Team*		appropriate use of language. 7-minute briefing promoted to all agencies.				
8	*Recommendation Eight* Somerset Council Community Safety Team to ensure that the impact of economic abuse is included within its training modules and to ensure that cuckooing and organised crime are included as being relevant to domestic abuse. *Ownership -Somerset Council Community Safety Team*	Local	1. SC review the domestic abuse training modules to ensure that economic abuse, cuckooing and organised crime is included. 2. If subject areas are not available then the training modules are	**SC Community Safety Team**	Training module updated as required. Updated training is promoted to agencies and professionals Professionals have a better understanding of the impact of domestic aue cuckooing and organise crime on a victim of domestic abuse.	June 2025	

	Recommendation	Scope	Action	Lead Agency	Key Milestone	Target Date	Completion date/Outcome
			updated to include economic abuse, cuckooing and organised crime				
9.	*Recommendation Nine* SSP to continue to review and audit the updated MARAC procedures in Somerset, to ensure that MARAC referrals are discussed at a MARAC and decisions are recorded. *Ownership – Safer Somerset Partnership*	Local	1. SSP to continue to audit the MARAC monthly SSP to ensure that all domestic abuse cases referred to a MARAC are reviewed	**SSP**	Professionals are utilising the MARAC process to provide a multi-agency response to a victim of domestic abuse.	Ongoing	
10	*Recommendation Ten* Somerset Council Community Safety Team to ensure that within its training module that children are included as being relevant to domestic abuse. *Ownership – Somerset Council Community Safety Team*	Local	1. Update SC training module to reflect children being the victim of domestic abuse 2. Promote the module to	**SC Community safety Team**	Professionals understand that children are victims of domestic abuse in their own right- Domestic Abuse Act 2021		Completed 2024

	Recommendation	Scope	Action	Lead Agency	Key Milestone	Target Date	Completion date/Outcome
			agencies and professionals.				
11	*Recommendation Eleven* Safer Somerset Partnership to request that the Home Office in partnership with other government departments identify how agencies can embed trauma informed practices within their professional practice. This to include social workers, health practitioners, police and probation. *Ownership -Safer Somerset Partnership*	National	1. Letter sent by SSP requesting the HO to review the request	**SSP**	Letter sent to Home Office	Dec 2024	Complete

Appendices B: Home Office Quality Assurance Feedback Letter

Home Office

Interpersonal Abuse Unit
2 Marsham Street
London
SW1P 4DF

Tel: 020 7035 4848
www.homeoffice.gov.uk

Heidi Hill
Project Change & Improvement Officer
Somerset Council
County Hall
Taunton
TA1 4DY

28th May 2025

Dear Heidi,

Thank you for submitting the Domestic Homicide Review (DHR) report (Libby) for Safer Somerset Partnership to the Home Office Quality Assurance (QA) Panel. The report was considered at the QA Panel meeting on 30th April 2025. I apologise for the delay in responding to you.

The QA Panel praised the report's empathetic tone and the respectful language used throughout. The tributes from the victim's mother and contributions from her friends provided a strong picture of her and her life as a daughter, mother and friend. The report is thorough and thought provoking and highlights the importance of multiagency working and collaboration. There is evidence of good practice being followed, including Libby's family and friends being supported by a Victim Support advocate, and support from GPs and the Police.

The QA Panel felt that there are some aspects of the report which may benefit from further revision, but the Home Office is content that on completion of these changes, the DHR may be published.

Areas for final development:

- Friends of Libby should be represented by pseudonyms consistently.

- Anonymity is compromised in some places and these references require amendment, for example.
  - at 3.17.1 the exact date of death is used
  - page 27 of the Executive Summary (Section 3, bullet point 7) contains the victim's surname.

- It is unclear how the Terms of Reference relating to DHR 039 on pages 33 to 38 in the Executive Summary relate to the subject's case. This may need removing.

- The report mentions that Libby had predicted her death and said that she was thinking of leaving the relationship. Please clarify where this information came from.

- The report requires a thorough proof-read to address some grammatical and formatting errors.

Once completed the Home Office would be grateful if you could provide us with a digital copy of the revised final version of the report with all finalised attachments and appendices and the weblink to the site where the report will be published. Please ensure this letter is published alongside the report.

Please send the digital copy and weblink to DHREnquiries@homeoffice.gov.uk. This is for our own records for future analysis to go towards highlighting best practice and to inform public policy.

The DHR report including the executive summary and action plan should be converted to a PDF document and be smaller than 20 MB in size; this final Home Office QA Panel feedback letter should be attached to the end of the report as an annex; and the DHR Action Plan should be added to the report as an annex. This should include all implementation updates and note that the action plan is a live document and subject to change as outcomes are delivered.

Please also send a digital copy to the Domestic Abuse Commissioner at DHR@domesticabusecommissioner.independent.gov.uk

On behalf of the QA Panel, I would like to thank you, the report chair and author, and other colleagues for the considerable work that you have put into this review.

Yours sincerely,

Home Office DHR Quality Assurance Panel