Domestic Homicide Review:

Executive summary:

Concerning the Death of Ben

(December 2018)

Contents

1. The Review Process

This review is initiated by the homicide of Ben, who was stabbed and killed by his partner Amy in December 2018. This took place during a violent assault by Ben on Amy. In any review it is important to try to understand the victim and this important perspective is often given by those who were close to them, the family and friends. In this case Ben's mother, sister and son were all met and discussed the case.

Ben was the oldest of four children. He grew up not knowing his father who left the family home before he was born. When he was aged 5, he was involved in a very serious car accident and spent over 6 months in hospital. It was not believed that Ben would survive his serious injuries. Although Ben recovered, his mother was told that he had a mental age below his years whilst he was at senior school. Ben is described, by his mother, as a 'normal' child and teenager.

Ben had a number of relationships over the years and was the father of 5 children and one other child who he treated as his own. His mother would say that there was turbulence in the early relationships, but no more than you might expect. More recently, Ben formed a relationship with Amy, and they moved in together. Amy had two children when their relationship started, these were Child A and Child B. Amy was not, in fact, the biological mother of these children but assumed the role of mother as the result of a Child Arrangement Order, previously initiated whilst she lived in a different area. This was not known to family members and there was only limited knowledge in agencies involved with the family.

Ben's family would describe Amy as a strong character, they were aware that both Ben and Amy drank alcohol every day and this, on occasions, fuelled conflict in their relationship. Both were involved in the use of controlled drugs, which they would take in the home. There was a period when Ben was estranged from Amy and during this time the family would say that to a large extent Ben was able to manage his alcohol and drugs use more and was seeking support from services for this.

After Ben's death, it was reported and referred by the police to the Fenland Community Safety Partnership in January 2019. The death was also referred to the HM Coroner.

The chair of the FCSP determined that a domestic homicide review was necessary in accordance with the 2016 Home Office statutory guidance for multi-agency domestic homicide reviews. Statutory agencies were duly notified of the requirement to identify and secure relevant material.

2. Contributors to the review

This report has been compiled based on the comprehensive Individual Management Reviews (IMRs) prepared by authors from the key agencies involved in this case and other relevant agency information, where IMRs have not been required. Each IMR author is independent of the victim, family of the victim and of management responsibility for the practitioners and professionals who have been involved in this case.

3. Agencies involved

- East Anglian Ambulance Service Trust (EAAST)
- Cambridgeshire Constabulary
- Cambridgeshire and Peterborough Clinical Commissioning Group – on behalf of involved GP Practices
- Cambridgeshire and Peterborough Foundation Trust (CPFT)
- Queen Elizabeth Hospital NHS Trust, Kings Lynn
- Fenland District Council Housing Services
- Inclusion/CGL Drug and Alcohol Services
- Cambridgeshire County Council, Children's Services
- Head Teachers of Children's school
- Cambridgeshire Education Authority
- Cambridgeshire County Council Adult Safeguarding
- Cambridgeshire and Peterborough Independent Domestic Violence Advisor (IDVA) services
- Lincolnshire Community Safety Partnership

3. The Review Panel Members

The following individuals and agencies comprise the DHR panel or have acted in an advisory capacity to the panel and independent chair. They are independent of the case being reviewed. The panel met on three occasions and there was ongoing and effective liaison and communication between the formal panel meetings.

Name	Agency	Role
Deidre Reed	Independent domestic abuse advisor to panel	Operational IDVA Manager
Mandy Geraghty	Independent domestic abuse advisor to panel	Refuge Service Manager
Selina White	Independent Advisor on substance misuse	Safeguarding Lead CGL
Tracey Martin Sarah Gove	Fenland Housing	Lead Housing Officers
James Bambridge Laura Koscikiewicz	Cambridgeshire Constabulary	Review Officer Head of Public Protection
Paul Collin	Cambridge and Peterborough NHS Foundation Trust (CPFT)	Head of Adult Safeguarding
Julia Cullum	Cambridgeshire County Council	Domestic Abuse and IDVA service
Carol Davies/Linda Coultrup	Cambridgeshire and Peterborough Clinical Commissioning Group	Designated Nurse/ Lead Nurse Safeguarding Adults

Caroline Sexby	East of England Ambulance Service NHS Trust	Safeguarding Lead
Jerry Green Tracey Denny	Queen Elizabeth Hospital Kings Lynn	Safeguarding Leads
Chris Meddle	Cambridgeshire County Council	Senior Leadership Advisor Education Services
Alan Boughen	Fenland District Council	Community Safety Partnership / Manager
Helen Duncan	Cambridgeshire County Council and Peterborough City Council	Head of Adult Safeguarding/Principal Social Worker
Jitka Kohoutova	Cambridgeshire County Council and Peterborough City Council	Team Manager Children Services
Jon Chapman	Independent	DHR Chair and report Author

4. Author of the overview report

The Independent chair and overview author, Mr Jon Chapman, is provided by RJW Associates.

Mr Jon Chapman is a retired senior police detective and senior investigating officer. He was formerly the head of the Public Protection Department of the Hertfordshire Constabulary. He is also the Independent Chair of several Child Safeguarding Practice Reviews. He has extensive experience in partnership working within safeguarding environments and authoring Serious Case Reviews. He also has significant experience in conducting Domestic Homicide Reviews, MAPPA reviews and other safeguarding practice reviews, having authored numerous reviews across the country.

Mr Chapman is the independent safeguarding advisor to the Diocese and Cathedral of Ely. He was also the Chair of Trustees to a Charity involved in providing refuge and outreach work to survivors of domestic abuse.

Mr Chapman and RJW Associates have no connection with the Fenland Community Safety Partnership.

5. Terms of reference for the review

The panel set terms of reference for the review, including the timeframe to be focused upon, although the panel was aware of the necessity to understand the background and context of the relationships and how these impacted on the current circumstances of the review. The timeframe of the review was from the 1st January 2011 to 31st December 2018.

a) Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims.

b) Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result.
c) Apply these lessons to service responses, including changes to inform national and local policies and procedures, as appropriate.
d) Prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity.

In addition, the panel wished to explore two other areas.

a) To what extent was the misuse of alcohol an issue in this DHR?
b) What extent were the children affected by the domestic abuse in the household?

6. Summary chronology

Both Amy and Ben had been involved in a number of relationships before they met, with Amy also being involved in a relationship with another man, since they had met.
In so far as the commencement of the relationship between Ben and Amy is concerned, this is believed to have started during the latter part of 2015.

There are several what appear to be domestic related incidents involving Ben with his partners at the time and also with Amy and her partners at the time. Ben had a relationship with Laura, who disclosed a history of domestic abuse and violence perpetrated by Ben.

Amy was known to agencies, primarily as a victim of domestic abuse.

In the latter part of 2015, Ben and Amy formed a relationship, although it would appear that Ben was still also involved with Laura.

There was a domestic incident between Amy and Ben in February 2017. In May 2017, the school that Child A attended was concerned as they had not been in school. Staff from the school attended the family address and were concerned regarding what they described as the very poor condition of the house. The police were informed and also attended and recorded that there were no safeguarding concerns.

In July 2017, both Amy and Ben were fined in the Magistrates Court as a result of proceedings for Child B's poor attendance at school.

During May 2018, Ben sought support for his alcohol abuse, he disclosed that he had been drinking significant amounts of alcohol each day. He also disclosed that Amy was being treated for cancer and that there had been a physical altercation between Amy and him the previous Christmas, although the severity of this was not disclosed.

At the beginning of September 2018, there was a fire outside Amy's address involving a mattress. Amy stated that she suspected Ben of being responsible for the fire as they had split up about four weeks earlier and she was now in a relationship with Paul. No DASH assessment was submitted in relation to this incident.

Amy disclosed to police that at Christmas 2017, Ben had assaulted her by punching her in the face. Ben's mother had witnessed the early part of the verbal argument, but the assault took place upstairs. Police were not informed at the time, but Amy did take photos on her phone and these were viewed by the review panel. They are very similar injuries to those sustained by Amy during the dispute which led to this review.

The police recorded the offence against Ben as common assault, for which there is a statutory time limit on prosecution of 6 months. Therefore, the case was not progressed due to the time elapsed between the event and the report and Ben was not interviewed for the offence.

The incident was notified to both the GP and Children Social Care (CSC). As a result, CSC visited the family in September and October 2018, there was no full narrative of these visits and there seemed to be some confusion over which of Amy's partners the domestic abuse risk related to.

At the beginning of October 2018, Paul contacted Cambridgeshire Police stating that he had been punched and bitten in an assault on him by Amy. Amy then came to the phone making a counter allegation and further calls were received from a neighbour and from Child B, who stated that Paul had broken into the house. Paul was arrested, however no prosecution ensued. A Multi-Agency Safeguarding Hub (MASH) referral was made by the police and records show that Amy's GP received a MASH safeguarding referral on the same date.

Just over a week later, police officers attended a reported disturbance at Amy's address. On attendance Amy informed officers that there was no dispute, but she was struggling with the recent deaths of her brother and sister and that Ben was there assisting Amy in coping with her issues. In short, Ben was back in the household within a week of Paul having left. Neighbours indicated that there had been no disturbance, however it was established that Amy was on the phone to mental health services at the time and for that reason officers chose to alert other agencies by making an adult at risk referral for Amy as opposed to a DASH referral.

At the end of October 2018, the single agency assessment was concluded by CSC. There was confusion over whether the assessment was focusing on the previous relationship with Ben and the historical assault or the current relationship with Paul. Amy indicated that she had since ended the relationship with Paul and on this basis the assessment was closed. Wider consideration to the continuing pattern of domestic abuse in relationships and the impact on the children was not given. Amy accepted that professionals had concerns about her partner and she was advised of accessing Clare's Law to gain information about his offences. Amy advised the CSC that she had worked with the police to ensure that her previous partner did not return to the home and had formulated a safety plan for Child A and Child B.

CSC reported that Child A was being referred to CAMH for assessment. Both children were reported to have witnessed the behaviour between Amy and Paul and neighbours also supported this perspective. However, both Child A and Child B were spoken to, but made no disclosures or mentioned anything that was worrying them at home.

In November 2018, Ben's mother contacted Cambridgeshire Police with concerns for the welfare of Ben, his partner and children. This appears to have stemmed from an incident that followed on from Christmas Day in December 2017, when Ben assaulted Amy and which, since that time, his mother

had not spoken to him. The mother had seen Ben in the town centre, and he had approached her in a threatening and confrontational manner, causing a member of the public to intervene. Ben was seen by officers but denied any wrong-doing and as his mother would not support any action, the incident was closed. On the same day, it was alleged that Ben caused some damage to another member of his family's home, which may possibly have been linked to the earlier incident involving his mother. There was no evidence against Ben and the matter was closed without further investigation.

In December 2018, the incident that led to Ben's death occurred.

7. Keys issues arising from the review

Amy has been in relationships with different men and appears to have been involved in several domestic abuse incidents with her partners. On examination of those instances, she was the victim of domestic abuse with these partners.

A real concern for Child A was their poor rate of attendance at school. A number of letters were sent, meetings arranged, and referrals made up to the date of the incident in December 2018. Most of these appear to have been ignored by Amy and Ben. Child A's attendance did not improve until they became a 'Looked after Child' (which was after the death of Ben). However, the school did follow Local Authority and Education Welfare Service guidance and protocols to follow up on this in the appropriate way.

During Child A's time at Primary School, staff had no awareness of any parental issues relating to Ben's alcoholism, depression, anxiety or anger management. They were unaware that support was in place for Ben or that there was any multi-agency involvement in the form of the Drug Counselling Team or the Inclusion Drug and Alcohol Team with Ben. It also appears that the school had no idea that there had been Social Care involvement with the family, or that Amy suffered depression and allegedly had cancer. In fact, the Primary School had not been made aware at any point that Child A was subject to any kind of Child Arrangement Order via another County or that the people presenting as Child A's parents were not in fact the biological parents. This information did not come to light for the school until after the fatal incident in December 2018.

The Primary School reports that both Amy and Ben always presented well when staff saw or spoke with them and they referred to themselves as Child A's 'Mum and Dad'. Amy regularly collected Child A from school, although not punctual but nevertheless did collect Child A and Child A always appeared happy to see her. After a time, Child A's sibling Child B began collecting Child A from school, walking home together with friends. Child A appeared to be equally happy with this arrangement.

Child A rarely talked about Ben, referring most often to 'Mum and Child B' during general discussions. Neither Amy nor Ben attended parents evening or came to school events. Primary School staff did not identify any signs of Domestic Abuse.

By the time Child B began attending the Secondary School in February 2016, they had already attended at least five other schools in two counties.

At the time of transfer to Secondary School, the school were not informed of any concerns relating to Amy or Ben, their physical and mental health, support from other agencies or their 'actual/non-biological' relationship to Child B. They were also unaware of input from Social Care or that Child B was subject to any kind of Child Arrangement Order. Like the Primary Schools, staff had no reason to believe that both Amy and Ben were not Child B's biological Mother and Father. Similarly, they were 'in the dark' with regards to any Domestic Violence, until it was brought to their attention at the point of the MASH referral made in September 2018 concerning the December 2017 alleged assault on Amy by Ben.

As with Child A, a significant concern for Child B was around their very poor attendance at school. A full range of attendance letters were sent to Ben and Amy, home visits were made, meetings set up and ultimately a court summons was issued. Throughout, Amy and Ben ignored these communications and Child B's attendance actually became worse.

In September 2018, the Cambridgeshire MASH Team called the school in relation to a referral about Amy's alcohol use and her relationship with the male in the home. The Local Authority Designated Safeguarding Lead contacted school staff regarding Child B's presentation and engagement and it was reported that they were in school at that time, looking relaxed, happy and well dressed.

Examination of the referrals made concerning domestic violence, shows there does appear to have been good communications between the agencies when DASH referrals were made by the police. The incident in September 2018, where there was a mattress fire at Amy's address, and she suspected Ben, should have initiated a DASH assessment. Amy also disclosed that she had been texted and followed by Ben. A DASH assessment would have put more multi agency focus on the incident. The incident should also have been more tenaciously followed up with interview and accounts from Ben.

Cambridgeshire Children's Services engaged with Amy and the children in September 2018, (arising from the December 2017 report in respect of Ben) and then again in October 2018 (arising from the report involving Paul). The CSC IMR author makes the observation that there was no assessment made in September from the visit but that the case remained open but was then closed following the latter incident involving Paul. Effectively this meant that the future risk for the children in respect of Amy's relationships was not considered, however the children's voices were heard concerning their apparent fear of Amy's partner. The assumption is that this related to Ben, but no name was recorded within the assessment. Effectively, the relationship between Amy and Ben was assumed to have been over but this was not effectively explored.

The CSC IMR is clear that domestic violence (DV) guidance was not followed by their practitioners, there was no DV risk assessment, no capacity to change assessment with a clinician and no direct work with the children around their experiences of DV. The review notes, there was in general terms, a lack of a multi-agency approach and no child in need planning and a lack of exploration of the children's lived in experience.

When looking at the wider picture there has been little, if any, joined up activity. Where any single agency has raised concerns about Amy and the children it could have been addressed by more incisive partnership working. Amy and the children lived in a household that was frequently affected by domestic abuse and the children appear to have been affected by living within such an environment.

There is little doubt that Amy was a repeat victim of domestic abuse at the hands of a number of different partners. In the case of both Ben and more recently with Paul, alcohol misuse has played a significant part in those relationships, and there is a clear inference that both the December 2017 assault on Amy and the December 2018 incident, were predicated by Ben and that the abuse of alcohol by him was a key factor. Although the family would say, that Amy would verbally antagonise situations. Whilst this review acknowledges the key subject of this review is Ben because he died in the incident, there can be little argument that Amy had suffered abuse from Ben in the previous 12 months, and professionals were not curious enough throughout to raise concerns about her and address the abuse with her. There was insufficient assessment and concern regarding the Child Arrangement Order and the risk that the ongoing domestic abuse presented to the children. There were a number of occasions when this should have been re-visited.

8. Conclusions

There are several issues to consider in line with the terms of reference which specifically relate to the children in Amy's care. This is an important consideration, given that they undoubtedly witnessed incidents within the household involving Amy and Ben and also other individuals involved with Amy.

There was the lack of knowledge and understanding by services within Cambridgeshire, that both children, Child A and Child B, were not Amy's biological children. Whilst this may not be a unique occurrence and the panel discussed this issue in some depth, there is a danger that assuming a biological parent/child relationship exists could lead to all safeguarding concerns and potential concerns not being fully considered.

Child A's poor attendance at primary school in April into May 2017, highlighted concerns and both the school and the police visited Amy's home to make enquiries as to Child A's welfare, albeit separately. The school noted that the home was in a "*very poor condition*", however there was no mention of this in the later police visit. Critically however, there were no referrals made to Children's Services by the school or the police which, given the circumstances, was an omission on the part of *both* services. Although the police IMR indicates that the officer attending the incident had '*no concerns'*, the fact that a visit was made in specific response to concerns raised by the school and there were opposing views, a safeguarding referral should have been made by both the school and the police. The police IMR indicates that just some 3 minutes attendance time was taken by the attending officer to the report. This must have been a superficial visit and lacked proper professional curiosity.

The Cambridgeshire County Council Children's Services IMR does also highlight that in reviewing their records of the family, that there was not a multi-agency approach throughout. At no time was there any child in need (CIN) planning and the children's lived experiences were not captured. The author of the IMR from Children's services states; *"In my view Children Social Care could have explored the relationship of [Amy] and [Ben] more. We could have considered [Amy's] future partners and the effect on the children who were displaying behaviours of living in a DV household".*

The serious assault on Amy allegedly inflicted by Ben in December 2017 went un-reported until some nine months later, in September 2018. By this time, the police quite correctly recorded the alleged assault as a crime. However, as there was seemingly no independent medical evidence for

what was alleged as Amy having suffered a broken nose and no other witnesses were seen by the investigating officer, the matter was closed as the time limitations for what was deemed to be a 'common assault', is limited to six months from the date of the offence. Photographs of Amy's injuries had been taken and a DASH risk assessment undertaken. However, both the police IMR author and the panel expressed a view that whether this was 'time barred' was a decision that should have been taken by the Crown Prosecution Service, bearing in mind the level of injury clearly seen on the photographs. Pre-judging the outcome before the case was fully investigated resulted in a premature closure of the investigation. The recording of the offence as a common assault limited the period for prosecution and also limited the action that could be taken. Had the crime been recorded as an assault occasioning actual bodily harm, which the evidence supported, there would have been no such limitations and the offence could have been more fully investigated.

There are two recorded incidents where Ben is accused of strangling partners during domestic incidents, Laura in August 2016 and Amy in October 2016. This is also the account given by Amy when she stabbed Ben, that she was being strangled. There is significant evidence that non-fatal strangulation is an important risk factor. This has been recognised after some determined campaigning and will become a specific recognised offence as a result to an amendment to the Domestic Abuse Bill and was announced on 1st May 2021[1].

There have been several occasions when the police's attendance at incidents involving Amy at her home address did not present a fully informed set of circumstances. Police officers are frequently on the front-line in the recognition and identification of safeguarding concerns and it is imperative that officers are confident of whom they are communicating with and who are present within a household, in particular when the inference is of domestic abuse and children are known or understood to be present.

Looking at what life was like in the family from the agency reports, the review author is unable to state that there was ever an incisive or clear view of what the family environment was like at Amy's home. No single agency has been able to present a perspective of this, which leaves significant gaps in knowledge and understanding. It is apparent that several agencies have made comment concerning the individuals, but this has tended to be at a particular time, rather than observations looking at the wider context and gaining a clearer understanding of the underlying issues.

9. Lessons to be learned

Agencies should ensure that where referrals take place to other statutory agencies for safeguarding concerns involving children, that an individual safeguarding referral is made to Children's Services. This will ensure that Children's services are able to make an independent assessment of the information as a whole.

This review is far from unique in respect of how professionals have lacked professional curiosity on occasions. This is not peculiar to any single agency as each statutory agency has not displayed this on different occasions. Amy's and the children's situation did not initiate any coordinated multi agency

[1] Domestic Abuse Bill amendments - https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/965820/Lord_Rosser_DA_Bill_Letter_01.03.21.pdf
(accessed 8th March 2021)

approach. For example, although the serious assault on Amy by Ben in December 2017 went un-reported for some nine months, the seriousness of that allegation was not recognised. The matter was filed by the police without action, a more enquiring approach could have established circumstances to initiate a referral to MARAC under professional judgement.

What is not clear is which agencies knew of the 'arrangement' for Amy to have care of both Child A and Child B. There certainly appears to be a complete lack of information shared by the external local authority to Cambridgeshire. Amy informed the IDVA service in 2014 that the children were hers from a previous relationship. Police and IDVA service records thereafter indicate that Amy had parental responsibility for the children but at no stage was the parental situation clarified. Amy's complex relationships and the lived experiences of the children have therefore not been identified fully to key agencies, where the background information about them may have triggered additional questions to be raised and agency referrals made.

Good recognition of concerns by the inclusion service to child safeguarding in May 2018 following disclosures made by Ben was identified, discussed with managers and passed to Children's Services. This was regarding the 'physical altercation' and concerns in respect of alcohol abuse being witnessed by Child B. These concerns could have extended to the exploration of potential abuse or conflict in the relationship.

The partnerships in Cambridgeshire need to consider what the offer is for persons, in particular, men who seek support when they or others identify that they are subjecting others to domestic abusive or controlling and coercive behaviour.

10. Recommendations from the review

1. The Fenland Community Safety Partnership should ensure that they compile a list of all agencies that are operating or can provide domestic abuse services within their area. They should make this list available to their partnership, so agencies are aware of what services are available to support victims of domestic abuse and that victims are appropriately referred to them.

2. The Cambridgeshire and Peterborough Domestic Abuse Partnership should consider what the offer is to those who subject others to domestic abuse or coercive behaviour and want support to address their behaviour.

3. The Fenland Community Safety Partnership should seek assurance from Cambridgeshire Children Services and Cambridgeshire Constabulary that: -
    - Appropriate cases are referred to MARAC.
    - That high risk cases coming into MASH are referred in a timely fashion.

    From Cambridgeshire Children Services

    - That where cases of domestic abuse are discussed at safeguarding meetings that IDVA services are represented where possible.

4. The Fenland Community Safety Partnership should seek assurance from Cambridgeshire Children Services.

   i) that when Domestic Abuse and its damaging effects are recognised, that there is an effective assessment undertaken and effective multi-agency plan put in place to support children according to risk being presented when thresholds are met, in particular those identified as high and medium risk.

   ii) that record keeping in similar cases, includes within the narrative sufficient detail to ensure it is clear who the perpetrator of the domestic abuse is.

5. The Fenland Community Safety Partnership should seek assurance from Cambridgeshire Constabulary that the recording and investigation of domestic abuse offences is appropriate to be able to support and sustain a prosecution and will not be limited by statutory limitations, as was the case with the December 2017 assault and that the following investigation is effective.

6. The Fenland Community Safety Partnership should write a practice note to make all agencies aware of the provisions of the Domestic Abuse Disclosure Scheme and ensure that due consideration is given to it when there are previous instances of domestic abuse. Further awareness should be considered to coincide and complement the Domestic Abuse Bill 2020.

7. The Fenland Community Safety Partnership should consider convening with their partners a practitioner event across the Fenland area for professionals and agencies using this case to highlight the effect of alcohol and coercive and controlling behaviour and domestic abuse.

8. The Fenland Community Safety Partnership should seek assurance from Cambridgeshire County Council Education Safeguarding Team that they have or will provide advice that at the student intake process, it includes an enquiry as to the status of the parent/carer/guardian and to establish if there are any care or guardianship orders in place.

9. The Cambridgeshire Clinical Commissioning Group should brief health practitioners that when they identify or are informed about substance misuse and/or anger management issues, in a patient, this should trigger professional curiosity regarding the potential for domestic abuse in the household.

10. Fenland CSP and County DASV Partnership should ensure the impact of alcohol and its links to domestic abuse still forms part of any awareness raising events and they reflect current best practise and provides practitioners with the tools to identify alcohol related domestic abuse and the ability to sign post perpetrators to appropriate support services.

11. The Fenland Community Safety Partnership should be assured that where CGL Drug and Alcohol Services receive a disclosure regarding domestic abuse that a referral is made to domestic abuse services.

12. The Fenland Community Safety Partnership should work with the Domestic Violence Strategic Partnership to highlight the risk of non-fatal strangulation and use this case to initiate training and awareness of the new offence and how this will feature in risk assessment.